

**REPORT OF THE BOARD OF DIRECTORS**

1  
2  
3 Subject: Maintenance of Licensure

4  
5 Referred to: Reference Committee  
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**Summary**

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10 In May 2009, the Federation of State Medical Boards (FSMB) House of Delegates  
11 directed FSMB to pursue the following scope of work and report back to the House of  
12 Delegates at the FY2010 annual business meeting:

- 13
- 14 • Conduct, collect and disseminate research on and give additional consideration to  
15 the evidence for the need for initiating an MOL program and the effects of such a  
16 program on patient care and physician practice.
- 17 • Conduct further analysis of outstanding issues which surfaced as a result of the  
18 MOL impact analysis report and state medical board and other stakeholders  
19 feedback to this report;
- 20 • In collaboration with appropriate stakeholders, develop recommendations for how  
21 MOL, maintenance of certification, and other continuous improvement activities  
22 could be aligned to support state medical boards in achieving a regulatory system  
23 that assures the public of a physician's competence while minimizing duplication  
24 and burden on the physician community;
- 25 • In collaboration with appropriate stakeholders, support/fund one or more pilot  
26 projects centering on issues relevant to MOL discussions;
- 27 • Actively engage state medical boards, the public, physicians and other  
28 stakeholders in discussions about MOL and solicit their input in the evolution and  
29 development of related policy recommendations.
- 30

31 Attached are reports commissioned by the FSMB Board of Directors over the past year to  
32 carry out that charge, specifically the report of the Impact Analysis Taskforce  
33 (Attachment 3) and the report of the Advisory Group on Continued Competence of  
34 Licensed Physicians (Attachment 4).

35  
36 The Impact Analysis Taskforce report is a continuation of work originally conducted by  
37 the Taskforce in response to a directive from the FSMB House of Delegates in 2008. The  
38 report focuses on evaluation of specific issues related to implementation of maintenance  
39 of licensure (i.e., licensed physicians not in active clinical practice, non-compliant  
40 physicians and unintended consequences of maintenance of licensure implementation)  
41 and includes methodologies for how licensing authorities might approach each of these  
42 areas when determining how best to implement maintenance of licensure requirements  
43 within their jurisdictions.  
44

45 The Advisory Group Report (page 77) proposes revisions to the maintenance of licensure  
 46 framework and recommendations that had been presented in the Report of the Special  
 47 Committee on Maintenance of Licensure in February 2008 (Attachment 1). The Advisory  
 48 Group Report concludes that the framework, as revised, is feasible, reasonable, consistent  
 49 with the guiding principles adopted by FSMB's House of Delegates in May 2008, and is  
 50 suitable for use by state medical boards in assuring the continued competence of licensed  
 51 physicians, and recommends that the modified framework and recommendations be  
 52 adopted by the FSMB.

53

## 54 **Background**

55

### 56 *Special Committee on Maintenance of Licensure*

57

58 The Special Committee on Maintenance of Licensure (Special Committee) was convened  
 59 in May 2003 by then FSMB chair Thomas D. Kirksey, MD, and charged to develop a  
 60 position statement regarding the responsibility of state medical boards in ensuring  
 61 physician competence over the course of his/her career; and further, to develop strategies  
 62 for state medical boards to use in implementing programs to ensure physicians maintain  
 63 an appropriate level of competence to practice medicine safely throughout their  
 64 professional careers.

65

66 In May 2004, the Special Committee issued an interim report that resulted in the FSMB  
 67 House of Delegates adopting the following statement as official FSMB policy:

68

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

71

72 A second interim report outlining the conceptual challenges associated with  
 73 implementing maintenance of licensure requirements was submitted to the House in May  
 74 2005.

75

76 The Special Committee issued a draft of its final report (**Attachment 1**) to the FSMB  
 77 Board of Directors in February 2008. In the report the Special Committee recommended  
 78 that state medical boards require physicians seeking relicensure to periodically  
 79 demonstrate competence within the scope of their professional practice. Such  
 80 requirements should include the following elements or expectations:

81

- 82 • Participation in an ongoing process of reflective self-evaluation, self-assessment  
 83 and practice assessment, with subsequent successful completion of educational  
 84 activities tailored to meet the needs or deficiencies identified by the assessment.
- 85
- 86 • Demonstration of continued competence in the following areas: medical  
 87 knowledge, patient care, practice-based learning and improvement, interpersonal  
 88 and communication skills, professionalism, systems-based practice and, if  
 89 applicable, osteopathic philosophy and osteopathic manipulative medicine;

90 including the knowledge, skills and abilities to provide safe, effective patient care  
 91 within the scope of their professional medical practice.

- 92  
 93 • Demonstration of accountability for performance in practice.  
 94

95 The Special Committee also recommended that licensees provide documented evidence  
 96 of compliance with these requirements, and that state medical boards provide guidance to  
 97 licensees as to the types of evidence deemed acceptable (e.g., active participation in  
 98 maintenance of specialty board certification processes or participation in recognized  
 99 quality improvement activities).

100

101 In considering the Special Committee's report, the FSMB Board of Directors took into  
 102 account feedback on the report from state medical boards and other key stakeholder  
 103 groups. Concerns primarily centered on the potential impact of such requirements on  
 104 state medical boards, the physician workforce and other stakeholders, as well as the  
 105 desire for evidence about the impact and benefit of maintenance of licensure on physician  
 106 practice and patient care. There was additional concern from state boards and physicians  
 107 about the Special Committee's recommendation that state medical boards should mandate  
 108 that component 2 (above) of the proposed maintenance of licensure requirements be met,  
 109 at least in part, by passage of a valid, secure, proctored examination in the physician's  
 110 current practice area at least once every 10 years.

111

112 Subsequently, in May 2008, the FSMB House of Delegates approved the Board of  
 113 Directors' recommendation that, prior to taking any action on the report of the Special  
 114 Committee on Maintenance of Licensure, FSMB engage in further evaluation to better  
 115 understand how implementation of the proposed maintenance of licensure requirements  
 116 will impact state medical boards and other stakeholder groups. The House further  
 117 directed that the results of this analysis be reported back to the House at its 2009 meeting.  
 118 The House of Delegates also adopted the following five Guiding Principles as official  
 119 FSMB policy to serve as a framework for guiding future FSMB activities related to  
 120 maintenance of licensure:

121

- 122 • Maintenance of licensure should support physicians' commitment to lifelong  
 123 learning and facilitate improvement in physician practice.  
 124 • Maintenance of licensure systems should be administratively feasible and should  
 125 be developed in collaboration with other stakeholders. The authority for  
 126 establishing maintenance of licensure requirements should remain within the  
 127 purview of state medical boards.  
 128 • Maintenance of licensure should not be overly burdensome for the profession and  
 129 should not hinder physician mobility.  
 130 • The infrastructure to support physician compliance with maintenance of licensure  
 131 requirements must be flexible and offer a choice of options for meeting  
 132 requirements.  
 133 • Maintenance of licensure processes should balance transparency with privacy  
 134 protections.  
 135

136 *Impact Analysis*

137

138 In October 2008, FSMB convened a taskforce of representatives from 13 state medical  
 139 boards to fulfill the House of Delegate's directive to evaluate the impact of maintenance  
 140 of licensure on state medical boards and other stakeholders. The Impact Analysis  
 141 Taskforce concluded that the model framework outlined in the Special Committee's  
 142 report appeared to be the most feasible with regard to minimizing impact and cost on  
 143 state medical boards and practicing physicians.

144

145 In its report (**Attachment 2**), the Taskforce recommended that state medical boards move  
 146 forward in a timely manner and use a consistent model in implementing maintenance of  
 147 licensure requirements, but also recognized that the ultimate decision of whether and how  
 148 to implement maintenance of licensure requirements up to each individual state medical  
 149 board. The report also highlighted a number of systems elements that will be critical to  
 150 minimizing burden on both states and physicians, and recommended removing physician  
 151 barriers by shifting towards quality improvement methods and away from "high states,  
 152 high risk exams." The report suggested that if the purpose of maintenance of licensure is  
 153 to improve physician practice and facilitate lifelong learning, passage of a high stakes  
 154 exam should not be mandated but rather offered as one of several options a physician can  
 155 use to demonstrate competence in his or her scope of practice.

156

157 Based on state medical board feedback on the Impact Analysis Taskforce report, in 2009  
 158 the FSMB Board of Directors recommended to the House of Delegates that FSMB pursue  
 159 the following scope of work and report back at the 2010 House of Delegates meeting.  
 160 The Board's recommendations were adopted by the House of Delegates in May 2009.

161

- 162 • Conduct, collect and disseminate research on and give additional consideration to  
 163 the evidence for the need for initiating a maintenance of licensure program and  
 164 the effects of such a program on patient care and physician practice.
- 165 • Conduct further analysis of outstanding issues which surfaced as a result of the  
 166 maintenance of licensure impact analysis report and state medical board and  
 167 other stakeholders feedback to this report;
- 168 • In collaboration with appropriate stakeholders, develop recommendations for how  
 169 maintenance of licensure, maintenance of certification, and other continuous  
 170 improvement activities could be aligned to support state medical boards in  
 171 achieving a regulatory system that assures the public of a physician's competence  
 172 while minimizing duplication and burden on the physician community;
- 173 • In collaboration with appropriate stakeholders, support/fund one or more pilot  
 174 projects centering on issues relevant to maintenance of licensure discussions;
- 175 • Actively engage state medical boards, the public, physicians and other  
 176 stakeholders in discussions about maintenance of licensure and solicit their input  
 177 in the evolution and development of related policy recommendations.

178

179 In summer 2009, the FSMB reconvened the Impact Analysis Taskforce to consider and  
 180 address the following issues in relation to maintenance of licensure: licensed physicians  
 181 not in active clinical practice, non-compliant physicians and unintended consequences of

182 maintenance of licensure implementation. The conclusions of the Taskforce included the  
 183 following:

184

- 185 • The Special Committee’s recommendation to hold all licensees accountable for  
 186 meeting maintenance of licensure requirements is appropriate and in the public’s  
 187 interest.
- 188 • There should be a number of means by which physicians can meet maintenance of  
 189 licensure requirements. The inclusion of a high-stakes, secure exam should only  
 190 be one option among a variety of tools a licensee could use to comply with  
 191 maintenance of licensure requirements.
- 192 • Criteria will need to be developed for use by state medical boards in determining  
 193 whether a tool or program is acceptable for meeting maintenance of licensure  
 194 requirements.
- 195 • State medical boards need to gather data regarding licensees’ scope of practice  
 196 and clinical activity as part of the license renewal process.
- 197 • State medical boards may choose to implement such maintenance of licensure  
 198 requirements in a variety of ways in order to minimize the burden on non-  
 199 clinically active physicians.
- 200 • Determination of compliance with maintenance of licensure should be based on  
 201 whether the licensee is actively participating in the maintenance of licensure  
 202 process and provides evidence of participating in maintenance of licensure  
 203 activities at the time of license renewal. It should be left to the discretion and  
 204 purview of each individual state medical board to determine how to handle  
 205 licensees who are not in compliance with maintenance of licensure requirements  
 206 at the time of license renewal.
- 207 • Since maintenance of licensure is not yet in place, it is difficult to say definitively  
 208 what consequences could result from its implementation. However, it is  
 209 important to think through possible future scenarios so that states may be as  
 210 prepared as possible.

211

212 The full report on the Taskforce’s subsequent work also addresses issues such as the  
 213 administrative burden for state medical boards in implementing maintenance of licensure,  
 214 inappropriate use of physicians’ self-assessment and performance data, and the impact of  
 215 maintenance of licensure on the physician workforce. The report of the Taskforce’s  
 216 subsequent work is provided in **Attachment 3**, and serves as an addendum to the original  
 217 impact analysis report presented to the House of Delegates in May 2009.

218

#### 219 *Advisory Group on Continued Competence of Licensed Physicians*

220

221 To perform a comprehensive review and to make final recommendations to the Board of  
 222 Directors on the FSMB MOL initiative, the FSMB convened an Advisory Group on  
 223 Continued Competence of Licensed Physicians in fall 2009. The Advisory Group was  
 224 charged to issue an opinion to the FSMB Board of Directors concerning FSMB’s  
 225 Maintenance of Licensure initiative and more specifically, whether the framework  
 226 proposed in the report of Special Committee on Maintenance of Licensure for use by  
 227 state medical boards in assuring the continued competence of licensed physicians is

228 feasible, reasonable, consistent with the guiding principles adopted by FSMB's House of  
 229 Delegates in May 2008 and suitable for use by state medical boards in assuring the  
 230 continued competence of licensed physicians.

231

232 In carrying out this charge, the Advisory Group was asked to include in its consideration  
 233 and, where appropriate, provide input regarding:

234

- 235 • Review of the FSMB's work on maintenance of licensure, to include public  
 236 policies, reports, documents and any active engagement of state medical boards,  
 237 the public, physicians and other stakeholders in discussions about maintenance of  
 238 licensure and the solicitation of their input in the evolution and development of  
 239 related policy recommendations.
- 240 • Review of the available research and published literature concerning the evidence  
 241 for the need for initiating a maintenance of licensure program and the effects of  
 242 such a program as well as other quality improvement methodologies on physician  
 243 practice and quality care outcomes.
- 244 • Review of further analyses of any outstanding issues that surfaced as a result of  
 245 the maintenance of licensure impact analysis report and state medical board and  
 246 other stakeholders' feedback to this report
- 247 • In collaboration with appropriate stakeholders, review and /or develop  
 248 recommendations for how maintenance of licensure, maintenance of certification  
 249 and other continuous improvement activities could be aligned to support state  
 250 medical boards in achieving a regulatory system that assures the public of a  
 251 physician's competence while minimizing duplication and burden on the  
 252 physician community
- 253 • Review of any pilot projects supported/funded by the FSMB in collaboration with  
 254 appropriate stakeholders centering on issues relevant to the maintenance of  
 255 licensure discussions.

256

257 The draft report of the Advisory Group (**Attachment 4**) recommends continued FSMB  
 258 support of its five guiding principles for maintenance of licensure, but that the third  
 259 principle be modified slightly to emphasize the positive implications of maintenance of  
 260 licensure. Specifically, the Advisory Group recommends that the third guiding principle,  
 261 which reads, "Maintenance of licensure should not be overly burdensome for the  
 262 professional and should not hinder physician mobility," should be revised to read:  
 263 *Maintenance of licensure should not compromise patient care or create barriers to*  
 264 *physician practice.*

265

266 The Advisory Group also revised and updated the maintenance of licensure framework  
 267 proposed by the Special Committee on Maintenance of Licensure with the intent of  
 268 providing greater clarity, simplicity and options to the state medical boards. In particular,  
 269 the Advisory Group felt the maintenance of licensure framework and recommendations  
 270 should be revised to reflect current thinking in the area of continuous professional  
 271 development and to incorporate additional examples of tools physicians could use to  
 272 comply with the proposed maintenance of licensure requirements.

273

274 The Advisory Group was also very sensitive to concerns expressed by physicians, state  
275 boards and other stakeholders about the Special Committee on Maintenance of  
276 Licensure's proposed recommendation that physicians be required to comply with some  
277 part of maintenance of licensure through passage of a valid, secure, proctored  
278 examination at least once every 10 years. In addressing this concern, the Advisory Group  
279 also recognized that examinations are a valid means of evaluating physician knowledge  
280 and felt physicians should be able to meet some component of maintenance of licensure  
281 through passage of a practice-relevant examination, *if they so choose*. Therefore,  
282 following suggestions received through feedback on the Special Committee report and  
283 the work of the Impact Analysis Taskforce, the Advisory Group modified the Special  
284 Committee's recommendation that physicians be required to pass a high-stakes exam as  
285 part of the maintenance of licensure process to reflect, instead, that an examination  
286 should be only one of many options available to physicians.

287

288 After reviewing and revising the maintenance of licensure framework and  
289 recommendations proposed by the Special Committee, the Advisory Group concluded  
290 that the framework, as modified and proposed by the Advisory Group, is feasible,  
291 reasonable, consistent with the guiding principles adopted by FSMB's House of  
292 Delegates in May 2008 and suitable for use by state medical boards in assuring the  
293 continued competence of licensed physicians. Therefore, the Advisory Group  
294 recommends that FSMB support and adopt the revised maintenance of licensure  
295 framework and recommendations.

296

297 The report also includes recommendations for complementary strategies FSMB could use  
298 in launching the maintenance of licensure initiative.

299

### 300 *Feedback on Draft Advisory Group Report*

301

302 The FSMB Board of Directors accepted the Advisory Group's report for dissemination to  
303 state medical and osteopathic boards and other stakeholder organizations in December  
304 2009. The draft report was subsequently distributed for comment to FSMB's member  
305 boards and other external stakeholders. Additional feedback was sought through a  
306 January 2010 conference call with state medical boards; presentations to state boards and  
307 other stakeholders; and direct, one-on-one contact with individual state medical boards.  
308 FSMB also maintained and updated a maintenance of licensure resource area on its  
309 website.

310

311 Comments received from state medical boards and other stakeholders were  
312 overwhelmingly positive of both the recommendations contained in the Advisory Group  
313 work and the FSMB's efforts to pursue the maintenance of licensure initiative. Concerns  
314 from state boards focused primarily on:

- 315 • the administrative burden implementation of maintenance of licensure might have  
316 on state boards,
- 317 • what options would be available to physicians who are not specialty board  
318 certified, and

- 319 • how to address physicians who hold a license but are not – or are partially –
- 320 clinically active (i.e., how or would such physicians be required to participate in
- 321 the performance in practice requirement for maintenance of licensure).

322

323 Feedback from external stakeholders addressed issues such as:

- 324 • the appropriateness of using continuing medical education to meet maintenance of
- 325 licensure requirements,
- 326 • adding issues like cultural competency, interprofessional learning and electronic
- 327 health records within the maintenance of licensure framework,
- 328 • how clinically inactive physicians could meet the practice in performance
- 329 requirement,
- 330 • reciprocity of maintenance of licensure between states,
- 331 • making sure physicians are not negatively burdened as maintenance of licensure
- 332 is implemented (e.g., giving consideration to a phase-in approach to implementing
- 333 maintenance of licensure),
- 334 • the need to periodically review the criteria for complying with maintenance of
- 335 licensure and making sure that criteria remains flexible as new modalities are
- 336 proven effective, and
- 337 • the need for evidence to support the benefits of maintenance of licensure.

338

339 The Advisory Group subsequently met to review and consider the feedback in the  
 340 finalization of its draft report to the Board of Directors. Overall, the Advisory Group  
 341 agreed that the language in the report was accurate and appropriate and should remain  
 342 broad enough to encompass the varying needs and requirements of the individual state  
 343 medical boards. The report was subsequently presented to the FSMB Board of Directors  
 344 for approval. In reviewing the report, the Board of Directors agreed that, in  
 345 implementing maintenance of licensure, states should be careful not to impede physician  
 346 mobility and should strive for consistency in standards and requirements between states  
 347 to facilitate license portability and interstate licensure. The Board subsequently moved to  
 348 approve the report, as presented, for inclusion in this Board report to the House of  
 349 Delegates in 2010.

350

## 351 **Conclusions**

352

353 Maintenance of Licensure represents a change in how state medical boards evaluate the  
 354 ongoing qualifications of physicians applying for license renewal or re-registration. As  
 355 such, there has been much concern on the part of state boards, physicians and other  
 356 stakeholders about how to best structure a maintenance of licensure system and how  
 357 implementation of such a system will impact state boards and licensees. In response to  
 358 these concerns, the FSMB had agreed that, prior to taking further action on the report of  
 359 the Special Committee on Maintenance of Licensure, it would engage in further  
 360 evaluation of the proposed maintenance of licensure framework and the implications of  
 361 its implementation on state boards, physicians and other stakeholders.

362

363 Since 2008, the FSMB has been engaged in a variety of activities aimed at fulfilling these  
 364 directives, primarily through the work the Impact Analysis Taskforce and the Advisory

365 Group on Continued Competence of Licensed Physicians. The Advisory Group's report  
366 indicates support for the basic tenets of maintenance of licensure as proposed by the  
367 Special Committee on Maintenance of Licensure but includes specific revisions to reflect  
368 current thinking about the evaluation and assessment of physician competency and  
369 performance on an ongoing basis as part of a continuous professional development effort  
370 and to address concerns about the impact of implementation of maintenance of licensure  
371 on both state medical boards and physicians. The work of the Impact Analysis Taskforce  
372 also indicates support for the basic maintenance of licensure framework and provides  
373 suggestions for how state boards might address other issues such as physicians not in  
374 active clinical practice, non-compliant physicians and unintended consequences of  
375 maintenance of licensure implementation.

376  
377 The Board of Directors believes the findings of the Advisory Group on Continued  
378 Competence of Licensed Physicians and Impact Analysis Taskforce provide the most  
379 reasonable and feasible framework and recommendations to support state boards in  
380 moving forward with maintenance of licensure.

381  
382 The Board of Directors recognizes that there are still issues that need to be addressed  
383 regarding maintenance of licensure, particularly around the operational impact to state  
384 boards of implementing maintenance of licensure and the future impact of maintenance  
385 of licensure on the physician workforce and patient care. Current FSMB Chair, Martin  
386 Crane, MD, recently appointed a Maintenance of Licensure Implementation Workgroup  
387 to 1) create a template proposal available to assist state medical boards in the  
388 implementation of an MOL program within and across their jurisdictions and 2)  
389 identify potential challenges to implementation of MOL programs and propose possible  
390 solutions to overcome these challenges. The FSMB is also continuing work on a  
391 background paper to evaluate the literature and other evidence surrounding maintenance  
392 of licensure and its implementation and future follow-up analyses.

393  
394 The Board of Directors believes that completion of this work should not impede the  
395 adoption of broad policy recommendations about maintenance of licensure. Indeed,  
396 adoption of a maintenance of licensure policy may be of benefit to those boards who are  
397 already looking ways to implement a maintenance of licensure system and/or who have  
398 identified few impediments with moving forward with implementing maintenance of  
399 licensure. Therefore, the Board of Directors recommends that the FSMB move forward  
400 at this time with adopting a policy on maintenance of licensure, particularly a framework  
401 for how maintenance of licensure should be structured and broad recommendations to  
402 support its implementation.

403  
404 The Board of Directors also recommends that the FSMB continue its work to evaluate  
405 and provide recommendations to state boards about how to implement maintenance of  
406 licensure in as efficient and less burdensome manner as possible and to evaluate how to  
407 best allocate FSMB resources to assist state boards in that task.

408  
409 Based on these findings, the Board of Directors makes the following recommendations:  
410

411 **RECOMMENDATIONS:**

412

413 **1. The following principle for guiding future FSMB activities related to**  
414 **maintenance of licensure be amended to read as follows:**

415

416 Maintenance of licensure should not be ~~overly burdensome for the~~  
417 ~~professional and should not hinder physician mobility~~ compromise patient  
418 care or create barriers to physician practice.

419

420 **2. The FSMB adopt the following maintenance of licensure framework and**  
421 **recommendations as proposed by the Advisory Group on Continued**  
422 **Competence of Licensed Physicians as policy.**

423

424 Maintenance of Licensure Framework

425

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

429

- 430 • medical knowledge
- 431 • patient care
- 432 • interpersonal and communication skills
- 433 • practice based learning
- 434 • professionalism
- 435 • systems based practice

435

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

438

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

440

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

444

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

447

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

451

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

453

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

457 Recommendations

458

459 *Documentation*

460 Licensees should be expected to provide documented evidence of compliance  
 461 with the state medical board's maintenance of licensure requirements. State  
 462 medical boards should provide guidance to licensees as to the types of evidence  
 463 deemed acceptable and not acceptable for purposes of meeting maintenance of  
 464 licensure requirements.

465

466 *Licensed Physicians not in Active Clinical Practice*

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

470

471 *Physicians with Inactive Licenses*

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

474

475 *Practice Profile Data*

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

486

487 *Practice Performance Data*

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

492

493 *Research*

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

498

499 *Assessment Resources*

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

501

- valid, reliable, and feasible
- credible with the public and the profession

502

- 503           • provide adequate feedback to the licensee to facilitate practice  
504           improvement

505

506           *Professional Development Activities*

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

511

512           *Board Certification in the Context of MOL*

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

522

523           **3. The FSMB continue pursuing the following scope of work and report back to**  
524           **the House of Delegates at the FY2011 annual business meeting:**

525

- 526           • Continue the Work of the Maintenance of Licensure Implementation  
527           Workgroup to develop a template proposal for state medical boards' use in  
528           implementing Maintenance of Licensure and to identify potential  
529           challenges to implementation of MOL programs and propose possible  
530           solutions to overcome these challenges.
- 531           • Conduct, collect and disseminate research on the evidence for the need for  
532           initiating an MOL program and the effects of such a program on patient  
533           care and physician practice; and
- 534           • In collaboration with appropriate stakeholders, support/fund one or more  
535           pilot projects centering on issues relevant to MOL discussions.

536

537

538

## **ATTACHMENT 1**

### **FEDERATION OF STATE MEDICAL BOARDS SPECIAL COMMITTEE ON MAINTENANCE OF LICENSURE DRAFT REPORT ON MAINTENANCE OF LICENSURE FEBRUARY 2008**

#### **INTRODUCTION**

In the United States, the practice of medicine is a privilege granted by the public through their elected representatives. Medical licensing authorities are charged through state medical practice acts to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent and/or deceptive practice of medicine.<sup>1</sup> Every medical practice act is built upon this same premise, and likewise, each state medical board uses criteria to assess a physician's competence and fitness to practice prior to granting initial licensure.

In 2003, the Federation of State Medical Boards (FSMB) established a special committee to develop a position statement regarding the responsibility of state medical boards to ensure licensees are competent over the course of their professional careers; and to develop strategies for state medical boards to use in implementing programs to carry out that responsibility.

The Special Committee on Maintenance of Licensure has met eight times. In carrying out its charge, the committee reviewed the factors precipitating the FSMB's interest in the continuing competence of physicians; information about recent initiatives undertaken by state medical boards and other health professions regulatory bodies to implement continuing competence requirements for their licensees; initiatives being pursued by international medical regulatory bodies to implement license revalidation requirements; FSMB policies that contain language regarding physician competence; and initiatives being implemented by medical professional organizations to increase the profession's accountability to the public.

The committee also sought input directly from the following organizations: Institute of Medicine (IOM), PEW Health Professions Commission, Accreditation Council for Continuing Medical Education (ACCME), American Board of Medical Specialties (ABMS), American Medical Association (AMA), American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS), The Joint Commission, the National Board of Medical Examiners (NBME), and the North Carolina Medical Board.

Early in its deliberations, the committee concluded that if the profession is to demonstrate to the public that it is committed to maintaining high standards for practice, all licensed physicians should be expected to periodically demonstrate competence beyond that required for entry to practice. The committee further concluded that state medical boards are the sole entities with the authority to require all licensed physicians to periodically demonstrate their ongoing competence.

In 2004, at the special committee's urging, the FSMB House of Delegates adopted the following statement as official FSMB public policy:

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

In developing recommendations for use by state medical boards to implement maintenance of licensure programs, the committee identified a set of guiding principles for use in developing a framework for how state medical boards should approach maintenance of licensure. In adopting these principles, the committee acknowledges the importance of responding to public calls for increased accountability while concurrently respecting the profession's commitment to lifelong learning and improvement:

1. The goal of maintenance of licensure is to support physicians' commitment to lifelong learning and to facilitate improvement in physician practice while ensuring that physicians identified as having deficiencies are remediated.
2. Collaboration with other stakeholders is critical. State medical boards should set requirements for maintenance of licensure and may rely on external parties to develop tools and resources for use by physicians in meeting those requirements.
3. Requirements should not be punitive, redundant or overly burdensome for physicians; and should be structured to allow consistent implementation across jurisdictions.
4. If problems or deficiencies are identified, the system should include mechanisms to ensure that appropriate training or intervention is prescribed.
5. Participation in intervention and training programs should be confidential and non-punitive, enabling physicians to obtain help without fear of recrimination or action from the state medical board.

This report provides guidance to state medical boards regarding how to implement maintenance of licensure requirements. The report is divided into the following sections:

- Section 1: Licensure Practices Today
- Section 2: Environmental Assessment
- Section 3: State Medical Boards and Maintenance of Licensure.
- Section 4: Conceptual and Methodological Challenges to Assessing Competence.
- Section 5: A Proposed Framework for Maintenance of Licensure Requirements.
- Section 6: Moving Forward

## **SECTION I. LICENSURE PRACTICES TODAY**

State medical boards have rigorous requirements in place to ensure individuals seeking to enter medical practice are competent. Applicants for initial licensure must provide evidence that they have graduated from an accredited medical school, passed a standardized, national medical licensing examination of cognitive knowledge and clinical and communication skills, and completed a certain amount of post-graduate training. When an applicant for initial licensure provides evidence of successfully meeting such conditions, state medical boards – and by extension, the public – can be confident that the physician has the requisite knowledge and skills to practice medicine competently and safely.

In contrast, license renewal is largely an administrative function that assumes licensees are competent unless a reported event or other development indicates otherwise. In all jurisdictions, licensees are required to complete a renewal form and pay a fee. As a part of the renewal process, many state medical boards ask licensees to provide information about hospital privilege reports, malpractice reports, specialty board certification status, and disciplinary actions taken by other jurisdictions to assess licensees' qualifications to practice at the time of license renewal.

In addition to providing evidence of qualifications, 60 out of 69 medical licensing boards require physicians to obtain a specified number of CME credits.<sup>2</sup> Physicians are required to attest on the license renewal form to having met CME requirements, and state medical boards conduct random audits of a certain percentage of license renewal applicants to ensure they have met CME requirements. While some states mandate that a certain number of required CME hours be content-specific, such as HIV/AIDS, palliative care, pain management and medical ethics, few jurisdictions require licensees to take CME that is directly related to his or her scope of practice. As currently mandated by state medical boards, CME is not sufficient to verify or ensure continued competence.

## **SECTION II: ENVIRONMENTAL ASSESSMENT**

While the question of how to assure ongoing physician competence has a long history of debate with little agreement, a number of developments over the past 15 years appear to be providing impetus for action by the health professions regulatory community.

### ***Public Expectations Regarding Physician Competence***

In the mid-to late 1990s, the Institute of Medicine and the Pew Health Professions Commission's Taskforce on Health Care Workforce Regulation released a series of reports addressing the quality and safety of the existing health care system. The IOM's *To Err is Human* report, which addresses medical error rates in the United States, challenges the health professions regulatory boards to do their part in making the overall health care system safer for patients by periodically re-examining and re-licensing providers "based on both competence and knowledge of safety practices."<sup>3</sup> Subsequent IOM reports also recommend that health regulatory boards take a more proactive and involved approach to practitioner competence.<sup>4,5</sup>

The Pew Health Professions Commission Taskforce on Health Care Workforce Regulation's initial report, *Reforming Health Care Workforce Regulation*, also is cited as a turning point for discussions within the health professions about addressing the issue of ongoing practitioner competence. Released as part of a series of reports focusing on the regulation of health care providers as a means of ensuring high-quality health care services, the report recommends that states "require each licensing board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals."<sup>6</sup>

In 1997, the FSMB commissioned a study of public awareness and attitudes about state medical boards. The periodic retesting of physicians was the second most-cited responsibility for state medical boards.<sup>7</sup>

In 2007, the AARP, in collaboration with the Citizens Advocacy Center, conducted a study of Virginians 50 years of age and older to assess their understanding and knowledge of Virginia's existing licensure requirements for health professionals to maintain competence. More than 95 percent of respondents believe that health care professionals should be required to show they have the up-to-date knowledge and skills needed to provide quality care as a condition of retaining their license. Ninety percent of the respondents indicated that it is at the least very important for health care professionals to periodically be re-evaluated to show they are currently competent to practice safely.<sup>8</sup>

An unpublished Harris Poll conducted by FSMB in October 2007 produced results similar to the AARP study. While a majority of respondents to the poll were unsure how licensing boards currently assess licensees to ensure they remain competent, an overwhelming majority believe physicians *should* be evaluated at least once every five to 10 years to ensure they are maintaining their competence.<sup>9</sup>

### ***Increased Emphasis on Continuous Improvement in Medicine***

Recent years have seen a number of national medical organizations implement initiatives that seek to instill principles of quality and performance improvement within the

medical profession. Such initiatives could provide resources for use by physicians in meeting maintenance of licensure requirements. The following paragraphs describe some of these initiatives.

### *American Board of Medical Specialties: Maintenance of Certification*

The American Board of Medical Specialties is an organization of 24 member boards responsible for specialty certification and recertification of physicians. In 1998, in response to concerns about the inadequacy of the existing recertification process to document physicians' ongoing competence, the ABMS proposed a Maintenance of Certification (MOC) program that requires physicians to provide evidence of meeting the following criteria on a continual basis in order to maintain specialty board certification:

- Part I: professional standing
- Part II: commitment to lifelong learning and involvement in periodic self-assessment
- Part III: cognitive expertise
- Part IV: evaluation of performance in practice

Maintenance of Certification has since been adopted by all ABMS member boards as the model for recertification. While each specialty board is developing tools and resources for use by their diplomats to meet MOC requirements, the systems being developed must adhere to the standards and guidelines set forth by the ABMS. Physicians participating in the MOC program are expected to demonstrate competence in the following six general competencies: medical knowledge, patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

Physicians who have certificates without time limit are exempt from participation in MOC. However, a recent systematic review suggests that physician performance, among multiple specialties, declines over time in both medical knowledge and skills.<sup>10</sup> Therefore, certifying boards recommend that physicians who have certificates without time limit voluntarily participate in MOC. Physicians will not lose their permanent certification if they choose to voluntarily participate in MOC but fail to meet the MOC requirements. Implementation of maintenance of licensure requirements could motivate this group of physicians to comply with MOC requirements in order to meet maintenance of licensure requirements.

### *Continuing Medical Education*

Historically, concerns about the utility of CME have centered on whether such activities truly impact physician performance, especially if the CME is not related to the physician's day-to-day practice or deficiencies.<sup>11,12</sup> There is now empiric evidence from meta syntheses that supports the use of CME as a tool for physician learning and change if it is part of a system of continuous professional development that includes self-assessment, remediation, and reassessment.<sup>13,14,15,16</sup> The CME community has made great strides in addressing concerns about CME's impact on physician practice and in developing CME programs and criteria that address physician performance and lifelong learning.<sup>17</sup> In 2005, in an effort to strengthen the role of CME in physician performance improvement and lifelong learning, the ACCME proposed a model for CME based on practice-based, self-directed physician learning and change.<sup>18</sup> Subsequently, in

September 2006, the ACCME released new standards for the accreditation of CME providers that focus on learning and change for both CME providers and learners. The new standards aim to improve physician practice and, thus, the quality of patient care by requiring CME providers to develop and implement CME programs that focus on improving physician competence, physician performance and/or patient outcomes.<sup>19</sup>

### *Graduate Medical Education*

As part of its mission to ensure and improve the quality of graduate medical education, in 2001 the Accreditation Council for Graduate Medical Education (ACGME) began implementation of the Outcome Project. While the accreditation process traditionally focused on the potential of a program to educate residents, the Outcome Project focuses on the actual accomplishments of a program through an assessment of its outcomes. As part of the Outcome Project, residency programs are required to provide educational experiences that enable their residents to obtain competencies in six general areas: medical knowledge, patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

Residency programs also must demonstrate a plan to assess residents' performance and to utilize the results to improve performance. Consequently, the Outcome Project is also involved in the identification and development of measurement tools. The ACGME, in collaboration with the ABMS, developed a "toolbox" of instruments that programs can use for educational outcomes assessment, including 360-degree evaluations, chart stimulated recall oral examinations, checklist evaluation of live or recorded performance, patient surveys and written examinations.<sup>20</sup>

In 2006 all osteopathic training programs began to use seven core competencies in osteopathic graduate medical education curriculum. The seven Core Competencies include Osteopathic Philosophy and Osteopathic Manipulative Medicine in addition to medical knowledge, patient care, professionalism, interpersonal/communication skills, practice-based learning, and systems based practice.

### *American Osteopathic Association Clinical Assessment Program (CAP)*

The AOA Clinical Assessment Program (CAP) is a quality improvement tool for osteopathic physician to evaluate the effectiveness and safety of patient care in their clinical practice during residency programs and physician practices. CAP's goal is to improve patient outcomes by providing valid and reliable assessments of current clinical practices. Using evidence-based guidelines to evaluate clinical practices and track patient outcomes, the data in CAP is compared to national benchmarks and the performance of other participants to determine whether their treatment protocols are consistent with the best standards of practice. CAP provides evidence-based measurement sets on eight clinical conditions including diabetes, coronary artery disease, hypertension, women's health screening, asthma, COPD, childhood immunizations, and low back pain.<sup>21</sup> CAP measurements of quality can be used as a component of board certification and osteopathic continuous certification to meet the requirement of practice performance assessment.

### *American Osteopathic Association Bureau of Osteopathic Specialists*

The American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS) is an organization of 18 member boards responsible for the specialty certification and recertification of osteopathic physicians. All member boards currently issue time-limited certificates, and the AOA BOS has begun incorporating seven core competencies (medical knowledge, osteopathic philosophy and osteopathic manipulative medicine, patient care, professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems based practice) into the recertification process. In addition, there has been ongoing dialogue between the AOA BOS and its member boards about moving to continuous, rather than periodic, evaluation of physicians' competence.<sup>22</sup> A schedule for implementation for continuous certification was approved by the AOA BOS in 2007, and all osteopathic certifying boards are required to submit a plan for continuous certification to the AOA BOS by November 2008. Plans will be implemented by 2012.<sup>23</sup> The American Osteopathic Board of Emergency Medicine (AOBEM) already has implemented a continuous certification program to replace traditional recertification. As part of this process, diplomats are required to provide evidence of meeting criteria in four components on a continual basis: Professional Status, Continuous Osteopathic Learning Assessment, Formal Re-Certification Examination, and Practice Status.<sup>24</sup>

### *The Joint Commission*

The Joint Commission is responsible for the accreditation of health care organizations and programs in the United States. As part of the accreditation process, the Joint Commission evaluates health care organizations' compliance with Joint Commission standards, including those for credentialing and privileging of physicians. Prompted by deficiencies in the existing system, in 2003 the commission began revising its credentialing and privileging standards to focus on the proactive evaluation of physicians' competence and to move beyond privileging decisions based primarily on an evaluation of physicians' technical skills.

The new standards, which were implemented in January 2007 and January 2008, are intended to make the credentialing and privileging process more objective and evidence-based by facilitating continuous monitoring of physicians' performance and by providing a basis for intervening when quality of care concerns are identified.<sup>25</sup> Under the new standards, organizations are required to implement a Focused Professional Practice Evaluation as well as an Ongoing Professional Practice Evaluation as part of the credentialing and privileging process. The Focused Professional Practice Evaluation standards apply to 1) the evaluation of currently privileged practitioners who are seeking new privileges they have never performed before in the organization and 2) situations in which the competence of a practitioner with existing privileges comes into question. The Ongoing Professional Practice Evaluation standards enable the continuous, rather than periodic, review of practitioners' performance.<sup>26,27</sup>

The new standards also require organizations to evaluate physicians on multiple competencies, such as the six core competencies developed by the Accreditation Council for Graduate Medical Education (i.e., medical knowledge, patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice). Finally, the new standards address hospital-based education and require that such activities relate, at least in part, to the

type of services offered by the organization and be based on the findings of performance improvement activities.

### *American Medical Association*

The American Medical Association is a national physician advocacy body in the United States and works to develop programs and policies that address physician practice. As part of this effort, the AMA, through its Initiative to Transform Medical Education (ITME), is collaborating with a broad array of stakeholders within the medical profession to address reformation of the medical education system, including the need for educational opportunities to support physicians' continuing professional development and to assist physicians seeking to reenter practice.<sup>28,29</sup>

Recognizing the increasing and varied ways in which physicians learn, in recent years the AMA has also expanded the credit for the AMA Physician Recognition Award (PRA) Category 1 Credit to include performance improvement activities and internet learning and point of care.<sup>30</sup>

### ***International Initiatives to Ensure Physician Competence***

Since 1998, the General Medical Council (GMC) in the United Kingdom has been in the process of implementing a "revalidation" program that will require all licensed physicians to undergo review of their practice every five years in order to maintain their licenses. The program, and the areas in which physicians' performance are reviewed, are based on the principles set forth by the GMC in its *Good Medical Practice* guidelines, which include good clinical care; maintaining good medical practice; teaching and training, appraising and assessing; relationships with patients; working with colleagues; probity; and health.<sup>31</sup>

The College of Physicians and Surgeons of Ontario evaluates the continuing competence of its licensees through its Peer Assessment Program, which it initiated in 1981. As part of the program, physicians undergo an office-based evaluation of their facilities, medical records and quality of care once every 10 years. Physicians found to have practice deficiencies participate in remediation programs developed by the College. The College also conducts Mini-Peer Assessments, in which physicians complete and submit a questionnaire and medical records to an assessor for determination of whether an on-site visit is necessary.<sup>32</sup> A December 2006 survey of Ontario physicians regarding the Peer Assessment Program shows that 73% of respondents rate the program as excellent (42%) or good (31%).<sup>33</sup>

In 2007, the Council of the College of Physicians and Surgeons of Ontario amended its Bylaws to require all physicians to participate in continuing professional development, which consists of educational programs designed to assist physicians in upgrading their knowledge and skills and addressing practice-specific needs in order to assure their ongoing competence. Following legislative approval of the change, the College will focus on developing standards and ways in which physicians can meet the requirements.<sup>34</sup> The Council is also considering requiring physicians to notify the College of any change in their scope of practice or of their intent to return to practice; this information is currently provided on a voluntary basis. The change would allow the College to ensure that physicians who are practicing a particular medical specialty have the necessary skills, training and experience.<sup>35</sup>

### **SECTION III: STATE MEDICAL BOARDS AND MAINTENANCE OF LICENSURE**

In the last 10 years, medical licensing authorities in California, Texas, and Nevada have attempted to or studied the feasibility of implementing requirements for periodic demonstration of competence for license renewal. In all three cases, the boards abandoned their initiatives due to the political climate, concerns about the negative impact on workforce, or resistance from the profession based on lack of evidence that such requirements would make a difference in the quality of care provided to patients.

According to a 2007 survey conducted by the Federation of State Medical Boards, continuing competence of physicians is a matter of concern to state medical boards. Sixty-three of 69 FSMB member boards responded to the survey, and 36 (57.2%) indicated that they had discussed the issue one or more times within the past 12 months. Three boards (4.8%) had formed a committee to study the issue. Nine (14.3%) had never discussed the issue. While many boards (29 or 47.5%) indicated that they were undecided on the issue, 22 (36.1%) said they are supportive. Eight (13.1%) responded that they are uninformed and only two (3.3%) responded that they are not supportive.

The vast majority of boards (55 or 87.3%) have not implemented or previously attempted to implement rules and regulations, policies or statutes regarding maintenance of licensure, but eight (12.7%) indicated that they have. Finally, most boards (25 or 42.4%) said that their existing statutes do not give the board the authority to implement maintenance of licensure requirements. Twenty-one (35.6%) said existing statutes do give them authority, while 13 (22.0%) were not sure.<sup>36</sup>

These results are similar to the results of a 2002 Citizen Advocacy Center (CAC) survey of 323 health professions licensing boards (45 of which were state medical boards) regarding continuing competence. Seventy boards (21%) stated that they were "considering introducing continuing competency requirements in the future," and 60 (19%) had already formed committees to study the issue. Responses from 16 boards (22%) indicated that their state's legislature was considering new initiatives to require licensees to periodically demonstrate their continuing competence. Program models being considered ranged from requiring all licensees to demonstrate current competence upon license renewal to requiring demonstration of current competence by only those licensees that meet specified "triggers", such as change in practice setting, disciplinary action and failure to recertify with a credentialing agency.<sup>37</sup>

In addition to questions about statutory authority, another impediment to establishing continuing competence requirements is the lack of resources available to assess licensees' ongoing competence. For physicians, only those who are board certified by an ABMS or AOA BOS certifying board are eligible to participate in the maintenance of certification programs developed by those boards. That leaves the cohort of physicians who are not board certified or otherwise not participating in the maintenance of certification process left without a mechanism to objectively establish their having maintained ongoing competence in their respective area of medical practice.

## **SECTION IV: CONCEPTUAL AND METHODOLOGICAL CHALLENGES TO DETERMINING COMPETENCE**

The following paragraphs provide a discussion of three challenges to assessing the competence of practicing physicians: determining the purpose of the assessment, differentiating between competence and performance, and assessment of undifferentiated medical practice versus specialty-specific assessment.

### ***Purpose***

The first and perhaps most fundamental conceptual challenge to developing an assessment process for practicing physicians is defining its purpose. When thinking about how assessment could support maintenance of licensure, it must be decided whether the assessment is intended to 1) exclude from practice physicians who are no longer able to practice safely and competently, 2) identify areas for improvement in otherwise competent physicians or 3) accomplish both.

If the assessment is intended to identify opportunities for improvement in practice, then it must be relevant to what the physician does in his or her practice. Because the majority of physicians embrace lifelong learning as an integral part of professionalism, an assessment process that seeks to improve physician practice would be perceived more positively by physicians and would likely have the greatest impact on quality of patient care. Since the outcome of such a process would be improved practice, such an assessment requirement could reasonably be applied to all licensees.

A number of medical organizations in the US and internationally are using assessment and remediation programs as the basis of their recertification or relicensure requirements. These programs fall into three broad categories: periodic comprehensive assessment of all physicians, performance-focused tiered approach (such as Canada's Monitoring and Enhancement of Physician Performance model<sup>38</sup>), and cyclical delivery of assessments over time (such as the American Board of Internal Medicine's Continuing Professional Development program<sup>39</sup>). In general, the defined purpose of each is the continuous professional development of practicing physicians. While this model has potential for significant quality improvement and focuses on the majority of physicians who are competent, it leaves unanswered how to identify and respond to the remaining small percentage of physicians who are not competent.

### ***Competence vs. Performance***

A second conceptual challenge to consider is the blurred distinction between competence and performance. While there is no single agreed upon definition for these terms, there is some consensus that competence points to the *ability* to do (or *can* do), whereas performance refers to *does* do<sup>40</sup>.

Standardized tests are associated with competence assessments, whereas workplace assessments are associated with performance assessments. There are valid, reliable standardized tests such as multiple-choice examinations that may be used to measure competence, and more tools are becoming available for use in measuring performance. Ideally, a physician should be expected to demonstrate accountability for both general competencies, including the knowledge, skills and abilities to provide safe, effective

patient care within the scope of their professional medical practice, as well as performance in practice.

### ***GUMP vs. Practice-Specific Assessment***

The third conceptual design challenge pertains to whether practicing physicians should be held accountable for maintaining competence in the general undifferentiated practice of medicine or in the area of practice in which they engage on a daily basis.

Because initial licensure is based on the general, undifferentiated practice of medicine (or the “GUMP” model), one could argue that assessment for relicensure should focus on the same general domains measured by examinations for initial licensure. However, because physician practice narrows over time, the deficiencies identified by a GUMP level assessment may have a low level of relevance to patient care; consequently, remediation may not result in improved practice. An assessment tailored to reflect at least in part what the physician does in his or her practice will be perceived by the physician as more relevant and credible than a GUMP-level assessment.

## **SECTION V: A FRAMEWORK FOR MAINTENANCE OF LICENSURE**

### ***Establishing Requirements for Demonstrating Competence***

State medical boards should require physicians seeking relicensure to periodically demonstrate competence within the scope of their professional practice. Such requirements should include the following elements or expectations:

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.

Evidence of self-evaluation, self-assessment and practice assessment could include participation in self-evaluation exercises or modules, such as 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.

While a variety of tools may be used by physicians to document evidence of compliance with this criteria, state medical boards should mandate that it 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.

3. Demonstration of accountability for performance in practice.

This could be met by peer assessment, such as 360-degree evaluations, letters of attestation of clinical activities, or by patient reviews, such as satisfaction surveys. Participation in recognized quality improvement activities as well as collection and analysis of practice data, such as thorough review of office records, chart review, case review and submission of a case log, could also be utilized.

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 for purposes of meeting maintenance of licensure requirements. For example, documentation of active participation in Maintenance of Certification processes could be deemed acceptable by state medical boards as meeting all maintenance of licensure requirements. Participation in recognized quality improvement activities such as those required by The Joint Commission or the AOA Clinical Assessment Program could 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 should include evidence of competence in that practice.

### ***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. Evidence of demonstration of accountability for performance in clinical practice could be met by evaluation of a physician's competence relevant to that practice. Assessment methods should address the knowledge, skills and behaviors necessary to deliver safe and effective care for the types of patients that would typically be encountered in their practice. Physicians whose licenses are inactive or have lapsed should be expected to meet these requirements prior to reentering active clinical practice.

### ***Disclosure***

Physicians who do not comply with maintenance of licensure requirements or who are identified through the program as deficient such that the deficiency rises to a level that would subject the licensee to a disciplinary action for violation of the practice act should be subject to normal adjudication processes and to public disclosure as required by state law. When an education or remediation plan is required by the state medical board for these practitioners, the state medical board should approve the elements and scope of the plan prior to its initiation. All other maintenance of licensure activities should not be subject to public disclosure.

### ***Reporting Requirements***

In order to assure that physicians are demonstrating competence within their scope of practice, state medical boards should require licensees to report information about their practice as part of the license renewal process. Such information should include: scope of 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 at all times by reporting any subsequent changes in practice status or scope of practice to the board within a specified timeframe as determined by the board.

### ***Research***

Developing evidence regarding the impact of maintenance of licensure programs on physician practice and patient care is a priority. State medical boards should work with relevant organizations to develop a research agenda aimed at gathering data to improve maintenance of licensure processes.

### ***Assessment Resources***

Assessment tools used to document compliance with maintenance of licensure requirements should be valid, reliable, feasible, have credibility with the profession and

should provide adequate feedback to facilitate practice improvement. FSMB and state medical boards should encourage development of programs and services for use by the cohort of physicians who are not board certified or otherwise not participating in the maintenance of certification/continuous certification processes in order that they have access to resources necessary to comply with maintenance of licensure requirements.

## SECTION VI: MOVING FORWARD

Maintenance of licensure represents a social and cultural change both for state medical boards and the physicians they license. State medical boards are being asked to take the first step in that process of change. Given that Maintenance of Licensure will have significant implications for multiple stakeholder groups, it will be important to move forward in a thoughtful and studied fashion that allows for course correction as necessary. With that in mind, the following steps could be taken to develop information to inform future dialogue and decisions.

1. Design implementation models that take into account the different regulatory configurations within which state medical boards operate.
2. Conduct pilot projects to evaluate the financial and operational implications of maintenance of licensure on medical regulatory systems and relevant stakeholders.
3. Encourage development of valid, reliable tools and resources for use by physicians in meeting maintenance of licensure and reentry to practice requirements.
4. Gather and disseminate studies documenting the validity and reliability of assessment instruments for use in measuring competence.
5. Engage appropriate organizations in developing evidence regarding the impact of maintenance of licensure on physician practice and patient care.
6. Encourage state medical boards to require that a certain amount of CME obtained for purposes of license renewal be practice-relevant.

FSMB could play a major role in facilitating this work. In addition to pursuing the activities noted above, the Federation of State Medical Boards should make appropriate revisions to its policy document *Essentials of a Modern Medical Practice Act*, which will provide sample language that state medical boards can use, if needed, in revising their medical practice acts to implement the requirements. (Proposed revisions are provided as Addendum 1.)

The FSMB could also assist states in developing campaigns to support implementation of the requirements. The FSMB should provide resource materials to assist state medical boards when speaking to their legislatures about the need to establish maintenance of licensure requirements, including testimony and letters of support. Furthermore, the FSMB should assist state medical boards with developing key messages and public relations tools to assist in reaching and educating legislatures, practicing physicians, the public and other relevant and interested entities about maintenance of licensure and reentry to practice requirements and rationale for their implementation.

## **SECTION VIII: CONCLUSION**

As policy makers and regulators, state medical boards play a critical role in influencing standards for physicians and the environment within which physicians practice. Public expectations that the health professions' regulatory boards do their part in making the health care environment safer for patients are putting the responsibility on state medical boards to take a more proactive approach to evaluating and ensuring physicians' ongoing competence.

State medical boards are charged to ensure that licensed physicians are qualified to practice medicine safely. Currently, physicians who meet conditions for initial licensure effectively are granted the privilege of licensure for a lifetime without having to demonstrate to the public on a regular basis that they have maintained the level of competence their patients expect and deserve. By requiring licensees to periodically demonstrate competence as a condition of relicensure, state medical boards have an opportunity both to make the health care environment safer and to improve the quality of medical care that patients receive.

Physicians, in turn, have an ethical and professional obligation to their patients to maintain their competence in order to provide safe and effective care. Participation in maintenance of licensure activities will assist physicians in fulfilling that responsibility and in improving the quality of health care.

## Definitions

For the purposes of this report, the following terms are defined as follows:

**Accredited** – having complied with the standards of a public or private organization approved to issue certificates of accreditation based on an examination of quality of services provided compared to established standards.

**Assessment** – a formal system to evaluate a practitioner’s competence and ability to perform safely and effectively within the practitioner’s scope of practice.

**Clinical practice** – the active involvement in providing direct patient care and/or consultative care.

**Competence** – A competent physician is one who demonstrates the requisite knowledge, technical skills, judgment, and interpersonal and communication skills to provide safe, effective patient care within the scope of professional medical practice while engaging in ongoing, practice-based learning and improvement.

**Continuing Medical Education** – educational activities that maintain, develop or increase the knowledge, skills, professional performance and relationships that a physician uses to provide services for patients, the public or the profession.

**Credentialing** – the process of obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care services in or for a health care organization. (JCAHO Hospital Accreditation Standards, 2003)

**License** – authorization by law to practice medicine.

**License renewal** – the process whereby a licensee demonstrates qualification for continued licensure.

**Licensure** – the process by which a state medical board grants a license pursuant to applicable statutes.

**Maintenance of competence** – the dynamic process of assessing and updating the knowledge, skills and attitudes required to meet the needs of the physician’s current practice. (From Aylmer I<sup>41</sup>)

**Maintenance of licensure** – the process by which a licensee demonstrates that he/she has maintained his or her competence and qualifications for purposes of continued licensure.

**Performance** – the translation of competence into action when managing patient care. (From Aylmer I)

**Privileging** – the process whereby a specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization based on evaluation of the individual’s credentials and performance. (JCAHO Hospital Accreditation Standards, 2003)

**Reentry to practice** – a return to clinical practice following a period of inactivity as defined by the licensing authority.

**Remediation** – The process whereby deficiencies in physician performance identified through an assessment system are corrected.

**Retraining** – updating one's skills or learning the necessary skills to move into a new clinical area.

**Self-assessment** – the evaluation process a professional uses to define any gaps, or differences, between their own knowledge or competence (ability) or performance-in-practice and that of a pre-determined self-, norm- or criterion- referenced standard.

**Specialty certification** – recognition granted by the American Board of Medical Specialties (ABMS), American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS) or other equivalent organization as determined by the state medical board that a practitioner has met certain published standards; provides evidence to the public that a practitioner has successfully demonstrated advanced training and experience in a given specialty.

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## ENDNOTES

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## ADDENDUM 1

### Revising *A Guide to the Essentials of a Modern Medical Practice Act*

#### Section XVI: Periodic Renewal

The medical practice act should provide for the periodic renewal of medical licenses to permit the Board to review the qualifications of licensees on a regular basis. At the time of periodic renewal, the Board should require the licensee to demonstrate to its satisfaction his or her continuing qualification for medical licensure. These provisions of the act should implement or be consistent with the following:

- A. The Board should require the following for license renewal and require documentation thereof:
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, and 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. This criterion must be met, in part, by passage of a valid, secure, proctored examination in the physician's current practice area.
  3. Demonstration of accountability for performance in practice.
- AB. At the time of periodic renewal, the Board should require the licensee to demonstrate to its satisfaction his or her continuing qualification for medical

~~licensure.~~ The application form for license renewal should be designed to require the licensee to update and/or add to the information in the Board's file relating to the licensee and his or her professional activity. It should also require the licensee to report to the Board the following information:

1. The licensee's completion of activities related to maintenance of licensure, specialty board certification or maintenance of certification within the registration period.
  
- ~~2~~2. Any action taken against the licensee by:
  - any jurisdiction or authority (United States or foreign) that licenses or authorizes the practice of medicine;
  - any peer review body;
  - any specialty certification board;
  - any health care organization;
  - any professional medical society or association;
  - any law enforcement agency;
  - any court; and
  - any governmental agency for acts or conduct similar to acts or conduct described in the medical practice act as grounds for disciplinary action.
  
- ~~3~~3. Any adverse judgment, settlement or award against the licensee arising from a professional liability claim.
  
- ~~4~~4. The licensee's voluntary surrender of or voluntary limitation on any license or authorization to practice medicine in any jurisdiction, including military, public health and foreign.
  
- ~~5~~5. Any denial to the licensee of a license or authorization to practice medicine By any jurisdiction, including military, public health and foreign.

- ~~56.~~ The licensee's voluntary resignation from the medical staff of any health care organization or voluntary limitation of his or her staff privileges at such an organization if that action occurred while the licensee was under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct or mental or physical impairment.
- ~~67.~~ The licensee's voluntary resignation or withdrawal from a national, state or county medical society, association or organization if that action occurred while the licensee was under formal or informal investigation or review by that body for any reason related to possible medical incompetence, unprofessional conduct or mental or physical impairment.
- ~~78.~~ Whether the licensee has abused or has been addicted to or treated for addiction to alcohol or any chemical substance during the registration period.
- ~~89.~~ Whether the licensee has had any physical injury or disease or mental illness within the registration period that affected or interrupted his or her practice of medicine.
- ~~9.~~ The licensee's completion of continuing medical education or other forms of professional maintenance and/or evaluation, including specialty board certification or recertification, within the registration period.
- ~~B. The Board should be authorized, at its discretion, to require continuing medical education for license renewal and to require documentation of that education.~~
- C. The licensee should be required to provide information about his or her practice. Such information should include: scope of 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 at all times by reporting any subsequent changes in practice status or scope of practice to the board within a specified timeframe as determined by the board.
- Ⓓ. The licensee should be required to attest to the accuracy of the information provided on the license renewal form. ~~sign the application form for license renewal and have it witnessed.~~ Failure to report fully and correctly should be grounds for disciplinary action by the Board.
- Ⓔ. The Board should be directed to establish an effective system for reviewing renewal forms. It should also be authorized to initiate investigations and/or disciplinary proceedings based on information submitted by licensees for license renewal.
- F. Licensees not in active clinical practice who wish to maintain an active license should be expected to comply with all maintenance of licensure requirements. Physicians whose licenses are inactive or have lapsed should provide evidence of meeting maintenance of licensure requirements when they reenter active clinical practice.

## ATTACHMENT 2

### 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.

## **ATTACHMENT 3**

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

**Addendum  
September 2009**

#### Overview

In May 2009, the FSMB House of Delegates received a report commissioned by the Board of Directors analyzing how state medical boards and other stakeholders would be impacted if maintenance of licensure requirements were implemented. The report identified several issues warranting further assessment. At the Board of Directors' recommendation, the House of Delegates directed further analysis be completed and reported back in April 2010.

In preparing the original analysis, FSMB invited 14 state medical board representatives to serve as content experts and to provide assistance in conducting the analysis. Representatives from this group graciously agreed to assist with the additional analysis requested by the House of Delegates. Taskforce members met twice by conference call during July and August to discuss the following issues:

- Non-clinical licensees
- Non compliant physicians
- Unintended consequences of MOL implementation

This document summarizes the results of those discussions and serves as an addendum to the original analysis report presented by the FSMB Board of Directors to the House of Delegates in May 2009.

## MOL AND NON-CLINICALLY ACTIVE PHYSICIANS

At any point in time, a small percentage of licensed physicians in the US are not clinically active. The reasons for this are varied: physicians interrupt their practice careers for personal reasons (e.g. raising a family, caring for a sick family member), to pursue administrative or research careers, or to pursue areas of specialization, such as preventive medicine, which do not all provide direct or consultative patient care. Insufficient data are available to definitively identify what percentage of the physician licensee population is clinically inactive at any point in time.

The draft report of the Special Committee on Maintenance of Licensure recommends that all licensed physicians – including those who are not clinically active – be held accountable for meeting maintenance of licensure (MOL) requirements as a condition of license renewal.<sup>1</sup> Questions have been raised about the feasibility and reasonableness of such a policy recommendation.

In carrying out its analysis, taskforce members recognized that FSMB policy recommendations provide a blueprint for state medical boards to use to develop rules and regulations that meet the unique needs of their jurisdictions. Ultimately, however, the authority to decide what is in the best interests of the citizens of their states resides with individual state medical boards.

In its discussions regarding the feasibility and impact of requiring all licensed physicians to comply with MOL requirements as a condition of license renewal, the Maintenance of Licensure Analysis Taskforce considered the following:

- It is not unusual for medical administrative positions to require physicians to stay abreast of changes in medical knowledge and practice in order to perform their administrative duties. It is also increasingly common for physicians in such positions, particularly those in academic or medical education settings, to provide some amount of clinical care, if only on a limited basis;
- Clinically inactive physicians with full and unrestricted licenses are able to prescribe medications for family members and friends, which requires currency in medical knowledge; and
- Many states include in their definition of the practice of medicine, activities such as serving as an expert witness. Physicians providing these types of services would be required to have a license even though they are not providing direct patient care.

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<sup>1</sup> The Special 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 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 third component of the proposed MOL requirements recommends physicians provide evidence of applying quality improvement methodologies to their clinical practice. Advances in simulations and computer-based case management tools offer reasonable options to clinically inactive licensees who may find it challenging to meet the third component of the MOL requirement since they do not have defined patient practices.

The MOL Analysis Taskforce concluded that the Special Committee on Maintenance of Licensure's recommendation to hold all licensees accountable for meeting MOL requirements is appropriate and in the public's interest. Further, the recommendation could be implemented in a variety of ways to minimize the burden on non-clinical physicians. For example, a state may choose to:

- Require non-clinical physicians to comply with components one and two of the proposed Maintenance of Licensure requirements, thus exempting them from providing evidence of complying with the third component, performance in practice.
- Recommend alternate ways for physicians not in clinical practice to participate in all three areas of MOL (e.g., use of limited or simulated performance data as a demonstration of accountability for performance in practice)
- Create an "administrative" license that exempts the licensee from participating in MOL, but at the same time restricts the licensee from engaging in any type of clinical activity.

The taskforce concluded there are advantages to holding all licensees accountable for complying with MOL requirements:

- Physicians in administrative positions may want to participate in MOL to have credibility with the practicing physicians with whom they work and interact
- By requiring all physicians to participate in MOL, states may have greater confidence that non-clinical physicians are more likely to be up to date with relevant medical knowledge should they decide to return to or resume clinical patient care.
- Likewise, participating in MOL may help some non-clinical physicians maintain competence should they re-enter practice. For several areas of medical practice, expertise can be maintained during prolonged intervals without patient contact, providing one keeps up with the knowledge in the field.

If a state medical board chooses to require non-clinical licensees to meet only components one and two of the proposed maintenance of licensure requirements, medical boards will need to communicate to licensees who wish to reenter clinical practice that they will be accountable for meeting all components of MOL upon return to patient care duties.

While the taskforce did not discuss reentry to practice, they did identify a number of administrative issues that need to be resolved. For example, when should such licensees be expected to provide evidence of complying with all or additional MOL requirements – prior to returning to clinical practice or at the next license renewal cycle? Should state medical boards require non-clinical licensees to notify the board in advance of a decision to return to clinical practice and at what point should such notification occur? There are also issues of remediation and retraining that need to be addressed.

Finally, the taskforce members emphasized that licensing boards need to gather data regarding licensees' scope of practice and clinical activity. The taskforce recommended states begin asking for and collecting practice information as part of the license renewal process. Such

information should include questions about whether licensees have provided direct or consultative care within the most recent license renewal cycle.

## **PHYSICIANS WHO FAIL TO COMPLY WITH MOL REQUIREMENTS**

The Special Committee on Maintenance of Licensure recommends that medical boards require licensees to submit verification that they are actively participating in or have completed the requisite activities required for MOL. In conducting the original impact analysis, the MOL Analysis Taskforce suggested the most feasible way of implementing this recommendation is to require licensees to submit attestations of participation in or completion of MOL programs or activities at the point of license renewal. The Taskforce also suggested that data used by the licensee to complete a self-assessment or quality improvement activity or program remain confidential and the property of the physician. In this model, a licensee would be deemed compliant with MOL requirements if he or she submits evidence – i.e., attests – that he/she is engaging in appropriate assessment and learning processes and is addressing areas of improvement identified through those processes.

All medical boards will encounter some number of physicians who fail to comply with MOL requirements at the time of license renewal, either by choice or ability. The following section assesses how medical boards might define non-compliance and how non-compliant licensees could be handled. The section also discusses what additional information or data the board may want to review.

### **Issues considered by the taskforce**

As part of its evaluation of this issue, the MOL Analysis Taskforce considered the following:

- How state medical boards will notify licensees of MOL requirements and how licensees can comply with those requirements;
- How state medical boards will verify compliance with MOL requirements;
- How state medical boards should handle licensees who fail to demonstrate compliance with MOL requirements; and
- Instances where state medical boards may wish to access individual physician performance data for licensees.

As part of its discussions of this issue, the Taskforce did not make a distinction between licensees who fail to comply with MOL requirements by choice and those who fail to comply because of ability. With a few exceptions, as noted below, the Taskforce agreed that its recommendations could apply to all licensees equally.

### **Facilitating compliance with MOL requirements**

As noted in the Impact Analysis Report provided to the FSMB House of Delegates in May 2009, licensees' ability to comply with MOL requirements will be contingent on the availability of tools and resources that have been approved by the state medical board. While it is reasonable to assume that many physicians will use ABMS Maintenance of Certification or AOA-BOS Continuing Certification to meet maintenance of licensure 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. 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. Such criteria will need to include provisions concerning the third party's obligation to notify the state medical board regarding significant concerns about the physician's competence. States will need to provide clear direction to licensees regarding what tools and programs have been approved as acceptable for meeting MOL requirements, and the penalties and processes to be followed in instances of non-compliance.

### **Verification of compliance with MOL**

If MOL is to be viewed by the public as responsive to calls for greater accountability, state medical boards will need to use more rigorous processes for verifying participation in MOL activities than is often used to verify participation in CME activities for license renewal. Medical boards should hold every licensee accountable for submitting documentation of participation in MOL activities. In situations where a state has the technological infrastructure to allow it, such submission could be done electronically. For example: it is reasonable to imagine situations where the provider of a board-approved MOL activity maintains documentation of the physician's participation in or completion of the activity. At the time of license renewal, the licensee could direct the provider to submit that documentation directly to the board via an electronic interface. The board would receive notification of the physician's participation in or completion of appropriate MOL activity; no other details or data (e.g., performance data) would be submitted to the board. In the future, it is likely that electronic learning portfolios will be available for use by licensees to manage their continuous professional development activities. Such tools could be also be used to enable electronic transmission of evidence of MOL compliance to the medical board.

Realistically, however, some state medical boards may not have the technological capacity to accept electronic verifications of MOL compliance. Therefore, in the early stages of implementing MOL, state boards may need to utilize a process similar to how they currently handle CME for license renewal (e.g., licensees attest on the license renewal form to having met or not met the MOL requirements). A percentage of licensees are then audited to verify compliance. In these situations, the audit should confirm that the MOL activities are practice relevant and have been approved by the state medical board.

### **Determination of compliance with MOL**

Determination of compliance with MOL should be based on whether the licensee is actively participating in the MOL process. As long as the physician provides evidence of participating in MOL activities at the time of license renewal, including appropriate educational activities as indicated, the physician should be deemed to be in compliance with MOL.

### **Non-compliant licensees**

The Taskforce strongly agreed that it should be left to the discretion and purview of each individual state medical board to determine how to handle licensees who are not in compliance with MOL requirements at the time of license renewal. Options may include:

- Not renewing the license;
- Handling the physician in the same manner as licensees who currently fail to meet CME requirements for license renewal (non-disciplinary route);
- Allow some grace period for the physician to complete MOL requirements; or

- Issue a warning for non-participation followed by disciplinary action (e.g., suspension of license) for continued non-compliance.

Other issues the state medical board may wish to consider regarding non-compliance include whether:

- There should be exemptions for illness or other extenuating circumstances;
- Licensees who are within one to three years away from retirement could be provided the option to discontinue participating in MOL; and
- A licensee's failure to comply with MOL requirements should be made public – or if the state medical board should simply note the status of the license with the board (e.g., “not renewed”).

### **State medical board access to performance data**

State medical boards need to carefully consider the pros and cons of requiring physicians or their proxies to submit to the board data resulting from a licensee's participation in self assessment and quality improvement activities. State medical boards' access to and review of such information could undermine licensees' confidence and full faith participation in the MOL process. Based on physicians' historical interactions with state medical boards, physicians will likely view state medical boards' interest in such data as punitive.

The most likely scenario wherein a state board may decide it necessary to access performance data would be in situations where a complaint has been filed against a licensee. If, as previously suggested in the Impact Analysis provided to the FSMB House of Delegates in May 2009, the performance data are considered the property of the physician, then the licensee should have the right to decide whether or not the board should have access to the information. If a board determines it is necessary to review the licensee's performance data as part of the complaint investigation, the board may ask the physician to sign a release form so that the board may obtain the information. Allowing the licensee the final decision in whether to provide this information to the board will help to mitigate physicians' concerns about boards' access to this data. Anecdotal evidence suggests that, in some instances, the licensee will want the board to have access to and to review this information.

In situations where a provider of an MOL activity notifies a medical board with concerns that a physician may be posing a threat to patient safety, such notification should be handled in the same way as any other complaint received by the medical board. If the complaint doesn't rise to the level of discipline, but suggests a pattern and the need for remediation, the board could communicate this to the licensee and direct him or her to address the areas of concern.

### **UNINTENDED CONSEQUENCES**

In addition to considering the two issues above, the MOL Analysis Taskforce also identified and discussed several potential unintended consequences that could occur as a result of implementation of MOL policies. The taskforce agreed that since MOL is not yet in place, it is difficult to say definitively what consequences could result from implementation of MOL but acknowledged that, regardless of how real or perceived the consequences, it is important to think through possible future scenarios so that states may be as prepared as possible.

Messaging will be extremely important to successful implementation of MOL. Such messaging should make it clear that the intent of MOL is quality improvement for all physicians; it is not

intended to identify and remove “bad” doctors from practice. Other important messaging points are:

- Implementation of MOL programs represents a conscious and proactive effort on the part of state medical boards to improve the quality of care being provided by physicians to patients;
- FSMB and state medical boards will have to help people (physicians and patients) understand what MOL is and is not; and
- In talking about MOL, states should avoid use of the terms “competence” or “competent”. Participation in MOL is participation in activities that are demonstrations of competence; it should not be equated to mean that the physician is competent.

### **Additional and unnecessary burden for physicians**

#### *Redundancy, time and cost*

- Many physicians will have concerns about the time and costs involved with meeting MOL requirements, as well as the availability of resources. To address these concerns:
  - There should be a number of means by which physicians can meet MOL requirements, one of which should be maintenance of specialty board certification.
  - MOL requirements should be monitored and revised on a regular basis to include assessment and educational activities that are demonstrated as most effective in helping physicians improve practice.
  - Physicians should be able to re-purpose activities (i.e., those activities a physician is engaged in to meet quality improvement requirements for other stakeholders should be acceptable for purposes of MOL).
  - Many tools to support quality improvement activities already exist or are being developed. Vendor competition will increase that activity.
  - It is likely that licensees who will be most impacted by MOL requirements will be those who are not participating in a Maintenance of Certification or Continuous Certification program, who are in solo practice or who do not have privileges at institutions like hospitals and as such are not being held accountable through other stakeholders to improve performance.
  - There should be reciprocity for participation in MOL for physicians who are licensed in multiple states. For example, if a physician is licensed in States A and B but only practices in State A, State B should also accept the physician’s participation in MOL for State A.

#### *Secure exam*

- The inclusion of a high-stakes, secure exam could have the unintended consequence of prompting licensed physicians who are close to retiring, to do so. It could also generate substantial negative reaction from practicing physicians who perceive a high-stakes examination as a potential threat to their ability to keep their license. To mitigate this possible consequence,
  - States could include an examination as one of several tools which a licensee could use to identify opportunities for improving his or her medical knowledge base or other competency.
  - If a secure exam is included as part of the MOL requirements, the exam should be practice-relevant and should be formative rather than summative.

### **Administrative burden for state medical boards**

Medical boards have concerns about the potential need for increased staff and financial resources to administer MOL and verify licensees' compliance with MOL requirements. These concerns are addressed below.

#### *Implementation*

- By setting MOL requirements and allowing third parties to develop tools and resources to be used in meeting these requirements, state medical boards will significantly minimize the need for additional human and financial resources needed to implement MOL requirements.
- Standardizing MOL requirements across jurisdictions will help to mitigate cost and burden for both licensing boards and physicians.
- A first step toward implementation of a full MOL system could be to build on the existing platform for CME (e.g., requiring CME for license renewal to be practice-relevant).
- Implementation of MOL will require coordination and collaboration with other stakeholders. FSMB can serve as a bridge between state medical boards and those stakeholders.
- MOL is a meaningful step in responding to calls for improvements in health care quality. MOL will result in better and more credible evidence to show the public that licensed physicians are providing quality health care.

#### *Increased burden to verify compliance with MOL*

- Rigorous enforcement of MOL requirements – i.e., requiring every physician to submit documentation of participation in MOL activities – could result in a need for states to invest resources up-front in systems to efficiently monitor compliance. The most efficient means of monitoring compliance will be to use technology that will enable electronic transmission and verification of licensee compliance with MOL.
- State medical boards may have concerns about the additional resources (human, financial, time) needed to identify and vet MOL activities and resources. This could be alleviated by the creation of a set of criteria that are endorsed by all state medical boards as acceptable for use in meeting MOL requirements. These criteria could then be used – by either states individually or by a national accrediting organization – to review and approve the validity and reliability of resources used to meet MOL requirements (similar to a Good Housekeeping Seal of Approval).

#### *Statutory authority*

- Some states may not currently have the authority to implement MOL; this may require the state medical board to open its medical practice act.
- MOL requirements should be structured to focus on quality improvement for all physicians. As such, a state medical board may be able to reinterpret existing statutes (in particular, statutes pertaining to CME for license renewal) as being sufficient for implementing MOL.
- Given the current national focus on healthcare reform, there may be concern that federal law could preempt state law. It is better for the profession to undertake this activity proactively, and to define its own criteria for MOL, than for the federal government to develop and implement requirements for the profession. The FSMB will continue to monitor and update its member boards on the national healthcare debate.

#### **Inappropriate use of self assessment and performance data**

Physicians will have concerns about the confidentiality of any performance data used as part of process of complying with MOL requirements. These concerns are addressed below.

#### *Confidentiality of Physician Data*

- Self assessment and performance improvement data should be considered the property of the physician engaging in the activity. Requiring physicians to submit attestations of participating in or completing MOL requirements precludes state medical boards from gaining access to individual physicians' performance data. If states choose to audit licensees for compliance purposes, such audits should confirm that the activities in which the physician is engaging in for MOL are aligned with the physician's practice and are approved by the medical board.

#### *Situations where state medical boards may wish to access physician performance data*

- It will be important to extend strong confidentiality protections for physicians who engage in self-assessment or performance improvement activities as a condition of license renewal. That being said, state medical boards are the ultimate decision makers as to whether and when they will request physicians to submit self assessment or performance data as situations warrant.
- In situations where a state medical board may be investigating a quality of care complaint or concern against a licensee, some medical boards could choose to request access to the licensee's performance data as part of the investigation. It will be important for states to be cognizant that such requests could undermine licensees' full and good-faith participation in the MOL process. If a state chooses to request these data from the licensee, the licensee should have the right to decide whether or not to send this information to the state medical board. Allowing the licensee the final decision in whether to provide this information to the state medical board will help to alleviate physicians' concerns about their quality improvement efforts being used in a punitive fashion.

#### *Patient access to information about physician participation in MOL*

- To address physicians' concerns about patient access to performance data as well as the public's increasing interest for information on physician performance, the State Medical Board:
  - Should post or provide for public information, a description of the MOL process and a list of the types of activities approved by the board as acceptable for use in meeting MOL requirements;
  - Could include a summary of the physician's compliance with MOL requirements (e.g., met/does not meet) as part of the physician's profile on the state medical board website; and
  - Will need to communicate clearly with the public about what this information is and what it means, to include a statement that MOL compliance does not represent a rating or stamp of approval of the physician.

### **Impact on workforce**

One unintended consequence of MOL could be the possibility of interstate medical migration to the states with the least stringent relicensing requirements, particularly if there is incremental, state by state implementation. This possibility, coupled with a second unintended consequence of early retirement by physicians frustrated by what they perceive as unnecessary burden posed by MOL, could have a negative impact on access to care. While it is difficult to assess the likelihood of this occurring, Taskforce members did note the following:

- While there is the potential for physicians to leave practice should state medical boards implement MOL policies, it is difficult, if not impossible, to anticipate the impact to the workforce in any tangible way.
- Consistency in MOL requirements established across jurisdictions will mitigate concerns about physician migration to states with easier requirements. This will also address concerns about MOL having a negative impact on the progress being made with license portability.
- Most states do not gather sufficient data to predict workforce issues (for MOL or otherwise) or to be informed about licensed physicians who are clinically inactive. State medical boards should begin collecting this information as part of the license renewal process.
- MOL is not likely to impact the number of new physicians coming into a state because medical students are already being educated and trained in a continuous improvement construct and are already engaging in the types of activities that would form the basis for MOL.
- In some states, retired physicians are able to maintain a full license (although such physicians often must meet any CME requirements in order to do so). Under MOL, such physicians may choose to relinquish their license unless there is an inactive license category. State medical boards may wish to explore the use of an “inactive license” category for retired physicians, and whether physicians with an “inactive license” would be exempt from participating in MOL. If retired physicians are able to retain a full license, it should be left to the discretion of each individual states to determine whether or to what extent those physicians should be required to participate in MOL (*see information regarding physicians not in active clinical practice for additional comments and recommendations*).

# ATTACHMENT 4



## **ADVISORY GROUP ON CONTINUED COMPETENCE OF LICENSED PHYSICIANS**

### **Report on FSMB Maintenance of Licensure Initiative**

**Approved as amended  
November 18, 2009**

**Amended for dissemination by FSMB Board of Directors  
December 13, 2009**

**Amended by the Advisory Group on January 27, 2010 after review of  
stakeholder comments**

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\* Organizational affiliations are presented for purposes of identification and do not imply organizational approval of the Advisory Group's work or content of the Report.

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**FEDERATION OF STATE MEDICAL BOARDS  
ADVISORY GROUP ON CONTINUED COMPETENCE OF LICENSED PHYSICIANS**

**Report to the Federation of State Medical Boards, Inc  
Board of Directors**

**INTRODUCTION AND CHARGE**

The Federation of State Medical Boards' (FSMB) Advisory Group on Continued Competence of Licensed Physicians was convened in the fall of 2009 and charged to issue an opinion to the FSMB Board of Directors concerning the FSMB's Maintenance of Licensure initiative and more specifically, whether the framework proposed in the report of Special Committee on Maintenance of Licensure for use by the state medical boards in assuring the continued competence of licensed physicians is feasible, reasonable, consistent with the guiding principles adopted by FSMB's House of Delegates in May 2008 and suitable for use by state medical boards in assuring the continued competence of licensed physicians.

In carrying out their charge, the Advisory Group was asked to include in its consideration and, where appropriate, provide input regarding:

1. Review of the FSMB's work on Maintenance of Licensure (MOL), to include public policies, reports, documents and any active engagement of state medical boards, the public, physicians and other stakeholders in discussions about MOL and the solicitation of their input in the evolution and development of related policy recommendations.
2. Review of the available research and published literature concerning the evidence for the need for initiating an MOL program and the effects of such a program as well as other quality improvement methodologies on physician practice and quality care outcomes.
3. Review of further analyses of any outstanding issues that surfaced as a result of the MOL impact analysis report and state medical board and other stakeholders' feedback to this report.
4. In collaboration with appropriate stakeholders, review and /or develop recommendations for how MOL, maintenance of certification and other continuous improvement activities could be aligned to support state medical boards in achieving a regulatory system that assures the public of a physician's competence while minimizing duplication and burden on the physician community
5. Review of any pilot projects supported/funded by the FSMB in collaboration with appropriate stakeholders centering on issues relevant to the MOL discussions.

## **DESIRED OUTCOMES**

After reviewing the charge, the Committee developed its list of desired outcomes from the planning process. It was agreed that it would like to achieve:

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

## **METHODOLOGY**

The Advisory Group on Continued Competence of Licensed Physicians held three conference call meetings and one face to face meeting during the period from August – November, 2009. At its first meeting, the Committee agreed to the following:

- A consensus-based process and report would be the goal of the Advisory Group. In addition to addressing the Advisory Group charge, the Group might also consider “complementary strategies” that may indirectly relate to the Group’s recommendations,
- While the members would have free access to discuss Advisory Group deliberations within their organizations, it was agreed that no member of the Group would prematurely represent any discussion as a decision of the Advisory Group as a whole.

The Advisory Group was cognizant that the desired deadline for its work was November, 2009, but that if additional time was needed, an extension would be granted.

## **INFORMATION PROVIDED TO THE ADVISORY GROUP**

The group used a knowledge based approach to its deliberations and considered all FSMB documents regarding Maintenance of Licensure (MOL), available research, policies from other organizations, including the American Medical Association. See Supplemental document A for a glossary of terms and acronyms. See Supplemental document B for the Maintenance of Licensure Timeline and see Supplemental document C for a complete listing of all documents distributed, read and considered by the Advisory Group.

The facilitator also conducted confidential phone interviews with members of the Advisory Group and FSMB staff involved in the Group. Advisory Group members were asked:

1. In the next few years, what are the greatest opportunities regarding the FSMB's Maintenance of Licensure Initiative? Greatest challenges?
2. To what degree is the framework proposed in the Special Committee on MOL Report feasible, reasonable, and suitable for use by state medical boards?
3. What are the key issues that our Advisory Group should be addressing?
4. What preliminary advice do you have for FSMB on its Maintenance of Licensure Initiative?
5. Any other ideas and suggestions you would like to place on the Advisory Group "table?"

The results were aggregated anonymously and served to "jump start" the discussion about Maintenance of Licensure and the role of FSMB. A summary of the interviews is in Supplemental document D.

In order to be absolutely clear about its charge, the Advisory Group Chair requested a legal opinion about the use of the term "assure" in a Maintenance of Licensure program. The legal opinion is Supplemental document E.

Finally, the Advisory Group requested and received a survey of State Medical Boards regarding their level of discussion/dialogue about MOL and their ability to implement MOL requirements, either through statutory authority or reinterpretation of existing Continuing Medical Education (CME) language. This survey repeated several questions that had been asked in 2007. Supplemental document F contains the most recent data from this survey, although the Advisory Group had the benefit of only the first 30 respondents when it met face-to-face on October 12-13, 2009.

## **ADVISORY GROUP ENDORSEMENT OF FSMB GUIDING PRINCIPLES**

In its first action, the Advisory Group recommends continued FSMB support of its five MOL principles from the Board of Director Report 08-3: *Assuring the Ongoing Competence of Licensed Physicians*, with the exception of the third bullet as modified below. The Advisory Group believes that the replacement suggestion for the third bullet emphasizes the positive implications of 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 compromise patient care or create barriers to physician practice. (Previously: "Maintenance of licensure should not be overly burdensome for the professional 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.*

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

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

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

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

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

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

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

*Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of 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?)***

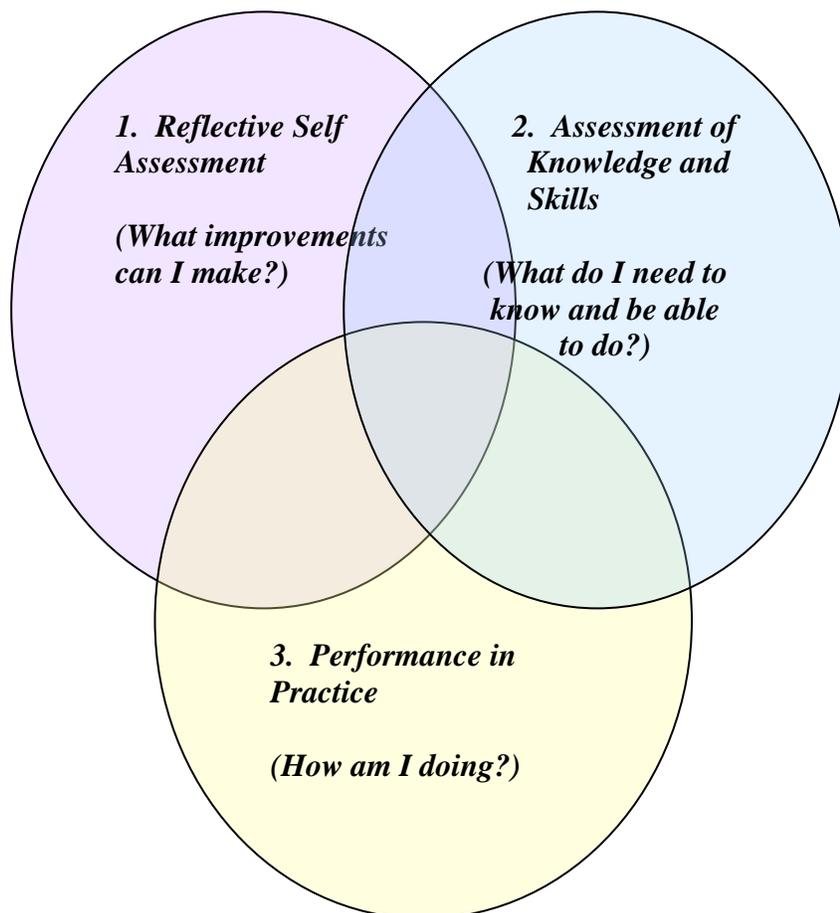
*Physicians must demonstrate accountability for performance in their practice using a variety of methods that incorporate reference data to assess their performance in practice and guide improvement.*

## CONTINUING COMPETENCE FOR PHYSICIAN LICENSE RENEWAL 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.*



## COMPONENTS OF PROFESSIONAL DEVELOPMENT PROGRAMS AND ACTIVITIES

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

GOALS	STRATEGY (HOW)	OPTIONS /EXAMPLES
<p><b>1. Reflective Self Assessment (What Improvements Do I Need to Make?)</b></p> <p>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.</p>	<p>Self assessment incorporates external measures of knowledge and skills or performance benchmarks.</p>	<p>Assessment tools could include:</p> <ul style="list-style-type: none"> <li>• Self-review tests such as                             <ul style="list-style-type: none"> <li>- MOC and Osteopathic Continuous Certification (OCC)</li> <li>- Home study courses or web-based materials</li> <li>- Medical professional society/organization or institution-based simulation</li> </ul> </li> <li>• Others approved by the state medical board</li> </ul> <p>Professional development activities could include:</p> <ul style="list-style-type: none"> <li>• Review of literature in the physician’s current practice area</li> <li>• CME in the physician’s current practice area that enhances patient care, performance in practice and or patient outcomes.</li> </ul>
<p><b>2. Assessment of Knowledge and Skills (What Do I Need to Know and Be Able to Do?)</b></p> <p>Physicians must demonstrate the knowledge, skills and abilities necessary to provide safe, effective patient care within the framework of the six competencies as they apply to their individual practice.</p>	<p>Assessments of knowledge and skills 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"> <li>• Practice relevant multiple choice exams, e.g., MOC/OCC exams, National Board of Medical Examiners (NBME) shelf exams, National Board of Osteopathic Medical Examiners (NBOME) COMAT Achievement Tests, NBOME shelf exams</li> <li>• Standardized patients</li> <li>• Computer-based clinical case simulations</li> <li>• Patient and peer surveys</li> <li>• Mentored or proctored observation of procedures</li> <li>• Performance improvement (PI) CME</li> <li>• Other performance improvement projects such as the Surgical Care Improvement Project (SCIP), American Medical Institute (AMI), Institute for Healthcare Improvement (IHI), Healthcare Effectiveness Data and Information Set (HEDIS)</li> <li>• Procedural hospital privileging</li> <li>• Others approved by SMBs</li> </ul>

GOALS	STRATEGY (HOW)	OPTIONS /EXAMPLES
<p><b>3. Performance in Practice (How am I Doing?)</b></p> <p>Physicians must demonstrate accountability for performance 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>3<sup>rd</sup> party attestation of participation will satisfy this component.</p>	<p>Assessment tools could include but are not limited to:</p> <ul style="list-style-type: none"> <li>• 360-degree/multi-source evaluations (self evaluation, peer assessment and patient surveys).</li> <li>• Patient reviews, such as satisfaction surveys</li> <li>• Collection and analysis of practice data such as medical records, claims review, chart review and audit, case review and submission of a case log</li> <li>• Registries</li> <li>• American Osteopathic Association (AOA) Clinical Assessment Program</li> <li>• An approved American Board of Medical Specialties (ABMS) MOC Part IV Practice Improvement activity</li> <li>• Medical professional society/organization clinical assessment/practice improvement programs</li> <li>• Peer review</li> <li>• Centers for Medicare and Medicaid Services (CMS) and other similar institutional based measures</li> <li>• Other performance improvement projects such as the Surgical Care Improvement Project (SCIP), American Medical Institute (AMI), Institute for Healthcare Improvement (IHI), Healthcare Effectiveness Data and Information Set (HEDIS)</li> <li>• Other tools approved by the state medical board</li> </ul>

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

The Advisory Group also discussed the recommendations included in the *Draft Report on Maintenance of Licensure*, February, 2008. The Advisory Group agrees that, as modified below, the recommendations are feasible, reasonable, consistent with the guiding principles adopted by FSMB's House of Delegates in May 2008 and suitable for use by state medical boards in assuring the continued competence of licensed physicians.

*The modified recommendations are indicated below in italics.*

### *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 MOL 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 MOL requirements should not be reported to state medical boards. Third party attestation of collection and use of such data (as part of a professional development program) will satisfy reporting requirements.*

## 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

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

## **COMPLEMENTARY STRATEGIES RECOMMENDED BY THE ADVISORY GROUP**

The Advisory Group recognized that additional work needs to be done to launch the MOL initiative and suggested the following complementary strategies:

1. **Implementation.** FSMB consider providing a suggested beginning and ending deadline date for SMB implementation of MOL. Concurrently, FSMB will need to prepare and provide resources of all types including grants, temporary staffing resources, web advice, model revisions of medical practice acts, and tools for state medical boards to use as they develop their own tailored MOL requirements.
2. **“Starter” Plan.** A “starter” plan or concrete list of actions, deadlines, and milestones is needed for FSMB’s use in planning and implementing Maintenance of Licensure among its member boards. It is suggested that the “starter” plan be developed through focused dialogue with state medical boards and other stakeholders, and that pilot programs be implemented in parallel to those discussions.
3. **Communications.** A communications strategy is strongly recommended so that current and future licensees, state medical boards, legislators, and the public understand the importance of lifelong learning and how Maintenance of Licensure can result in improved outcomes for

patients and the health care system. The Advisory Group suggests that a tagline be developed to clearly communicate the benefits of Maintenance of Licensure. Concepts considered were: Professional Development for Continued Licensure, Lifelong Learning for Practice Improvement, and Continuous Practice Improvement through License Renewal.

Additionally, there is an immediate need for a unified message, talking points, a standardized “Question and Answer”, and power point presentation for use prior to the upcoming FSMB Annual meeting.

4. **Outreach.** Continued outreach to the public and the profession, regulatory and assessment organizations, national, state and specialty medical societies, and other stakeholders will be critical to the success of Maintenance of Licensure. It is suggested that this begin immediately in anticipation of the first wave of SMBs beginning to implement the program.

## CONCLUSION

The Advisory Group on Continued Competence of Licensed Physicians agreed with current FSMB policy stating that state medical boards have an obligation to the public to assure the continuing competence of physicians seeking license renewal. The Advisory Group believes that the public wants physicians to be up to date in medical practice and that state medical boards have the authority within their public mandate to require all licensed physicians to periodically demonstrate their ongoing competence. There is some evidence that supports continued lifelong medical education as an effective means of physician learning and change if it is part of a system of continuous professional development that includes self-assessment, remediation and reassessment. There is also a widespread, national focus on improving quality of care and initiatives that are creating a “culture of improvement” in medicine.

Persuaded by the information it reviewed, the Advisory Group recommends that FSMB support and adopt the Advisory Group on Continued Competence of Licensed Physicians Report on FSMB Maintenance of Licensure Initiative, dated November 18, 2009.

It is recognized that there may be challenges to implementation of Maintenance of Licensure. However, the Advisory Group believes that the framework as amended is feasible, reasonable, consistent with the guiding principles adopted by FSMB’s House of Delegates in May 2008 and suitable for use by state medical boards in assuring the continued competence of licensed physicians. The Advisory Group believes that these challenges can be overcome through clear communication of a compelling rationale, leadership, and resources.

The Advisory Group believes that FSMB can and should commit to a leadership role with the state medical boards by providing significant human, financial, and legal resources to help them implement MOL programs designed to assure the public of the continuing competence of physicians seeking license renewal.

## GLOSSARY OF TERMS AND ACRONYMS

For the purposes of this report, the following terms are defined as follows:

**Accredited** – having complied with the standards of a public or private organization approved to issue certificates of accreditation based on an examination of quality of services provided compared to established standards.

**Assessment** – a formal system to evaluate physicians’ competence and ability to perform safely and effectively within the practitioner’s scope of practice.

**Clinical practice** – the active involvement in providing direct patient care and/or consultative care.

**Competence** – A competent physician is one who demonstrates the requisite knowledge, technical skills, judgment, and interpersonal and communication skills to provide safe, effective patient care within the scope of professional medical practice while engaging in ongoing, practice-based learning and improvement.

**CME** – Continuing medical education.

**Continuing Medical Education** – educational activities that maintain, develop or increase the knowledge, skills, professional performance and relationships that a physician uses to provide services for patients, the public or the profession.

**Credentialing** – the process of obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care services in or for a health care organization. (JCAHO Hospital Accreditation Standards, 2003)

**D.O.** - Doctor of Osteopathic Medicine.

**FSMB** – Federation of State Medical Boards.

**Federation of State Medical Boards** - The Federation of State Medical Boards (FSMB) is a national non-profit organization representing the 70 medical boards of the United States and its territories. The FSMB's mission is to continuously improve the quality, safety, and integrity of health care through developing and promoting high standards for physician licensure and practice.

**License** – authorization by law to practice medicine.

**License renewal** – the process whereby a licensee demonstrates qualification for continued licensure.

**Licensure** – the process by which a state medical board grants a license pursuant to applicable statutes.

**MOC** – Maintenance of Certification.

**Maintenance of Certification** – A program enacted by the American Board of Medical Specialties that requires physicians to provide evidence of meeting the following criteria on a continual basis in order to maintain special board certification:

- Part I: professional standing
- Part II: commitment to lifelong learning and involvement in periodic self assessment
- Part III: cognitive expertise
- Part IV: evaluation of performance in practice

**Maintenance of competence** – the dynamic process of assessing and updating the knowledge, skills and attitudes required to meet the needs of the physician’s current practice. (From Aylmer I)

**MOL** – Maintenance of licensure.

**Maintenance of licensure** – the process by which a licensee demonstrates that he/she has maintained his or her competence and qualifications for purposes of continued licensure.

**OCC** – Osteopathic Continuous Certification.

**Osteopathic Continuous Certification** - A program adopted by the American Osteopathic Association’s Bureau of Osteopathic Specialists that requires physicians to provide evidence of meeting the following criteria on a continual basis in order to maintain osteopathic board certification:

- Component 1: Professional Licensure
- Component 2: Lifelong Learning
- Component 3: Cognitive Assessment
- Component 4: Performance/Practice Assessment
- Component 5: AOA Membership

**Performance** – the translation of competence into action when managing patient care. (From Aylmer I)

**Privileging** – the process whereby a specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization based on evaluation of the individual’s credentials and performance. (JCAHO Hospital Accreditation Standards, 2003)

**Reentry to practice** – a return to clinical practice following a period of inactivity as defined by the licensing authority.

**Remediation** – The process whereby deficiencies in physician performance identified through an assessment system are corrected.

**Retraining** – updating one’s skills or learning the necessary skills to move into a new clinical area.

**SMB** – State medical and osteopathic board.

**Self-assessment** – the evaluation process a professional uses to define any gaps, or differences, between their own knowledge or competence (ability) or performance-in practice and that of a pre-determined self-, norm- or criterion- referenced standard.

**Specialty certification** – recognition granted by the American Board of Medical Specialties (ABMS), American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS) or other equivalent organization as determined by the state medical board that a physician has met certain published standards; provides evidence to the public that a physician has successfully demonstrated advanced training and experience in a given specialty.

### Maintenance of Licensure (MOL) Timeline

- 2002: FSMB Board of Directors approves a motion to include the issue of physicians' continued competence in its FY 2004 action plan.
- September 2003: FSMB Special Committee on Maintenance of Licensure convened. Committee is charged, in part, with 1) developing a position statement regarding the responsibility of state medical boards in ensuring physician competence over the course of his/her career and 2) developing strategies for state medical boards to use in implementing programs to ensure physicians maintain an appropriate level of competence to practice medicine safely throughout their professional careers.
- February 2004: The Board of Directors endorses a recommendation by the Special Committee on Maintenance of Licensure that FSMB adopt policy stating that medical boards are responsible to the public for assuring the continued competence of physicians at the time of license renewal.
- April 2004: *Board of Directors Report 04-1: Report on Special Committee on Maintenance of Licensure* sent to House of Delegates for approval. The following policy statement is adopted by the House of Delegates as FSMB policy:
- “State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking relicensure.”
- March 2005: In response to member medical board feedback that FSMB should take a leadership role in national discussions about assuring the continued competence of licensed physicians, FSMB convenes the first national Physician Accountability for Physician Competence summit. The purpose of the summit was to engage the medical community in a dialog about the future of healthcare in the United States with the ultimate goal of answering the question, “How does the profession of medicine identify, measure and evaluate the ongoing competence of its members to assure the public of its commitment to accountability?”
- February 2005: *Special Committee on Maintenance of Licensure Interim Report* sent to Board of Directors for approval. The report outlines the conceptual challenges associated with implementing maintenance of licensure requirements and discusses issues considered by the committee to date.
- May 2005: Board of Directors report on Efforts to Address the Continued Competence of Licensed Physicians sent to the House of Delegates for information. The report includes the *Special Committee on Maintenance of Licensure Interim Report* as an attachment.
- June 2005: Recognizing that the Physician Accountability for Physician Competence initiative could positively impact the political landscape within which the Special Committee's final report would be released, the Board of Directors asks the committee to defer issuing recommendations about how state medical boards should implement maintenance of licensure initiatives until this national dialogue is further along.
- July 2005: The Board of Directors refers *Resolution 05-3, Physician and Physician Assistant Advisory Group Report* – supplemental documents

*Reentry to Practice*, to the Special Committee. Specifically, the Board asks the committee to draft guidelines for reentry to practice that may be broadly applied to all health professions regulated by state medical boards.

2007: Special Committee completes work on final report with recommendations regarding MOL. Draft model guidelines for reentry to practice are also included.

October 2007: Special Committee completes initial draft of final report and submits to Board of Directors. The Board approves distributing the draft report to member boards and other interested stakeholders for comment.

February 2008: Special Committee submits final report, *Special Committee on Maintenance of Licensure Draft Report on Maintenance of Licensure*, to Board of Directors for consideration. The report includes recommendations for MOL and reentry to practice. The Board of Directors separates the recommendations regarding maintenance of licensure and reentry to practice into independent documents, with the former to be forwarded immediately to the House of Delegates and the latter to be considered by the Board of Directors later in the year. Based on questions and issues raised by state medical boards and other stakeholders concerning the committee's recommendations, the Board of Directors defers acting on the report of the Special Committee on Maintenance of Licensure and instead, recommends to the House of Delegates that the FSMB pursue further information-gathering activities to answer questions about the implications of implementing MOL policies.

May 2008: *Board of Directors Report 08-3: Assuring the Ongoing Competence of Licensed Physicians*, which includes the *Special Committee on Maintenance of Licensure Draft Report on Maintenance of Licensure* as an attachment, forwarded to House of Delegates. The report recommends 1) that the House of Delegates adopt a set of guiding principles that are based upon but broader than those developed by the Special Committee to guide its work and 2) that the House of Delegates approve a motion directing FSMB to pursue information-gathering activities.

The House of Delegates 1) endorses the Board of Directors' recommendation that prior to taking any action on the report of the Special Committee on Maintenance of Licensure, FSMB engage in further evaluation to better understand how implementation of the proposed maintenance of licensure requirements will impact state medical boards and other stakeholder groups and report back to the House of Delegates in 2009 and 2) adopts the following guiding principles as FSMB policy:

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

September 2008: Board of Directors receives a draft document prepared by staff summarizing relevant research findings concerning issues related to assuring the continuing competence of

licensed physicians (e.g., effectiveness of CME, impact of board competence over time). This document forms the basis for the white paper that is currently being developed.

The following motion is adopted by the Board of Directors:  
“Given the current efforts by FSMB to carry out the 2008 House of Delegates directive regarding maintenance of licensure (MOL), the task force organized to assist with this initiative should do the following in order of priority:  
(1) gather scientific evidence supporting the MOL initiative;  
(2) develop strategies/programs for carrying out the initiative;  
(3) analyze the impact these strategies/programs would have on state medical boards.”

October 2008: A taskforce comprised of members and staff of 13 state medical boards is convened to assist in analyzing the impact of implementing MOL requirements on state medical boards and other stakeholders. Discussions from the meeting form the basis for a draft impact analysis report to be submitted to the Board of Directors.

January 2009: The draft report, *An Analysis of the Impact of Implementation of Maintenance of Licensure Requirements*, based on the work of the taskforce convened in October 2008 is disseminated to FSMB’s member state medical boards for comment.

February 2009: The FSMB Board of Directors receives the draft report, *An Analysis of the Impact of Implementation of Maintenance of Licensure Requirements*. The Board approves a motion that the Board of Directors submit an interim report to the House of Delegates recommending that additional study on matters related to maintenance of licensure be conducted in order to assure member boards have as much comprehensive and useful guidance as possible.

Spring 2009: A workgroup of experts in the field of physician evaluation and continuous quality improvement agree to help review and expand the white paper summarizing the literature regarding various issues relevant to physician competence. When completed, the white paper will be disseminated to state medical boards for information.

May 2009: *Board of Directors Report 09-2: Assuring the Ongoing Competence of Licensed Physicians* submitted to House of Delegates. The report includes the impact analysis report, as well as a summary of feedback received on the report. The Board of Directors recommends and the House of Delegates adopts the following:

The FSMB pursue the following scope of work and report back to the House of Delegates at the FY2010 annual business meeting:

1. Conduct, collect and disseminate research on and give additional consideration to the evidence for the need for initiating an MOL program and the effects of such a program on patient care and physician practice.
2. Conduct further analysis of outstanding issues which surfaced as a result of the MOL impact analysis report and state medical board and other stakeholders feedback to this report;
3. In collaboration with appropriate stakeholders, develop recommendations for how MOL, maintenance of certification, and other continuous improvement activities could be aligned to support state medical boards in achieving a regulatory

system that assures the public of a physician's competence while minimizing duplication and burden on the physician community;

4. In collaboration with appropriate stakeholders, support/fund one or more pilot projects centering on issues relevant to MOL discussions;
5. Actively engage state medical boards, the public, physicians and other stakeholders in discussions about MOL and solicit their input in the evolution and development of related policy recommendations.

July 2009:

Members of the MOL Impact Taskforce reconvene to continue analysis of additional issues regarding the impact of the Special Committee's draft MOL policy on state medical boards. Specific issues of focus are:

- Strategies to mitigate possible unintended consequences that may result from implementing MOL policies
- Options for dealing with licensed physicians who are pursuing careers in nonclinical settings (e.g., administration), such as different types of licenses
- How states would address physicians who choose not to or are unable to comply with MOL requirements

Fall 2009:

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

**BILBIOGRAPHY**

Below is a list of reports reviewed by the Advisory Group on Continued Competence of Licensed Physicians.

1. *Special Committee on Maintenance of Licensure Draft Report on Maintenance of Licensure* (February 2008)
2. *FSMB Board of Directors Report 08-3: Assuring the Ongoing Competence of Licensed Physicians* (May 2008)
3. *An Analysis of the Impact of Implementation of Maintenance of Licensure Requirements* (March 2009)
4. *FSMB Board of Directors Report 09-2: Assuring the Ongoing Competence of Licensed Physicians* (May 2009)
5. *Draft Addendum to An Analysis of the Impact of Implementation of Maintenance of Licensure Requirements* (September 2009)
6. *Board Report on Efforts to Address the Continued Competence of Licensed Physicians* (May 2005)
7. *Board of Directors Report 08-3: Assuring the Ongoing Competence of Licensed Physicians* (May 2008)
8. *Board of Directors Report 09-2: Assuring the Ongoing Competence of Licensed Physicians* (May 2009)
9. *Competence, Licensure and Improving Patient Care: An Analysis of the Literature* (draft October 2009)
10. *Report 16 of the Council on Medical Education (A-09: Maintenance of Certification/Maintenance of Licensure* (June 2009)

## Summary of Interviews with Advisory Group Members

Henrichs & Associates  
September, 2009

### 1. In the next few years, what are the greatest opportunities regarding the FSMB's Maintenance of Licensure Initiative? Greatest challenges?

#### OPPORTUNITIES –

##### Regain Public Confidence

- I do believe that there is a clamor from consumer group/ insurers/government demand enhanced accountability for physicians. We use clumsy surrogates to describe it – not keeping current; not professionalism; communication; surrogates for the public; consumer groups are the ones with the complaints.
- Past 10 years or so; appears to have been loss of public confidence in the practice of medicine. This is an opportunity to regain the confidence of the public by showing them that the house of medicine is taking responsibility for assuring of competence now and the future.
- In reality medicine changing so fast; that even if you were certified 10 -20 years ago because of pace of change; need some way to reassure public.
- Creates a significant opportunity for Federation and SMBs to demonstrate commitment to public. Public perspective – they think that we are already.
- Talk about transparency; we need to be doing something to say that physicians remain competent, not just recordkeeping.
- A matter of credibility as far as compact we have with the public; we guarantee competency and quality when we issue a license and that is where we have to regain our credibility.

##### Encourage Standardization

- My experience with FSMB and state medical boards; it appears that all state medical boards not on the same page – opportunity to standardize the processes to make it less burdensome for physicians to go from state. Will ultimately increase public confidence in licensing boards.
- Greatest opportunity is to create some standardization and ability to implement. – get states to all sign off of what we do. If FSMB comes out with a recommendation, state board has to have a good reason not to do it.
- This is ultimately for the public and I would hope that whatever they do around MOL will become more overarching among the 70 jurisdictions.

##### Catalyst for Change

- This could be a catalyst to break up some old ways of doing things.
- Focus on positive than negative aspects – counting scalps for the positive.

## **Improve Health Care Quality and Physician Practice**

- An opportunity to improve health care quality and physician practice.
- Show what works best in preventive and standardized care. Look at long range; if FSMB is considered a resource in a new prevention mindset. Why shouldn't we be the one to say look at standardized care more.
- FSMB can find a path that acknowledges what is credible about public concerns and find a way to reasonably foster an environment, where physicians are reminded that physicians are required to maintain currency on latest medical evidence, attentiveness, etc.

## **Recognized and Relevant in Health Care Reform**

- It makes us recognized and relevant in health care reform.

## **Other**

- Concluded that the highest bar is set by the hospitals and let's begin with the local credentialing process and peer review process. What is happening at hospital level is getting direct observational up to minute assessments in practice; technical; knowledge base, interaction with peers, teams, how do they use the system. THAT is really what we are looking for and what we get when apply for initial licensure. That information is where competency rests.
- Needs to remain requirement neutral; can't do 20 steps to renew a license. Board certification recognized and alternates for not certified.

## **CHALLENGES –**

### **Physician Understanding/Acceptance**

- One of the biggest challenges is that a physician participating in process and perceives it as non-threatening. Feels that license is threatened will get push back. We have to have a process that the physician understands is helping them rather than hurting them.
- Convince physicians that it is necessary and that it will work to benefit patients; that is why we are looking at evidence; need to answer physician question - be able to answer "What is in it for me?"
- Licensee buy in; need to explain why this is necessary.

### **Difficulty of Standardization**

- Can we get most of the boards on the same page with same vision? We wouldn't want to have a process where state would change it for their particular constituency.
- Significant diversity between state medical boards; an appropriate goal to strive for a national standard and therefore national recommendations; challenge to find sweet spot that satisfies all of the different stakeholders; stay focused on patient safety and physician competence. More effective than if we seek political solutions.

## **Difficulty of Adding Value and Making a Difference**

- How do they come up with something that is unifying, adds value, and is strong enough to make a difference?
- Have to avoid complaint that it “takes too much time, too much money and is really not helpful or meaningful?”
- If FSMB is going to steer the course, we need to be focused on root cause analysis.

## **Workable and Practical/Acceptance by SMBs**

- Only concern when I reread it is that it has to be a workable system; practice information collected is ideal. For example, notify SMBs with scope and shift in practice.
- Reality check – Can we really ask them to keep practice history up to date, when we can’t even get current addresses?
- Acceptance by our members; do they have resources and funds at this time?
- Federation wise in doing this step wise. We don’t need expensive and really intrusive test; don’t tell a licensing board what they need. If we could find easy to use, validated alternatives that are meaningful, they would drop their oppositions.
- Challenge with legislators, will every SMB need to open state medical practice act?
- Financial – for many SMBs, this will be a struggle financially.

## **Danger of Irrelevancy**

- Concern that quality initiatives may pass them by and they may become irrelevant. Still a pressure to stay with the status quo.
- At some point others will get ahead of FSMB – progressive SMB, federal government in health reform.

## **FSMB Governance/Ability and Willingness to Act**

- FSMB particularly challenged due to nature of their governance, and use it almost as an excuse. Exert some leadership and make some tough decisions.
- Concern about FSMB track record; been going on for years; yet another group.
- Our own internal structure is thin and suspect with ability to carry it out to SMBs.

## **Medical Politics**

- Some issues with competition among other stakeholders; problem with medical system of stakeholders; everyone is jockeying for position and not a lot of stroking together.

## **Other**

- Also legal issues; how much can you ask for from hospital is large group practice going to share?
- Risks are (specialty board also) will not themselves do it the diligence required to analyze real issues is dissatisfaction with system; system is so challenging; being asked to respond.
- Future is not in discipline, but to move ourselves ahead in improvement in remediation and rehabilitation.

- If every physician had a requirement for standardized 360 degree process for all physicians, then you would have national benchmark survey for that and go to licensing board. Difficulty with MOL is that you don't have good information. If we had tools, not expensive and not time consuming and put the onus on the physician

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**2. To what degree is the framework proposed in the Special Committee on MOL Report feasible, reasonable, and suitable for use by state medical boards?**

**Yes, with Phase-in**

- I believe it is, but with some kind of a phase-in period. Only concern is that a number of physicians in various stages in medical practice; some change specialties with no prep, and others are. Administrative physicians. How do we include all those people and do in a way that is appropriate, but still fair?
- We need a REAL LIFE solution; define what would be ideal and do it in phases; can't do whole concept and drop into Board's lap. If a doctor asks: I am not Board certified; what does Board want me to do?, there should be a very easy answer.
- The framework is well thought out, only its practicality in question. We are looking at an evolutionary process; framework is something to build on, not the whole body of work

**Yes, but it will take selling**

- IS MOL report feasible? Yes, but it is going to take a selling – SMBs and Executives, but it is going to take a change in mind set

**Yes, with options**

- We have to offer options. Example: over a 10 year cycle at year 3 -4, do a self assessment, year 5 – 6 a second portion where you actually have a record review; at 7 – 8 take a standardized test, but have two or three opportunities to retake in a time period.
- If we have a range of options 2 – 3 that are reasonable, that still allows for standardization. We don't want it rammed down their throats.
- Another example, the Canadian model, and it wasn't very expensive. Look at a random selection of charts. - \$1,250 and if you maintain Board cert you are exempt.

**Need to meet public needs while not harming profession**

- FSMB and member boards have the tools and resources to respond back confidently and assuredly but not to overreach. Looking out for well being of public does not necessitate disadvantage and harming the profession.
- How do you reasonably, but not intrusively remind physicians that they must make a credible attestation that they are current; professional in relationship and how do you represent that in a non-punitive way to the public.

**Other**

- Say how evidence will be shown to the public. How is the public going to know if a physician is competent?

- Recertification really needs to be some sort of a test. Not looking for physicians to fail. I look at it as a people person for consumer perspective. How to help physicians do better and have more of a personal relationships with them, consumer advocate asking questions but trying to get underneath for reasons for their problems.

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### **3. What are the key issues that our Advisory Group should be addressing?**

#### **What is Evidence/Impact?**

- Special Committee provided a framework, now we need evidence and the white paper group report.
- Needing evidence; white paper group report.
- Impact of MOL.
- Need to do due diligence to make sure it is not redundant.
- We need seminal articles that address the real evidence that supports a need to change/ maintenance of certification or CME reporting. What is evidence that suggests a problem, or better way? Very useful to go forward that there is credible academic research on these sorts of things.

#### **Buy in of Profession and SMBS**

- Role of SMBs and how to achieve professional buy in.
- Addressing the benefits and show benefits.
- Make sure that we have options, but limit the number of options to 3 or 4.
- How do we get a feel for the public's views on this?

#### **Ensure Practicality/Feasibility**

- Ensure that the process is practical, not just a mandate certain things, actually helps people.
- Should not be burdensome.
- Have an answer to "How costly?"
- We need to streamline the system.

#### **Action Plan**

- We are not much use unless we have action plan.
- Timeline for implementation.

#### **Build on What Has Been Done**

- Rally around principles and timeliness of the issue = a great outcome.
- Endorse or build on recommendations from previous groups; strengthen those recommendations.
- Pilots – engaged in those conversations – devil is in details; seems to point towards and substantive of physician competence as well as a pathway that would be tolerable by most SMBS and physicians.

## **Focus on Solutions**

- Could FSMB work with partners to find a 360 degree product or assessment model; reasonably priced, accessible, reliable, and valid?
- And focus on challenges to solutions.

## **Tie in with Major Payors**

- Factor in significant – quite possible that payers are going to really mandate some type of MOL/QI/competency whether we do anything or not. Tie in with major payors. If not we will be laggards and stumbling blocking in terms of patient safety – if not moving forward we will lose credibility.

## **Other**

- Would MOC serve as an equivalent so we have no more jumping through hoops But once you get into that; some really tough issues with non certified physicians.
- Link ABMS organizations and MOL will be very important.

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## **4. What preliminary advice do you have for FSMB on its Maintenance of Licensure Initiative?**

- As we go forward, there may not consensus on every point; foster discussion; recognize that we have a majority/minority opinion and reflect those both. Not final arbiter of MOL and what it looks like. Better outcome than striving for false consensus and having a process where individuals were unheard or solution rammed down their throats.
- Get back to reality issues; financial issues all states facing in next 2 – 3 years. Going back to phase in.
- Look at our opportunities and prepare for those to answer challenges to Federation.
- We need to be all inclusive - appears as though it is all inclusive; go back to individual state. Have we gotten feedback from those that are not on same page? How do we get their input, and improve the process in their state. Make sure we include younger physicians and early training.

## **5. Any other ideas and suggestions you would like to place on the Advisory Group “table?”**

### **Advisory Group Process**

- Not sure that this group and timeframe is really going to have the perspective, energy and time to weigh in on the specifics. Still need to do pilot work.
- Make sure that the Advisory Group can raise disconfirming opinions.
- Use organizational experience and professional judgment; what is future of medical regulation and can process meet that?
- Don't let FSMB Board/Staff opinion to influence you. Let group do own thing with time and resources that you need.

- Wants to know status of White paper and impact analyses. These are urgent for our deliberations.
- Perhaps it would be helpful at some point to identify "deal breakers" and what we need to do to satisfy particular individuals or not.

### **Need for Specificity**

- We need to be more specific; Committee agreed MOL should support to continuous professional development; what does that mean?
- Changes in *Essentials of a Modern Medical Practice Act* – what are they specifically?
- Real work – we have to have recommendation of how to implement.
- Sell it to state boards; go ahead and get to some detail; some action plans; ways to accomplish it so cost doesn't need to be prohibitive.
- Need more specific outcomes – has somebody tried it and how has it gone?

### **Balancing Act**

- Can we be menu driven and evolve; how do we start so everyone is comfortable and on board with it?
- How to be measured and effective at the same time?
- How do we differentiate between competence and performance accountability?
- Peer review doesn't always work; numerous times physicians are not disciplined through Board. Peer review at hospital is also challenging; external group review is okay, just want to make sure it helps.

### **Role of FSMB**

- How is the Federation going to facilitate this process for SMBS that are less sophisticated than other boards in how they do it and what are resources. Not every state is electronic and this impedes Federation's work.

### **Other issues**

- Still not sure if we are dealing with generalist maintenance or more specialty basis – more worried about non certified group.
- Boards have had to struggle with practice improvement component with non typical physicians.
- There are places that do retraining and maybe they would will to share it so SMBS are not reinventing the wheel.
- It may well be that MOL is not just one format; MOC other ways that can count. Do not have to have a high stakes proctored exam as only pathway. QI in practice; onus on licensee to help design their MOL program. Shouldn't just be one pathway.
- Financial impact – diversification in what it cost to get and maintain. If a process is being mandated that requires a state to develop significant resources. Where is money going to come from?

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## 6. Ideal Outcome

- Love to see a unified process that would be non-threatening and not burdensome and cost effective.
- Looking forward to participating in this with all the experienced leaders – looking forward to learning as well as participating.
- Very specific recommendation to push the envelope.
- Whatever it is, the vision needs to be simple – if not, it will be so band aid as to be meaningless
- Need to be challenged; should it be linked to board certification with 80/20 rule?  
Are we dealing with 100% or 20% then go on record as having said that?
- Offer an option that the state boards can look at and see that it is workable and that it increases patient safety.
- Help doctors – soon third party payors will be saying “show us what you have done.”

**MEMORANDUM**

Tuesday, 06 October, 2009

To: Carol Clothier

From: Tim Miller

Subject: Use of the term “assure” in a Maintenance of Licensure program

Using the term “assure” within maintenance of licensure program will not increase the boards’ exposure to liability. Note that the boards in almost every jurisdiction have exposure to negligent licensing suits, this exposure does not change by using the term “assure.”<sup>2</sup>

By statute and case law the boards are assuring the public that physicians meet minimum legal requirements. Some states specifically assert that they created the boards to assure the public safety; for example California, Florida, Louisiana, Minnesota, Nebraska and North Carolina.<sup>3</sup> The states that do not specifically assert that the board is assuring public safety imply it. For instance, an Idaho court pointed out that “[t]he practice of medicine is a privilege granted by the state of Idaho, which retains the authority to license and regulate physicians practicing in this state in order to assure the public health of the citizenry.”<sup>4</sup> Further, “[o]ne of the purposes of the Medical Practice Act is to assure the public health, safety and welfare. . .”<sup>5</sup>

Additionally, the act of licensing it self is an assurance. “States may require a variety of licenses to protect health, safety and welfare. For example, medical licenses are required to protect the public to ensure that doctors have achieved the requisite training prior to practicing medicine.”<sup>6</sup> Finally, several boards have the term “assurance” in their titles and there is no indication that this has increased their liability (e.g. the Florida Board of Medicine Medical Quality Assurance, the California Board of Medical Quality Assurance, the Maryland Board of Physician Quality Assurance and North Carolina Division of Medical Quality Assurance).

<sup>2</sup> In researching this issue I have used the terms “assure” and “ensure” interchangeably.

<sup>3</sup> CA Stats.1876, ch. 518, § 10, p. 794; F.S.A. § 458.301; LSA-R.S. 37:1261; M.S.A. § 214.001, N.R.S. 630.003; N.C.G.S.A. § 90-2; see, *Borden v. Division of Medical Quality*, 30 Cal.App.4th 874, 35 Cal.Rptr.2d 905, Cal.App. (4 Dist., December 02, 1994); *Uckun v. Minnesota State Bd. of Medical Practice*, 733 N.W.2d 778, Minn.App., June 26, 2007; *Riggs v. Woman To Woman, Obstetrics and Gynecology, P.C.*, 351 Ill.App.3d 268, 812 N.E.2d 1027, 286 Ill.Dec. 12, (Ill.App. 2 Dist., July 08, 2004); *Brockett ex rel. Brockett v. Davis*, 325 Ill.App.3d 727, 762 N.E.2d 513, 260 Ill.Dec. 854, Ill.App. (3 Dist., September 13, 2001); *Kayfetz v. State of California*, 156 Cal.App.3d 491, 203 Cal.Rptr. 33, Cal.App. (1 Dist., May 29, 1984); *People v. Tilton*, 273 Ill.App. 52, 1933 WL 2708, Ill.App. (1 Dist., December 11, 1933); *In re Kim*, 403 N.J.Super. 378, 958 A.2d 485, (N.J.Super.A.D., October 28, 2008); *Nguyen v. State, Department of Health Medical Quality Assurance Commission*, 144 Wash.2d 516, 29 P.3d 689, (Wash., August 23, 2001); *Matter of Polk*, 90 N.J. 550, 449 A.2d 7, (N.J., July 30, 1982).

<sup>4</sup> *Miller v. Haller*, 129 Idaho 345, 924 P.2d 607 (Idaho, Sep 03, 1996).

<sup>5</sup> *Haw v. Idaho State Bd. of Medicine*, 140 Idaho 152, 90 P.3d 902 (Idaho, Apr 22, 2004).

<sup>6</sup> *Amunrud v. Board of Appeals*, 158 Wash.2d 208, 143 P.3d 571, (Wash., 2006).

The explicitly and implicitly assurances stated in the medical practice acts, the assurances pointed out in case law and some boards using the term “assurance” in their titles have not created additional liability for the boards. Adding the term “assurance” to maintenance of licensure programs will not increase the boards’ liability exposure. Assuring continued competence is no different from assuring initial competence. Most statutes and cases however, speak of assuring the public safety rather assuring physician competence. One way to express this consistently would be to say “a maintenance of licensure program ensures continuing competency to assure public safety.” However, if the sentence is reversed we get “the medical board ensures the public safety by assuring the competence of a physician.” Therefore, it’s only a matter of semantics and it should not make a difference whether the board uses ensure or assure.

While the term “assurance” may not create additional liability exposure, operating a maintenance of licensure program can create additional liability exposure. Most likely, this increased liability exposure for the boards will stem from negligent licensing. Undertaking the task of assuring a physician’s competency during the license renewal phase increases the possibility the board will conduct a negligent licensing investigation or negligently make a licensing decision.

The medical practice act specifically creates a duty upon the board to protect the public. The courts have also found a duty exists when an agency undertakes licensing responsibilities. “If an entity chooses to license and regulate an area, a duty to exercise reasonable care in doing so follows.”<sup>7</sup> Further, “[o]ften, the duty to license is deemed to invoke corresponding duties of investigating and monitoring.”<sup>8</sup> That assuring continued competency within a maintenance of licensure program will create a duty upon the board is unavoidable. The boards, however, have very low exposure to negligent licensing claims because they have immunities.

The broadest immunity is sovereign immunity. Almost every state has abrogated or significantly limited this immunity, so it has limited application. In those few states, however, the boards enjoy near absolute immunity for all their acts except intentional wrongdoings. As the states abrogated sovereign immunity, the courts began using the public duty doctrine to limit lawsuits against the government.

The most widely available broad immunity is the public duty doctrine. The public duty doctrine states that a duty owed to everyone is a duty owed to no one. “The rationale behind the public duty doctrine ‘is to encourage the effective administration of governmental operations by removing the threat of potential litigation.’”<sup>9</sup> Essentially, the boards are immune from lawsuits by individuals because the boards’ duties are to the public and not the individuals. Almost every board enjoys this immunity, but some states have abrogated this immunity.

The assurance of continued competence will not change the boards’ duties from to the public to the individual, thus, the boards will have immunity pursuant to the public duties doctrine. There are, however, two exceptions to the public duty doctrine - the special relationship exception and the egregious conduct exception.

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<sup>7</sup> Amy D. Whitten, *CAUGHT IN THE CROSSFIRE: EMPLOYERS' LIABILITY FOR WORKPLACE VIOLENCE*, 2000 Article 70 Miss. L.J 505, 534; citing, *R.E. v. Alaska*, 878 P.2d 1341, 1347 (Alaska 1994).

<sup>8</sup> *Id.*; citing, *Washoe County v. Transcon. Ins. Co.*, 878 P.2d 306, 308 n.3 (Nev. 1994).

<sup>9</sup> *David Torres v. Kathleen Damicis*, in her capacity as Treasurer of the Town of Richmond, 853 A.2d 1233, (R.I.,

Jun 24, 2004).

The special relations exception to the public duty doctrine applies when there is a special relationship between the governmental entity and a recognizable plaintiff.<sup>10</sup> This special relation gives rise to a special duty that is “more particular than the duty owed to the public at large.”<sup>11</sup> Most often, the exception fails because the governmental entity owes the duty to the public at large and not specifically to the plaintiff.

Several courts, however, have broadly interpreted the term “recognizable plaintiffs.” One court held that “[a]lthough the statute uses general terms, “all persons” and “others,” . . . that the statute imposed a duty on drivers of law enforcement vehicles and created “a special class of persons—those, who by use of the streets and highways are potential victims of a high speed chase—to whom the duty is owed. Thus, a special relationship was established and the public duty doctrine did not apply.”<sup>12</sup>

The problem broad interpretations cause for the boards is a court could conclude that a particular physician’s patient population would be sufficiently small enough as to open up liability for the board. Certainly, a physician’s patient population is smaller than the pedestrians and drivers on the road during a high-speed chase. One court, however, concluded that a patient could not sue the medical board for negligent licensing because the special relation exception did not apply. The court stated, “we consistently have held that allegations of negligent licensing do not establish that the state or a political subdivision thereof owes a special duty to a plaintiff or foreseeable group of plaintiffs.”<sup>13</sup>

On the other hand, other courts have held a special duty does exist from licensing and investigating activities.<sup>14</sup> One court has held that “[i]ncompetent or haphazard licensing investigations contribute to problems, and are morally blameworthy.”<sup>15</sup> In this case, the State negligently investigated and issued a license to a day care facility. In finding liability, the court noted, “[p]resumably, the effect of state licensing was to instill a greater feeling of security in parents who utilized the licensed day care facilities. Having undertaken the responsibility of licensing, the State was under a duty to exercise reasonable care in carrying out that function.”<sup>16</sup>

These cases demonstrate that some courts in certain circumstance are willing to find a special relation exists between the licensing authority and an individual plaintiff based solely upon the act of licensing. Worrisome, is a court could find that assuring competency could instill a greater feeling of security among the patients, thus, opening up the special relation exception.

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<sup>10</sup> Nelson v. State, 346 Mont. 206, 195 P.3d 293, 2008 MT 336 (Mont., Oct 06, 2008).

<sup>11</sup> Nelson v. State, 346 Mont. 206, 195 P.3d 293, 2008 MT 336 (Mont., Oct 06, 2008).

<sup>12</sup> Id.

<sup>13</sup> David Torres v. Kathleen Damicis, in her capacity as Treasurer of the Town of Richmond. 853 A.2d 1233, (R.I., Jun 24, 2004).

<sup>14</sup> Andrade v. Ellefson, 391 N.W.2d 836, 843 (Minn.1986) (holding that “small children in a licensed day care facility are a particular protected class”); Brasel v. Children's Servs. Div., 56 Or.App. 559, 642 P.2d 696, 699 (1982) (holding that state owed duty to plaintiff users of a state-certified day care facility as members of a protected class); Gagnon v. State, 570 A.2d 656, 659 (R.I.1990) (holding that the state may have a special duty to supervise licensed day care facilities, but noting that “a claim of negligent licensing does not allege anything more than a statutory obligation owed by the state to the public-at-large”); C.T. v. Martinez, 845 P.2d 246, 248-49 (Utah 1992) (“Because the licensing provisions were intended to protect patrons of licensed day-care facilities, a special relationship exists between [the state agency] and those patrons.”).

<sup>15</sup> R.E. v. State, 878 P.2d 1341 (Alaska, Jul 29, 1994) (NO. S-5153)

<sup>16</sup> Id.

The special relation exception is the most likely avenue for board liability exposure. While unlikely, a patient may be able to prove that he or she fell within a small group of foreseeable people who could be harmed by a physician relicensed by the board.

A second exception to the public duty doctrine is the egregious conduct exception. This exception provides that when “the state has knowledge that it has created a circumstance that forces an individual into a position of peril and subsequently chooses not to remedy the situation,” the state can then be held liable for its negligence.<sup>17</sup> This exception is not widely used, but it could create liability for a board that discovers a physician is incompetent during a maintenance of licensure screening designed to assure competency but does not act upon that knowledge.

Unrelated to the public duty doctrine and its exceptions, is the official immunity doctrine. This doctrine is limited to discretionary decision making. “The official immunity doctrine protects government employees from civil liability for conduct that would otherwise be actionable.”<sup>18</sup> This immunity has two basic components - discretionary acts and ministerial acts. Discretionary acts enjoy the immunity while ministerial acts do not.

This immunity protects board staff and members from individual liability for the performance of his or her duties when the duties are discretionary rather than ministerial duties<sup>19</sup> “It does not, however, provide immunity when the State fails to exercise due care in carrying out its own policy, rules and regulations.”<sup>20</sup>

A board’s determination as to whether a physician is currently competent would be discretionary act and immune from liability, but assuring competence through a maintenance of license program, including screening, reviewing, investigating and abiding by all policies and rules would be ministerial and not immune.

As stated above, the boards’ use of the term “assurance” does not increase the boards’ liability. Operating a maintenance of licensure program does increase the possibility of liability exposure only because it increases the opportunities for the boards to make mistakes. However, with sovereign immunity, the public duty doctrine and/or the official immunity doctrine protecting the boards, they have very little liability exposure for assuring competency through a maintenance of license program operated for the protection of the public.

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<sup>17</sup> Bowland v. Town of Tiverton, 670 A.2d 1245, (R.I., February 09, 1996)

<sup>18</sup> Ramos v. Texas Dept. of Public Safety, 35 S.W.3d 723 (Tex.App.-Houston [1 Dist.], 2000)

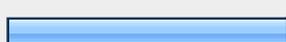
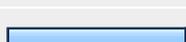
<sup>19</sup> Id.

<sup>20</sup> R.E. v. State, 878 P.2d 1341 (Alaska, Jul 29, 1994).

Maintenance of Licensure Survey

1. Name of board		
		Response Count
		51
		<i>answered question</i> 51
		<i>skipped question</i> 4

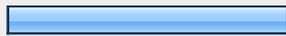
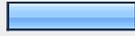
2. Completed by (include title)		
		Response Count
		51
		<i>answered question</i> 51
		<i>skipped question</i> 4

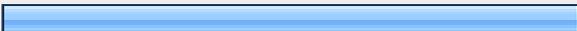
3. How frequently has your board discussed whether physicians should be required to periodically provide evidence of continued competence as a condition of license renewal/reregistration?			
		Response Percent	Response Count
Never		2.0%	1
Once in the past 12 months		21.6%	11
<b>2 to 4 times in the past 12 months</b>		<b>43.1%</b>	<b>22</b>
Formed a committee to study the issue		5.9%	3
Other (please specify)		27.5%	14
		<i>answered question</i>	<b>51</b>
		<i>skipped question</i>	<b>4</b>

**4. Based on the discussions that have occurred at board meetings about this issue, what is your board's general attitude about requiring physicians to provide evidence of continued competence as a condition of license renewal/reregistration?**

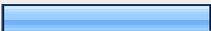
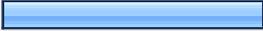
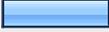
		Response Percent	Response Count
Uninformed about issue		4.1%	2
<b>Undecided about issue</b>		<b>44.9%</b>	<b>22</b>
Supportive		42.9%	21
Not supportive		8.2%	4
Indifferent		0.0%	0
		<b><i>answered question</i></b>	<b>49</b>
		<b><i>skipped question</i></b>	<b>6</b>

**5. If your board decided to require licensees to provide evidence of continued competence as a condition of license renewal/reregistration, does your statute give you the authority to implement such requirements?**

		Response Percent	Response Count
Yes		43.1%	22
No		37.3%	19
Not sure		19.6%	10
		<b><i>answered question</i></b>	<b>51</b>
		<b><i>skipped question</i></b>	<b>4</b>

6. Does your board require CME as a condition of license renewal/reregistration? If yes, please go to question #7. If no, please go to question #9.			
		Response Percent	Response Count
Yes		89.1%	49
No		10.9%	6
		<b>answered question</b>	<b>55</b>
		<b>skipped question</b>	<b>0</b>

7. Which of the following best describes how your CME requirements are set up?			
		Response Percent	Response Count
All in statutes (Statutes authorize the board to require CME and specify what the requirements are - e.g., content, number of hours)		20.0%	10
<b>Combination of statutes and rules and regulations (Statutes contain broad language authorizing the board to require CME, but the specifics are defined in the board's rules and regulations)</b>		<b>76.0%</b>	<b>38</b>
Other (please specify below)		4.0%	2
		Please add any additional comments here	6
		<b>answered question</b>	<b>50</b>
		<b>skipped question</b>	<b>5</b>

8. Could your board interpret the CME language in your statute or rules to allow the board to require physicians to provide evidence of continued competence as a condition of license renewal?			
		Response Percent	Response Count
Very likely		32.0%	16
Somewhat likely		12.0%	6
<b>Not at all likely</b>		<b>40.0%</b>	<b>20</b>
Unsure		16.0%	8
		<i>answered question</i>	<b>50</b>
		<i>skipped question</i>	<b>5</b>

9. Please feel free to add any comments here.		
		Response Count
		17
		<i>answered question</i>
		<b>17</b>
		<i>skipped question</i>
		<b>38</b>

**SECTION V: A FRAMEWORK FOR MAINTENANCE OF LICENSURE**

From Special Committee on Maintenance of Licensure  
Draft Report on Maintenance of Licensure February 2008

***Establishing Requirements for Demonstrating Competence***

State medical boards should require physicians seeking relicensure to periodically demonstrate competence within the scope of their professional practice. Such requirements should include the following elements or expectations:

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.

Evidence of self-evaluation, self-assessment and practice assessment could include participation in self-evaluation exercises or modules, such as 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.

While a variety of tools may be used by physicians to document evidence of compliance with this criteria, state medical boards should mandate that it 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.

3. Demonstration of accountability for performance in practice.

This could be met by peer assessment, such as 360-degree evaluations, letters of attestation of clinical activities, or by patient reviews, such as satisfaction surveys. Participation in recognized quality improvement activities as well as collection and analysis of practice data, such as thorough review of office records, chart review, case review and submission of a case log, could also be utilized.

Licenses 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 for purposes of meeting maintenance of licensure requirements. For example, documentation of active participation in Maintenance of Certification processes could be deemed acceptable by state medical boards as meeting all maintenance of licensure requirements. Participation in recognized quality improvement activities such as those required by The Joint Commission or the AOA Clinical Assessment Program could 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 should include evidence of competence in that practice.

### ***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. Evidence of demonstration of accountability for performance in clinical practice could be met by evaluation of a physician's competence relevant to that practice. Assessment methods should address the knowledge, skills and behaviors necessary to deliver safe and effective care for the types of patients that would typically be encountered in their practice. Physicians whose licenses are inactive or have lapsed should be expected to meet these requirements prior to reentering active clinical practice.

### ***Disclosure***

Physicians who do not comply with maintenance of licensure requirements or who are identified through the program as deficient such that the deficiency rises to a level that would subject the licensee to a disciplinary action for violation of the practice act should be subject to normal adjudication processes and to public disclosure as required by state law. When an education or remediation plan is required by the state medical board for these practitioners, the state medical board should approve the elements and scope of the plan prior to its initiation. All other maintenance of licensure activities should not be subject to public disclosure.

### ***Reporting Requirements***

In order to assure that physicians are demonstrating competence within their scope of practice, state medical boards should require licensees to report information about their practice as part of the license renewal process. Such information should include: scope of 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 at all times by reporting any subsequent changes in practice status or scope of practice to the board within a specified timeframe as determined by the board.

### ***Research***

Developing evidence regarding the impact of maintenance of licensure programs on physician practice and patient care is a priority. State medical boards should work with relevant organizations to develop a research agenda aimed at gathering data to improve maintenance of licensure processes.

### ***Assessment Resources***

Assessment tools used to document compliance with maintenance of licensure requirements should be valid, reliable, feasible, have credibility with the profession and should provide adequate feedback to facilitate practice improvement. FSMB and state medical boards should encourage development of programs and services for use by the cohort of physicians who are not board certified or otherwise not participating in the maintenance of certification/continuous certification processes in order that they have access to resources necessary to comply with maintenance of licensure requirements.