

Report of the MOL Workgroup on Clinically Inactive Physicians

Adopted as policy by the House of Delegates of the Federation of State Medical Boards in April 2013

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REPORT OF THE MOL WORKGROUP ON CLINICALLY INACTIVE PHYSICIANS

EXECUTIVE SUMMARY

In summer 2011, then-FSMB Chair, Janelle Rhyne, MD, MACP, appointed the MOL Workgroup on Clinically Inactive Physicians to further explore and address clinically inactive physicians' participation in MOL. The Workgroup was charged to define the clinically inactive physician and develop pathway(s) that clinically inactive physicians may follow to successfully participate in MOL.

For the purposes of this report, the Workgroup defined the clinically inactive physician as one who is not engaged in direct, consultative or supervisory patient care at the time of licensure renewal, but who, as a result of their professional activities, influences the care provided by clinically active practitioners.

Given that the purpose of MOL is to advance professional development for all physicians, the MOL framework and process for clinically active and clinically inactive physicians should be similar (or equivalent) and should be grounded in the general competencies model. The Workgroup expects, however, that as clinically inactive physicians engage in this process, they will select different activities aimed at improving and evaluating their knowledge, skills and performance from those selected by clinically active physicians.

In order to assist state medical boards in implementing a process and system that will facilitate the participation of clinically inactive physicians in MOL, the Workgroup outlined responsibilities and guidelines for physicians, state boards and the FSMB. These are organized as follows:

Responsibilities and guidelines for physicians:

- Understand and engage in a process of practice-relevant lifelong learning based in the general competencies and utilizing the three MOL components.
- Participate in activities that reflect their day-to-day professional activities and maintain appropriate documentation of participation in such activities.
- Provide an accurate reflection of clinical status to the licensing authority for licensure purposes and to the specialty certification board for eligibility for MOC/OCC.

Responsibilities and guidelines for state medical boards:

- Define options for how physicians will comply with MOL, including how compliance will be verified
- Strive for consistency in the creation and execution of MOL programs.
- Undertake a readiness assessment when beginning an MOL program and incorporate questions about physicians' practices and daily professional activities and responsibilities as part of the license renewal application process in order to facilitate identification of clinically inactive physicians as well as those needing to participate in a reentry process.
- Implement a communication strategy to appropriately notify licensees of the requirements for MOL.

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Responsibilities and guidelines for the FSMB:

- Advise and consult on MOL policies, procedures, recommendations, legislative activity and best practices.
- Consult and collaborate with and encourage appropriate organizations to identify and develop appropriate tools and activities.
- Encourage a pilot project(s) specifically directed at implementation of MOL for clinically inactive physicians.
- Monitor, periodically review the status of, and report on implementation of MOL for clinically inactive physicians to identify and share successes and best practices.
- Develop and disseminate modules or other education/communication tools explaining lifelong learning for use by state boards.
- Develop a separate communication strategy around the issue of clinically inactive physicians and their participation in MOL specifically.

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BACKGROUND

In 2010, the Federation of State Medical Boards (FSMB) adopted as policy the following framework for Maintenance of Licensure (MOL):

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 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.

The FSMB also adopted as policy a recommendation that 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 a state medical board. The issue of how clinically inactive physicians might participate in MOL was further addressed in the 2011 report of the FSMB MOL Implementation Group, which provided more detailed guidance to state boards regarding implementation of MOL programs. As part of its recommendations, the MOL Implementation Group recognized that clinically inactive physicians pose a unique challenge within MOL, noting that there is “little data about individual licensees and their types of practice and the nature of those practices.” To address this issue, the MOL Implementation Group recommended that state boards begin collecting data about licensees’ practice status and scope of practice as part of the license renewal process. This will be facilitated by adoption of the recommended data elements contained in the report of the FSMB Workgroup to Define a Minimal Data Set ([Appendix A](#)).

Charge to the MOL Workgroup on Clinically Inactive Physicians

In summer 2011, then-FSMB Chair, Janelle Rhyne, MD, MACP, appointed the MOL Workgroup on Clinically Inactive Physicians to further explore and address clinically inactive physicians’ participation in MOL. The Workgroup was charged to define the clinically inactive physician and develop pathway(s) that clinically inactive physicians may follow to successfully participate in MOL.

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Given the complexity of the issue and the desire to fully identify, review and discuss all relevant aspects of clinically inactive physicians' participation in MOL, the Workgroup spent the next 18 months addressing and completing its charge. The Workgroup used a deliberative process, including review of relevant information (e.g., state statutes regarding licensure of clinically inactive physicians, types of licenses issued by state boards, statutory and regulatory definitions of active clinical practice, definitions of clinically inactive physicians from other health care organizations) and interviews and discussions with subject matter experts regarding potential tools to facilitate clinically inactive physicians' participation in MOL ([Appendix B](#)).

Preamble

The recommendations of the MOL Workgroup on Clinically Inactive Physicians are intended to align with other MOL principles and policies that have been previously adopted by the FSMB, including the MOL Guiding Principles ([Appendix C](#)) and the recommendations of previous MOL workgroups. For the purposes of this report, the term “physicians” encompasses both MDs and DOs.

The purpose of MOL is to advance professional development; therefore, the professional development process for clinically active and clinically inactive physicians should be similar (or equivalent). While it is recognized that the knowledge, skills and performance that will be evaluated for clinically active physicians and clinically inactive physicians will differ, the general competencies (medical knowledge, patient care and procedural skills, interpersonal and communication skills, practice-based learning and improvement, professionalism, systems-based practice) should be incorporated as part of the MOL framework and process for all physicians.

Defining the clinically inactive physician

For the purposes of this report, the Workgroup defined the clinically *active* physician as one who, at the time of license renewal, is engaged in direct, consultative, or supervisory patient care, or as further defined by the states. The committee agreed that volunteer physicians, regardless of number of hours worked, provide direct, consultative, or supervisory patient care and, therefore, should comply with the same MOL standards as clinically active physicians.

The workgroup defined the clinically *inactive* physician as one who is not engaged in direct, consultative or supervisory patient care at the time of license renewal, but who, as a result of their professional activities, influences the care provided by clinically active practitioners. This definition is for the purposes of this report only; the workgroup acknowledges that state boards can and may have their own definitions and standards for what constitutes a clinically inactive physician. In the interest of license portability, however, similar definitions are encouraged. Examples of clinically inactive physicians include individuals with significant administrative responsibilities, for example, medical school deans, hospital and health plan medical officers, leadership of professional societies or health regulatory organizations, etc.

A clinically inactive physician who wants to reenter active clinical work should be required to go through a reentry process, as defined in the Report of the FSMB Special Committee on Reentry to Practice.¹

Clinically inactive physicians who engage in some clinically active medical practice

The Workgroup 1) endorses the recommendation from the FSMB MOL Implementation Group that MOL should be relevant to the day-to-day activities of the individual physician; 2) acknowledges that the tools to assess and support continuous professional development for clinically inactive physicians are less developed at this

¹ FSMB. Report of the Special Committee on Reentry to Practice, April 2012. <http://www.fsmb.org/pdf/pub-sp-cmt-reentry.pdf>

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point in time than tools that support continuous professional development for clinically active physicians; and 3) believes the ability to provide high-quality care will remain paramount. Therefore, the Workgroup expects that, as MOL is initially implemented, physicians whose primary job responsibilities are administrative in nature but who also engage in some clinical medical practice will elect to participate in MOL activities that focus on their clinical practice and care. As MOL implementation evolves over the next 10 years, however, it is expected that physicians who are primarily administratively focused will shift their MOL activities to reflect that focus. The MOL system will simultaneously ensure that physicians with solely a clinical focus will pursue sufficient continuous professional development in clinical realms to provide high-quality care.

Identification of clinically inactive physicians

As noted in the FSMB MOL Implementation Group report, clinically inactive physicians pose a unique challenge within MOL because little data is available to state boards about individual licensees and the nature/type of their practices. To ensure that physicians are engaging in MOL activities that are relevant to their practices and to their daily professional responsibilities, it will be important for state boards to be able to identify the practice profiles of their licensees. The Workgroup recommends adoption of the recommended data elements contained in the report of the FSMB Workgroup to Define a Minimal Data Set. Adoption and utilization of this data will be vital in identifying clinically inactive physicians and will facilitate identification of physicians' practice profiles and verification of appropriate participation in MOL.

Administrative licenses

The Workgroup does not recommend implementation or adoption of an administrative license category for clinically inactive physicians, particularly as a means to exempt clinically inactive physicians from participating in MOL. This recommendation stems from a recognition that many clinically inactive physicians desire to have a full, unrestricted license, either because of the issues of professional identity tied to having such a license or the requirement to have a full, unrestricted license for employment purposes. Additionally, an administrative license may be perceived as a restricted license by state boards and specialty boards, which may have a negative impact on a physician's ability to obtain licensure elsewhere and/or ability to maintain specialty board certification. Furthermore, some state boards have already had extensive discussions about whether to implement administrative license categories and have decided against utilizing them.

The Workgroup acknowledges, however, that some states already have an administrative license option and defers to states where they have existing language that deals with these issues. In all instances, however, MOL should allow clinically inactive physicians to maintain a license in keeping with existing practices used by the state board. In addition, in implementing MOL, state boards should, to the extent possible, utilize definitions already within their statutes and rules and regulations.

Regardless of the license type available to and sought by clinically inactive physicians, state boards ultimately should ensure safe and effective practice by all physicians. In addition, all license types/categories should be valued equally and should not discriminate against nor interfere with license portability for non-clinical physicians.

General Observations

The Workgroup made the following general observations about the participation of clinically inactive physicians in MOL:

1. Clinically inactive physicians engage in a wide spectrum of activities, many of which support other physicians performing direct patient care.

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2. The three components of lifelong learning and the general competencies are the core of demonstrating MOL and can be used for clinically inactive physicians as well.
3. Continuing medical education (CME) is a valuable tool to facilitate clinically inactive physicians' compliance with MOL, when it is relevant to what the physician does in his or her daily professional responsibilities.

Recommendations

The Workgroup also made the following general recommendations for the development of systems and processes to facilitate the participation of clinically inactive physicians in MOL:

1. There is a need for parity of pathways in how clinically active and clinically inactive physicians participate in MOL. Specifically, while it is recognized that the activities clinically inactive physicians engage in for MOL may differ from those for clinically active physicians, clinically inactive physicians should be required to meet all three components of MOL. The Workgroup acknowledges that participation in MOL Component 3 may be challenging for clinically inactive physicians but recognizes that relevant organizations have and will develop tools to support participation. The guidelines for implementation of MOL for clinically active physicians as outlined in the report of the FSMB MOL Implementation Group should be followed (see [Appendix D](#)).
2. All licensed physicians should engage in self-assessment and improvement specific to their professional activities and identify any practice gaps in their own practice (e.g., measure, intervene, re-measure).
3. Participation in MOL should be optimally integrated into physicians' clinical and professional activities. Therefore, the tools and processes used for MOL should be flexible and broad enough to offer reasonable options to the spectrum of clinically inactive physicians. In addition, existing tools and activities that clinically inactive physicians utilize and are engaged in should enable them to comply with MOL requirements if such tools and activities attain appropriate quality standards.
4. Participation in the American Board of Medical Specialties' (ABMS) Maintenance of Certification (MOC) program or the American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS) Osteopathic Continuous Certification (OCC) program should allow both clinically active and clinically inactive physicians to substantially comply with MOL.
5. There should be consistency in the auditing processes used for clinically active and clinically inactive physicians. Clinically inactive physicians should be subject to audit as part of the license renewal process at the same rates as other physicians.
6. The options and processes for MOL for clinically inactive physicians should balance transparency with privacy protection.
7. State boards should have a communication strategy in place to inform clinically inactive physicians of the requirements for MOL.

General Competencies

The general competencies (medical knowledge, patient care and procedural skills, interpersonal and communication skills, practice-based learning and improvement, professionalism, systems-based practice) adopted across the continuum of medical education and training should be incorporated as part of the MOL framework and process for physicians.

These competencies can be broadly defined within the context of both clinical and non-clinical medical settings and help maintain parallel standards between clinically inactive physicians and clinically active physicians for purposes of MOL. Types of activities clinically inactive physicians might engage in or utilize to meet a state's MOL

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requirements and to demonstrate utilization of the general competencies are discussed below. These examples are provided as guidance only and not meant to be inclusive or prescriptive.

- A physician administrator may have improvement plans in place and be engaged in ongoing development activities. The state board would not look at outcomes or specific data, but would rely on attestation that the physician engaged in appropriate activities.
- A medical school dean might be required to demonstrate that he/she has participated in an accreditation process that measured outcomes (e.g., using Liaison Committee on Medical Education self-study).
- A public health/community physician might evaluate improvement in vaccination rates, epidemiologic tracers done during outbreaks, improvements in water systems, zoonosis tracers, etc.
- A health plan Chief Medical Officer (CMO) might evaluate aggregate patient experience of care results for a site or specialty group before and after an intervention on clinical staff education, or focusing on simplifying system-related complications in getting prescriptions filled. Community to hospital times, or door to balloon/bypass surgery times for patients with acute coronary events could also be evaluated. A last example might focus on the credentialing process with outcomes being the number of physicians who completed 360 evaluations, met institutional targets for decreasing re-admissions or are participating in MOC/OCC.

MOL Component 3 activities match with activities already being done in hospitals, managed care organizations, and other institutions.

Responsibilities/Guidelines for Physicians

The following guidelines are intended to define physicians' responsibilities within a MOL system:

1. Understand lifelong learning and how it works, as well as the general competencies.
2. Engage in a lifelong learning and quality improvement process utilizing the three MOL components.
3. Provide an accurate reflection of his/her clinical status to his/her licensing authority for licensure purposes and to his/her specialty certification board for eligibility for MOC/OCC.
4. Engage in appropriate activities for MOL (e.g., those that have been "approved" by the state board as appropriate for MOL) and maintain records of engagement in such activities.
5. When determining and selecting activities to engage in for MOL, choose those that reflect their day-to-day professional activities.
6. Keep records of attestations and any data needed for the purpose of audits conducted as part of the license renewal process. Physicians are already required to maintain records of CME; policies around retention of records and data for MOL should be similar.

Responsibilities/Guidelines for State Medical Boards

The following guidelines are intended to define state boards' responsibilities within a MOL system:

1. Define options for how physicians will comply with MOL. Specifically, the state board should review current requirements for license renewal (for most state boards, this will just be CME), decide whether they are appropriate for clinically inactive physicians, and define additional options. When evaluating options and tools beyond CME and MOC/OCC, the state board should take into account the cost and availability of options, avoid options that are onerous for either physicians or state board staff and attempt to include options that would be performed by the physician in

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other venues. As stated in prior FSMB MOL reports, a high-stakes exam (summative assessment) is not required for purposes of MOL, and should not be required for clinically inactive physicians. However, examinations should be an option available to all physicians to comply with MOL. In addition, MOL is a low-stakes process which focuses on formative assessment, not summative assessment; therefore, other activities and evaluation tools are more appropriate.

2. Determine how physicians' participation in activities will be verified. The state board should specifically decide whether it will audit some percentage of licensees as part of the license renewal process and, if so, if attestations of participation in relevant activities can be used and how to confirm adequate completion of options without breaching confidentiality and HIPAA issues. The workgroup anticipates this process will be similar to processes currently used to verify compliance with CME requirements and will be subject to the development of pilot projects.
3. Adopt and implement the guidelines set forth in the Report of the FSMB Workgroup to Define a Minimal Data Set to obtain estimates of numbers for reentry and clinically inactive physicians.
4. If a clinically inactive physician wants to reenter active clinical work, the state boards should require him/her to go through a reentry process, as defined in the Report of the FSMB Special Committee on Reentry to Practice.
5. Develop and implement a communication strategy to appropriately notify physicians of the requirements for MOL. As previously noted in the report of the FSMB MOL Advisory Group, the communication strategy should also ensure that all licensees (both current and future), the public, and all other relevant stakeholders and interested parties (e.g., state societies, specialty societies, malpractice insurers, payers, hospitals) understand the importance of lifelong learning and continuous professional development and how participation in such activities can result in improved outcomes for patients and the health care system.
6. As previously recommended in the FSMB MOL Implementation Group report, state boards may want to undertake a readiness assessment when they begin an MOL program within their jurisdiction (see [Appendix E](#) for specific recommendations from the FSMB MOL Implementation Group).
7. As recommended in the FSMB MOL Implementation Group report, state boards should strive for consistency in the process and periodicity of MOL programs. While there is a need for guidelines that are flexible to meet state-specific criteria and regulations that are already in place regarding clinically inactive physicians, physicians may be concerned about an overly complicated process where they might have to meet varying criteria to maintain licensure in different states. The FSMB should assist state boards in coordinating the implementation of MOL so there is as much consistency as possible in order to facilitate license portability.

Responsibilities/Guidelines for FSMB

The following recommendations are provided to facilitate FSMB's continued collaboration with its member boards regarding implementation of MOL for clinically inactive physicians:

1. Advise and consult on MOL policies, procedures, recommendations, legislative activity and best practices.
2. Consult and collaborate with appropriate organizations to identify appropriate tools; encourage other organizations and medical specialty societies to develop additional tools and activities. Tools should meet all of the following criteria, as recommended in the report of the FSMB MOL Implementation Group: 1) be developed by an objective third party with demonstrated expertise in these activities; 2) be structured, validated, and reproducible; 3) be credible with the public and profession; 4) provide meaningful assessment feedback to the licensee appropriate to the scope of the activity to guide subsequent education; and 5) provide formal documentation that describes both

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the nature of the activity (i.e., content and areas assessed) and successful completion of the activity as designed.²

3. Encourage a pilot project(s) specifically directed at implementation of MOL for clinically inactive physicians.
4. Monitor implementation of MOL to identify and share successes and best practices.
5. Periodically review the status of implementation of MOL for clinically inactive physicians and report back to the FSMB Board of Directors. Review and revise policies as needed.
6. Develop and disseminate modules or other education/communication tools explaining lifelong learning for use by state boards; such modules could be posted on state boards' websites or in relevant publications.
7. Develop a separate communication strategy around the issue of clinically inactive physicians and their participation in MOL specifically.

Conclusion

The general intent of MOL is to facilitate physicians' participation in lifelong learning and continuous professional development activities that will lead to improved patient care and outcomes. As such, the integration of clinically inactive physicians into the MOL process poses unique challenges to state boards, due in part to the extensive variety in their professional roles and responsibilities. However, even though clinically inactive physicians do not engage in direct patient care, their daily professional responsibilities ultimately have an impact on the quality of patient care provided by clinically active physicians. Therefore, clinically inactive physicians who wish to maintain an active license should be required to participate in all three components of MOL; there should not be separate processes or standards for MOL between clinically active and clinically inactive physicians, nor should clinically inactive physicians be exempt from any component of MOL.

To facilitate clinically inactive physicians' participation in MOL, state boards should begin collecting information about licensees' daily professional responsibilities to enable them to identify clinically inactive physicians, and FSMB should collaborate with state boards to develop appropriate communication and education pieces about clinically inactive physicians, the value they add to the health care system, and how they can participate in MOL. The FSMB should also consult and collaborate with other external stakeholders to expand the type and availability of tools and activities to support clinically inactive physicians' participation in MOL.

² FSMB. Report of the MOL Implementation Group, 2011. http://www.fsmb.org/pdf/BD_RPT_1103_%20MOL.pdf

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APPENDIX A

Recommended Data Elements from the Report of the FSMB Workgroup to Define a Minimal Data Set: Report on a Recommended Framework for a Minimal Physician Data Set (2012)

RECOMMENDED DATA ELEMENTS FOR A MINIMAL PHYSICIAN DATA SET

The MDS Workgroup identified the data elements listed below to be included in a uniform, minimal physician data set. The workgroup believes that many of the elements identified fall into one of three categories: (1) data currently provided by state boards as part of their regular transmissions of licensure data; (2) data that is or may be obtained by the FSMB through data sharing agreements with other organizations; or (3) unique and standardized data that state boards can obtain by adding questions to their renewal application or by asking questions as part of a separate questionnaire tied directly to the renewal process.

Data Element	Source and Rationale (when applicable)
Licensure status (active or inactive)	Currently provided by state boards.
Date of birth (mm/dd/yy)	Currently provided by state boards. FSMB has the date of birth for more than 96% of physicians with an active license.
Medical school graduated	Currently provided by state boards. FSMB has medical school matriculation data for more than 99% of physicians with an active license.
Medical school graduation year	Currently provided by state boards. FSMB has the medical school graduation year for more than 98% of physicians with an active license.
Specialty and subspecialty board certification	Obtained by FSMB. Specialty and subspecialty certification data is currently provided to FSMB by ABMS on a daily basis. FSMB is working with AOA to obtain access to their specialty and subspecialty certification data.
Maintenance of Certification and Osteopathic Continuous Certification	Obtained by FSMB from the ABMS and the AOA as the information becomes available.
Maintenance of Licensure	Provided by state boards as MOL programs are adopted and implemented.
Employment status	State board question. Physicians may hold an active license but be retired.
Provide clinical or patient care.	State board question. Physician may hold a position in a field of medicine, but do not provide direct patient care (important for reentry decisions by state boards).
If no, number of years since provided clinical or patient care	State board question. Provides important input for physician re-entry.
Areas of practice	State board question. This question provides input on the true areas of practice for a physician (primary care, dermatology, surgery).
Practice settings	State board question. Physician can practice in different settings (e.g., clinic or hospital).
Number of weeks worked during the past year	State board question. This information will help state boards better understand the level of participation among licensed physicians in their jurisdictions.
Average number of hours worked per week by activity	State board question. Some physicians are involved in direct patient care and work as an administrator and conduct research during the same week.
Clinical locations	State board question. Some physicians may work in more than one location.
Hours per week providing patient care by location	State board question. Some physicians may work varying amounts in more than one location.
Gender	State board question. FSMB to supplement with AAMC, AACOM, and ECFMG data.
Race (optional)	State board question. FSMB to supplement with AAMC, AACOM, and ECFMG data.

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Data Element	Source and Rationale (when applicable)
Ethnicity (optional)	State board question. FSMB to supplement with AAMC, AACOM, and ECFMG data.
Languages spoken (optional)	State board question.

Federation of State Medical Boards. Workgroup to Define a Minimal Data Set: Report on a Recommended Framework for a Minimal Physician Data Set, April 2012. Available at: <http://www.fsmb.org/pdf/grpol-min-phy-dataset.pdf>

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APPENDIX B

Advisors

The MOL Workgroup on Clinically Inactive Physicians consulted with the following individuals and organizations regarding potential tools to facilitate clinically inactive physicians' participation in MOL. The Workgroup expresses their gratitude to them for their assistance.

- Peter Angood, MD, FRCS(C), FACS, FCCM (American College of Physician Executives)
- Ronald Ayres, DO, and Cheryl Gross (AOA Bureau of Osteopathic Specialists)
- John Combes, MD (American Hospital Association)
- Norman Kahn, Jr., MD (Council of Medical Specialty Societies)
- Murray Kopelow, MD, MS(Comm), FRCPC (Accreditation Council for Continuing Medical Education)
- Richard Siegrist, MS, MBA, CPA (Harvard School of Public Health)

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APPENDIX C

MOL Guiding Principles

(Adopted 2008, revised 2010)

- 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.
- 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.

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APPENDIX D

Key MOL Recommendations from the Report of the FSMB MOL Implementation Group (2011)

1. MOL Component 1: State member boards should require each licensee to complete certified and/or accredited Continuing Medical Education (CME), a majority of which is practice-relevant and supports performance improvement.
2. MOL Component 2: State member boards should require licensees to undertake objective knowledge and skills assessments to identify learning opportunities and guide improvement activities. Component Two activities should meet all of the following criteria:
 - a. be developed by an objective third-party with demonstrated expertise in these activities;
 - b. be structured, validated and reproducible;
 - c. be credible with the public and profession;
 - d. provide meaningful assessment feedback to the licensee appropriate to the scope of the activity to guide subsequent education; and
 - e. provide formal documentation that describes both the nature of the activity (i.e., content and areas assessed) and successful completion of the activity as designed.
3. MOL Component 3: State member boards should require licensees to use comparative data and, when available, evolving performance expectations to assess the quality of care they provide and then apply best evidence or consensus recommendations to improve and subsequently reassess their care.
4. Periodicity: State member boards should require each licensee to complete a minimum Component One activity on an annualized basis, a majority of which is devoted to practice-relevant CME that supports performance improvement; and to document completion of both one Component Two and one Component Three activity every five to six years.
5. Board Certification in the Context of MOL: SMBs should consider physicians who provide evidence of successful ongoing participation in ABMS Maintenance of Certification (MOC) or AOA BOS Osteopathic Continuous Certification (OCC) to have fulfilled all three components of MOL.
6. Need for More Information about Physician Practices: State member boards should regularly collect data from individual licensees about the extent of their engagement in direct patient care and the nature of their daily professional work.

Federation of State Medical Boards. Report of the MOL Implementation Group, 2011. Available at: http://www.fsmb.org/pdf/BD_RPT_1103_%20MOL.pdf

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APPENDIX E

Key Components of a State Medical Board Readiness Assessment from the Report of the FSMB MOL Implementation Group (2011)

1. Communicate with licensees, training programs and medical schools about the MOL changes, available support resources and suggested preparations;
2. Review their medical practice act, policies, rules and regulations to identify any modifications required to enable the state medical board to implement MOL in the short and longer term, such as the need to define or redefine “clinically inactive”; anticipate any legal or legislative opportunities or challenges;
3. Take inventory of state medical board financial and staff resources and make any changes possible to align them with the final scope and design of the state medical board’s MOL program;
4. Evaluate data needs and determine if additional physician demographic and practice data will be collected at the state level or secured from a third party repository (as available);
5. Make concrete decisions on program design and determine which activities will be deemed approved by the state medical board as meeting MOL requirements;
6. Determine the manner of verification of licensee participation in each component of MOL (e.g. physician attestation with verifying audit of a defined percentage of licensees each license cycle, electronic/automated reporting of compliance with certain elements, 3rd party attestation, etc.);
7. Meet with legislators, state medical and osteopathic societies, the physician community, the public and other key stakeholders to explain MOL changes and to discuss the impact of MOL on physicians and the public;
8. Revise the license renewal application as needed to collect information about licensees’ scope of practice and practice status; and
9. Evaluate “types” of licenses available and whether additional license categories need to be created to accommodate licensees’ expected participation in MOL. As part of this evaluation, state medical boards are encouraged to consider, in particular, licensees not involved in direct patient care, including any fiscal or other impact to the state medical board.

Federation of State Medical Boards. Report of the MOL Implementation Group, 2011. Available at: http://www.fsmb.org/pdf/BD_RPT_1103_%20MOL.pdf

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** Organizational affiliations are presented for purposes of identification and do not imply organizational approval of the Workgroup's work or content of this report.*

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