Maintenance of Licensure: Evolving from Framework to Implementation

Humayun Chaudhry, D.O., Janelle Rhyne, M.D., Sandra Waters, M.E.M., Frances E. Cain, and Lance Talmage, M.D.

IN BRIEF **The authors provide a report summarizing progress to date in the Federation of State Medical Boards' long-term Maintenance of Licensure (MOL) initiative.**

Introduction

Shortly after April 2010, following the adoption by its House of Delegates of a framework for Maintenance of Licensure (MOL), the Federation of State Medical Boards (FSMB) began earnest deliberations and discussions to facilitate MOL process design and implementation by interested state medical and osteopathic boards. An MOL Implementation Group established by the FSMB has since developed a series of practical recommendations addressing such issues as the optimum timing and periodicity of a state board's MOL requirements and the role of specialty board recertification and continuing medical education (CME).[1]

The FSMB has also had preliminary discussions with a wide range of organizations with experience and expertise in the areas of physician assessment and specialty certification, and organizations that already offer a variety of tools and activities that could meet one or more MOL requirements. Last summer, 11 state medical and osteopathic boards reported to the FSMB that they were interested in collaborating to consider participation in specific MOL pilot projects.

This article — a follow-up to "Maintenance of Licensure: Protecting the Public, Promoting Quality Health Care," a monograph approved by the FSMB's Board of Directors and published in the *Journal of Medical Regulation* in 2010[2] — summarizes and reports on the progress that has been made in moving MOL from framework to implementation. Though MOL is a few years away from implementation by any state board, the FSMB has pledged to continue to lead, coordinate and proceed in a logical fashion to provide the necessary support to state boards so that progress with its implementation remains methodical and evolutionary, not revolutionary, as physicians with active medical licenses are asked to periodically demonstrate their ongoing clinical competence in their area of practice as a condition for licensure renewal.

MOL Implementation Group and Its Deliberations

The MOL Implementation Group (IG) was charged by the FSMB's Board of Directors in 2010 to act in support of FSMB policy. Its report, presented to the FSMB's House of Delegates last year as a follow-up to the 2010 report of the FSMB's Advisory Group on Continued Competence of Licensed Physicians (AG), was "intended to provide more detailed guidance to FSMB's state member boards … as they consider implementation of MOL programs." The IG said that it sought to offer recommendations for MOL as "a rational and well-considered proposal to facilitate the engagement of physicians in a culture of continuous improvement and to assure the public, through a verifiable and reproducible system, that physicians are actively participating in such an effort."

THOUGH MOL IS A FEW YEARS AWAY FROM IMPLEMENTATION…THE FSMB HAS PLEDGED TO PROVIDE THE NECESSARY SUPPORT TO STATE BOARDS.

First and foremost, the IG noted, "nearly half of U.S. physicians already fulfill the intent of MOL" through their participation in the continuous specialty certification programs of the American Board of Medical Specialties (ABMS) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS). Both of these recertification programs were listed in the AG report among the tools that practicing physicians have available to them to fulfill the requirements of each of the three components of MOL (reflective self-assessment, assessment of knowledge and skills, and performance in practice). While the report of the AG had acknowledged that physicians actively engaged in the ABMS Maintenance of Certification (MOC) or soon to be engaged in AOA BOS Osteopathic Continuous Certification (OCC) programs "could substantially meet" MOL

requirements, the IG report in 2011 definitively supported the concept. It noted also that both MOC and OCC programs were themselves evolving—like MOL—into fully continuous quality improvement programs.

In a census of actively licensed physicians in the United States conducted two years ago, the FSMB found that 74.5 percent of the nation's 850,085 physicians were certified by at least one ABMS specialty board. Among doctors of medicine (M.D.), 77 percent were specialty certified by the ABMS; among doctors of osteopathic medicine (D.O.), 38 percent were ABMS-certified and 40 percent certified by an AOA BOS specialty board. The IG's conservative assessment that "nearly half of U.S. physicians already fulfill the intent of MOL" reflects a reality noted in the census, that 216,352 physicians (both M.D. and D.O.) are not specialty-certified, that a large plurality of physicians are either grandfathered for MOC or OCC (that is, they are not required to recertify) and that another plurality are not participating in MOC or OCC for whatever reason. An additional group of physicians that is not specialty–certified includes those who are in graduate medical education training but have not yet taken their specialty board examinations. Because state licensing boards have never provided a specialty medical license—instead providing a license for the general undifferentiated practice of medicine—the IG made clear that neither MOC nor OCC are intended to become mandatory requirements for medical licensure but should be recognized as substantially meeting any state's MOL requirements. The majority of MOL pilot projects, in fact, will likely be designed to determine and identify multiple options and pathways by which physicians who are not specialty-certified or are not engaged in MOC or OCC may fulfill a state board's MOL requirements.

Alluding to the fact that many physicians serve as leaders in emerging team-based models of health care delivery, such as the patient-centered medical home, the IG said it hoped that its recommendations "can serve as a model for other health care professions as they look at developing their own continuous improvement processes." In fact, the National Council of State Boards of Nursing, the National Association of Boards of Pharmacy, the National Commission for Certification of Physician Assistants and the American Association of Physician Assistants have all embarked on such programs for their health professionals.

MOL Implementation Group's 2011 Recommendations

The 2011 recommendations of the IG (see Figure 1) were calibrated to adhere to the guiding principles

Figure 1
MOL Implementation Group's 2011 Recommendations to State Boards[1]

1	Consider pursuing a "phased approach" for MOL implementation.
2	Require each licensee to complete certified and/or accredited CME, a majority of which (at least half) should be practice-relevant.
3	Require licensees to undertake objective knowledge and skills assessments to identify learning opportunities and guide improvement activities.
4	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.
5	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 practice improvement, and to document completion of one Component Two and one Component Three activity every five to six years.
6	Consider physicians who provide evidence of successful ongoing participation in ABMS Maintenance of Certification (MOC) or AOA BOS Osteopathic Continuous Certification (OCC) programs to have fulfilled all three components of MOL.
7	Regularly collect data from individual licensees about the extent of their engagement in direct patient care and the nature of their daily professional work.
8	Strive for consistency in the creation and execution of MOL programs.

for MOL adopted by the FSMB's House of Delegates in 2010 as part of the AG report (see Figure 2). Recognizing that the adoption of MOL represents a "substantial paradigm shift" for state medical and osteopathic boards, the IG advised state boards to consider pursuing a "phased approach" for MOL implementation, though it said it would encourage state boards that were interested in a more expedited process. It recommended that once a state board has decided to implement MOL, a year or two should be spent in preparing for MOL, including a "readiness assessment, preparatory steps, initial communication to licensed physicians (and) involvement of stakeholders." Such preparation, the IG said, should address program implementation activities, including communication with training programs and medical schools; a review of the board's medical practice act, policies, rules and regulations; an inventory of staff and financial resources; review and use of an FSMB "MOL Toolbox" that will consist of practical guidance, assistance and resources; an evaluation of data needs; concrete decisions on program design and physician activities deemed acceptable for MOL compliance; and revisions to the medical license renewal application as needed. (Many of these items will likely be incorporated in the first phase of MOL pilot projects.) The IG also recommended that state boards hold informational meetings about MOL with legislators, state medical and osteopathic societies, physicians, the public and other key stakeholders.

THE MAJORITY OF MOL PILOT PROJECTS WILL LIKELY BE DESIGNED TO IDENTIFY MULTIPLE OPTIONS BY WHICH PHYSICIANS WHO ARE NOT SPECIALTY-CERTIFIED MAY FULFILL A STATE BOARD'S MOL REQUIREMENTS.

After this preparatory time, the IG suggested that each of the three components of MOL (i.e., reflective self-assessment, assessment of knowledge and skills, and performance in practice) be sequentially implemented in a phased approach (up to two to three years for each component), noting that once MOL is fully implemented by a state board, all licensed physicians in that jurisdiction will be "expected to comply with the entire MOL program as designed." In calling for the adoption of the first component of MOL first, rather than all three components at once, the IG said it hoped to demonstrate early success in MOL implementation to build momentum for subsequent components, to "build on the known and familiar" to ease the transition from license renewal to MOL and to "develop buy-in over time" for more elaborate continuous professional development activities. In the area of CME, a critical element of the first component of MOL, the IG advised state boards to require each licensee to complete certified and/or accredited CME, a majority of which (that is, at least half) should be practice-relevant.

Regarding the assessment of knowledge and skills, the second component of MOL, the IG advised state boards to require licensees to participate in knowledge and skills assessments to identify learning opportunities that guide their improvement activities. The IG suggested such activities should be developed by an objective third party with demonstrated expertise in these areas; be structured, validated and consistently reproducible; be credible with the public and the profession; provide meaningful assessment feedback; and provide formal documentation that describes the nature of the activity and its successful completion. In reiterating a point made by the AG a

Figure 2
The Guiding Principles of Maintenance of Licensure[4]

1. MOL should be administratively feasible and developed in collaboration with other stakeholders.
2. The authority for establishing MOL requirements should remain within the purview of state medical boards.
3. MOL should not compromise patient care or create barriers to physician practice.
4. The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
5. MOL should balance transparency with privacy protections.

year earlier, the IG said high-stakes examinations may be an option by which a physician may choose to meet this requirement (as with MOC or OCC) but such an examination should not be mandated for MOL for physicians not engaged in MOC or OCC activities. Recognizing the limited resources of most state boards, particularly in challenging economic times, the IG said it "would not expect" state boards to develop external assessments unless they chose to do so but could see state boards accepting external, objective assessments that met their licensing requirements.

For the third MOL component, performance in practice, the IG advised state boards to require licensees to use comparative data and, when available, evolving performance expectations to assess the quality of care they provide in their area of practice and then apply best evidence or consensus recommendations to improve and subsequently reassess their care. In essence, the IG suggested that physicians should be asked to use their available practice data to evaluate patient outcome variation, both within their own practices as well as in comparison to local and national peers "when such data is available." Recognizing that component three of MOL "will evolve over time," the IG recommended that state boards consider the "full range of ongoing high-quality practice improvement activities that are now being implemented by specialty and professional societies, certifying boards, hospitals, physician groups and quality improvement organizations" that it listed in its report as examples.

Although the term of license renewal currently varies between one and three years among state boards, the IG advised state boards to require each licensee to annually complete a minimum MOL Component One activity, a majority of which is devoted to practice-relevant CME that supports practice improvement, and to document completion of one Component Two and one Component Three activity every five to six years. Until physicians and state boards are able to demonstrate continuous engagement in MOL activities in a "rolling and uninterrupted manner through automated data reporting," the IG said, most state boards will have to rely upon periodic documentation and verification as evidence of participation in required MOL activities. Explaining its rationale for different periodicities for the three components, the IG said "requiring completion of some Components less frequently than every license re-registration cycle will make implementation of MOL more administratively feasible for SMBs [state medical boards] and strikes a balance between ensuring sufficient rigor in the MOL process and ensuring that compliance with MOL is not overly burdensome for licensees."

The IG noted that MOL, MOC and OCC are similar but not identical in purpose or design. While they each require a physician's commitment to lifelong learning and self-assessment through a variety of approaches, MOL does not require specialty board certification. However, the IG advised state boards to consider physicians who provide evidence of successful ongoing participation in ABMS Maintenance of Certification (MOC) or AOA BOS Osteopathic Continuous Certification (OCC) to have substantially fulfilled all three components of MOL. Since MOL—unlike MOC or OCC—is expected to be mandatory for all physicians as a requirement of medical licensure renewal, the IG said it should be reasonably adaptable for a more heterogeneous physician population that includes those that are and are not specialty-certified, and those that are and are not engaged in MOC or OCC activities.

The IG also advised state boards to regularly collect data from individual licensees about the extent of their engagement in direct patient care and the nature of their daily professional work, an effort currently being addressed in part by an FSMB working group looking at a minimal data set of questions that all state boards could require of physicians when they renew their license. There is also an FSMB working group looking at ways in which non-clinical physicians may meet a state's MOL requirements. Finally, recognizing that 22.7 percent of the nation's physicians have more than one state medical license, the IG advised state boards to strive for consistency in the creation and execution of state-based MOL programs across the country.

AS MOL ADVANCES, THE FSMB HAS AN INTEREST ON BEHALF OF STATE MEDICAL BOARDS TO COLLABORATE WITH ORGANIZATIONS THAT HAVE EXPERTISE IN ACTIVITIES THAT COULD SATISFY MOL REQUIREMENTS.

Preparing for MOL Pilot Project Implementation

Several months before the IG presented its report to the House of Delegates, in 2011, a meeting was held in Chicago of the FSMB, the National Board of Medical Examiners (NBME), the National Board

of Osteopathic Medical Examiners (NBOME), the ABMS and the AOA BOS to begin to explore ways in which discussions could be pursued to develop and design pilot projects for state medical boards to consider as they implement MOL.

As MOL advances, the FSMB has an interest on behalf of state boards to collaborate with organizations that have expertise in physician assessment, specialty certification and practice-specific tools and activities that could satisfy MOL requirements. The five organizations have met on a regular basis, rotating between Dallas and Philadelphia and Chicago, and have exchanged information and explored opportunities for bilateral (e.g., NBME-NBOME) or multilateral work on specific MOL pilot implementation projects. The members of the group have also acknowledged the need to engage with organizations like the Council of Medical Specialty Societies (CMSS), the Accreditation Council for Continuing Medical Education (ACCME) and the American Medical Association (AMA), to name just three, to better identify existing CPD tools, activities and processes. The FSMB has taken the lead in most of these communications and is still in the early phases of these discussions.

On March 18, 2011, then-FSMB Chair Freda Bush, M.D., sent a letter to the executive directors of all 70 state medical boards in the United States, updating them on the progress being made with the advancement of MOL and noting that the FSMB and several collaborating organizations were now "ready to explore specific methodologies by which a state may wish to pilot MOL implementation." She asked them to formally respond by June 1 if they were interested in participating with the FSMB in MOL pilot implementation projects. The June 1 deadline was selected in part to enable further discussions with state boards at the FSMB's annual meeting that April in Seattle.

Between March and June, FSMB board members and staff fielded queries and comments from several state boards, both at the annual meeting and at selected site visits to specific boards at their request to talk about MOL. While there was widespread interest among many states to be among the first to consider implementing MOL, there was also concern about the resources that may be required to do so. Many respondents expressed a desire to move forward, however, with several state boards openly sharing some of the steps they were already considering in order to implement MOL in their jurisdictions. The Massachusetts Board of Registration in Medicine, for instance, expressed a desire to implement MOL in that state by 2015, the same year that its rules requiring physicians to demonstrate familiarity with electronic health records as a condition for license renewal are expected to go into effect. The Vermont Board of Medical Practice announced that it would require, for the first time, completion of CME credits for licensure renewal, an important precursor to MOL implementation. The Colorado Medical Board reported that the Colorado Medical Society had created an MOL committee and would be collaborating with them on possible implementation strategies. Some state boards, such as the Pennsylvania State Board of Medicine, have created their own MOL Committee to further examine the issue. The Minnesota Board of Medical Practice reported that it had adopted a rule change to recognize physicians engaged in MOC and OCC programs as having satisfied that state's CME requirements for licensure renewal. Other state boards expressed an interest in MOL but said there were more pressing agenda items at the moment, while others expressed an interest in allowing best practices to emerge as they continued to follow developments.

By June, 11 state boards replied that they were interested in considering participation in MOL pilot implementation projects with the FSMB: Osteopathic Medical Board of California, Colorado Medical Board, Delaware Board of Medical Practice, Iowa Board of Medicine, Massachusetts Board of Registration in Medicine, Mississippi State Board of Medical Licensure, Medical Board of Ohio, Oklahoma State Board of Osteopathic Examiners, Oregon Medical Board, Virginia Board of Medicine and the Wisconsin Medical Examining Board.

The Evolution of MOL Pilot Implementation Projects

During a conference call on September 7, 2011, the FSMB led a discussion with those state boards that had expressed an interest in participating in MOL pilot projects. During this call, FSMB staff members shared the results of discussions they have had with a wide range of organizations, and concluded by the end of the call that there was wide interest among the state boards in the ultimate implementation of as many as 20 to 30 pilot projects, with perhaps a third of that number developed for implementation by early 2012.

The state boards were given an opportunity to share their thoughts on three broad, hypothetical approaches to MOL implementation: an open system, a closed system and a hybrid system. In an open MOL system, a wide variety of tools and options

could be seen as acceptable to support the needs of state boards and licensees such that content for each of the three MOL components could be provided by multiple users with distributed data repositories; the onus would be on physicians and state boards, however, to determine on a continuous basis which activities could meet MOL requirements. In a closed system, by contrast, a specified system to support a state's MOL needs could link with a centralized data repository with defined schedules and designated registration for MOL compliance; the onus in this case would be on the system. In a hybrid system, there could be both open and closed elements but standards for each MOL component would need to be identified in advance and the system centralized. Similar discussions were held with the MOL IG — shortly after Janelle Rhyne, M.D., began her term as FSMB Chair — and a council of chief executive officers from a wide range of stakeholder organizations across the continuum of medical education and practice.

Partly as a result of those discussions, 10 possible pilot projects were identified and presented for feedback in a conference call in November to interested state boards. The proposed projects include processes to determine a state board's readiness to implement MOL, to integrate a state board's existing license renewal process with what will be needed for MOL and to demonstrate how physicians engaged in MOC and OCC may be able to report compliance with MOL to state boards.

In meetings in December and January, additional discussions have continued with the hope of ultimately offering interested state boards the opportunity to initiate pilot projects by early 2012. As MOL advances with more granularity and progress, the FSMB is preparing a formal communications plan that goes beyond educational and informational presentations, including the FSMB's publications and website, to educate a larger population of physicians about MOL and its implementation. Internally, the FSMB has created an MOL Team to coordinate its messages, activities, meetings, discussions, communications, media queries and leadership of MOL. Additional information about planned MOL activities will also be provided to state boards and interested stakeholders at the FSMB's annual meeting in April 2012 in Fort Worth, Texas. ■

(This report was formally approved by the FSMB Board of Directors.)

References

1. Federation of State Medical Boards. "Report from the Maintenance of Licensure Implementation Group." Available at http://www.fsmb.org/m_mol_reports.html. Accessed November 14, 2011.
2. Chaudhry HJ, Rhyne J, Cain FE, Young A, Crane M and Bush F. Maintenance of Licensure: Protecting the Public, 2010; 96(2):13-20. Available at http://www.fsmb.org/mol.html. Accessed November 14, 2011.
3. Young A, Chaudhry HJ, Rhyne J, Dugan M. A Census of Actively Licensed Physicians in the United States, 2010. *Journal of Medical Regulation*. 2011: 96(4): 10-20. Available at http://www.fsmb.org/mol.html. Accessed on November 17, 2011.
4. Federation of State Medical Boards. Advisory Group on Continued Competence of Licensed Physicians: Report on FSMB Maintenance of Licensure Initiative. Available at http://www.fsmb.org/m_mol_reports.html. Accessed November 14, 2011.