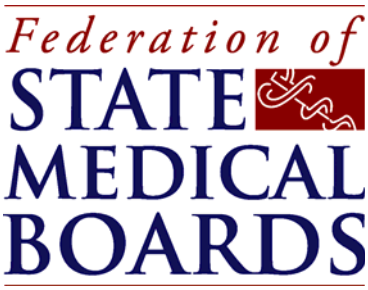

Report from the Maintenance of Licensure Implementation Group

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

February 14, 2011

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EXECUTIVE SUMMARY

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

Overall Goal of Maintenance of Licensure

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

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

Establishing a Maintenance of Licensure Program

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

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

Lifelong Professional Improvement: Three Components

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

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

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

MOL Component One: Reflective Self-assessment

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

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

MOL Component Two: Assessment of Knowledge and Skills

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

Component Two activities should meet all of the following criteria:

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

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

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

MOL Component Three: Performance in Practice

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

Periodicity Requirements

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

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

Board Certification in the Context of MOL

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

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

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

Need For More Information about Physician Practices

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

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

Consistency across Jurisdictions

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

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

Role of FSMB

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

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

Future Directions

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

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

FINAL REPORT

PREAMBLE

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

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

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

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

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

1) will impact every licensed physician in the United States;

2) must reasonably address a more heterogeneous physician population;

3) relies upon financial resources and support that are in short supply at this time; and

4) is subject to variable state laws and regulations that may require medical practice act amendments.

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

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

1) engage physicians in a culture of lifelong learning and practice improvement; and

2) demonstrate physicians' effort and success in measurably improving their patient care processes and outcomes.

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

WHAT IS MAINTENANCE OF LICENSURE?

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

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

PHASED APPROACH

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

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

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

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

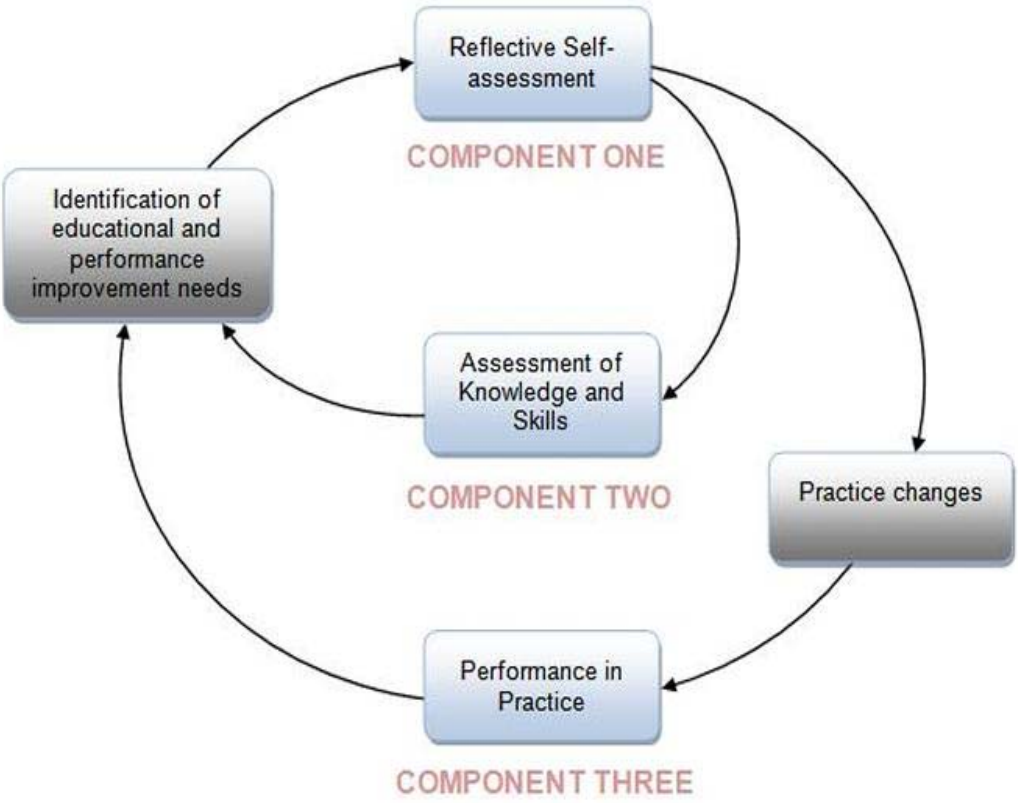
Additionally, this Implementation Group knows that some states may be ready, willing and able to move more quickly than proposed below. In these jurisdictions, MOL may be implemented in an accelerated manner.

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

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

> Preparation – SMB readiness assessment, preparatory steps, initial communication to licensed physicians, involvement of stakeholders
>
> Component One – Require Reflective Self-assessment demonstrated by certified and/or accredited CME
>
> Component Two – Require Assessment of Knowledge and Skills
>
> Component Three – Require Measurement of Performance in Practice

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



Preparation

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

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

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

MOL Component One: Reflective Self-assessment

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

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

1) demonstrate early success in MOL implementation to build momentum for MOL Components Two and Three;

2) build on the known and familiar to make best use of existing resources and to ease the transition to this new paradigm of continuous licensure; and

3) develop buy-in over time for even more effective professional development activities.

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

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

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

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

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

MOL Component Two: Assessment of Knowledge and Skills

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

Component Two activities should meet all of the following criteria:

1) **be developed by an objective third party with demonstrated expertise in these activities;**

2) **be structured, validated, and consistently reproducible;**

3) **be credible with the public and profession;**

4) **provide meaningful assessment feedback to the licensee appropriate to the scope of the activity to guide subsequent education; and**

5) **provide formal documentation that describes both nature of the activity (i.e., content and areas assessed) and successful completion of the activity as designed.**

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

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

MOL Component Three: Performance in Practice

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

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

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

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

PERIODICITY OF MOL REQUIREMENTS

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

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

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

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

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

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

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

BOARD CERTIFICATION IN THE CONTEXT OF MOL

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

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

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

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

TYPES AND NATURE OF PHYSICIAN PRACTICES

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

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

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

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

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

CONSISTENCY OF MOL ACROSS JURISDICTIONS

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

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

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

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

SUMMARY OF KEY IMPLEMENTATION ISSUES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FUTURE DIRECTIONS

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

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

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

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

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

ATTACHMENT A

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

Maintenance of Licensure Framework

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

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

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

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

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

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

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

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

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

Recommendations

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

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

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

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

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

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

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

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

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

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

Board Certification in the Context of MOL

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

ATTACHMENT B

FSMB TOOLBOX FOR IMPLEMENTATION OF MAINTENANCE OF LICENSURE

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

COMPONENTS OF PROFESSIONAL DEVELOPMENT PROGRAMS AND ACTIVITIES

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

COMPONENTS	STRATEGY (HOW)	OPTIONS /EXAMPLES
1. Reflective Self-assessment Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of CME activities. Attestation of participation would be required.	Self-assessment incorporates measures of knowledge and skills or performance benchmarks. Learners independently evaluate an aspect of their medical practice and skills, identify opportunities for improvement and then successfully complete a tailored educational or improvement activity. SMBs may want to use attestation by the physician as proof of completion. Licensees successfully engaged in ABMS MOC or AOA-BOS OCC automatically fulfill Components One, Two and Three.	Assessment tools could include: Self-review tests such as: • ABMS MOC and AOA-BOS Osteopathic Continuous Certification (OCC) • Home study courses or web-based materials that meet SMB quality standards • Medical and osteopathic professional society/organization or institution-based simulations that meet SMB quality standards • Others approved by the state medical board Professional development activities could include: • Review of literature in the physician's current practice area • CME in the physician's current practice area that addresses an identified deficiency, enhances patient care, performance in practice and/or patient outcomes
2. Assessment of Knowledge and Skills Physicians must demonstrate the knowledge, skills and abilities necessary to provide	External assessments of competencies should be structured, valid, practice-relevant, and should produce data to identify learning opportunities.	Examples of assessments addressing one or more of the competencies include but are not limited to: • Practice relevant multiple choice exams, e.g., ABMS MOC and AOA-BOS OCC exams, National Board of

safe, effective patient care within the framework of the six competencies as they apply to their individual practice.	SMBs may want to use third-party documentation as proof of completion. Licensees successfully engaged in ABMS MOC or AOA-BOS OCC automatically fulfill Components One, Two and Three.	Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME) subject exams • Medical and osteopathic professional society assessment programs/tools • Standardized patient assessments • Computer-based clinical case simulations • Mentored or proctored observation of procedures • Procedural hospital privileging • Formalized assessment/PI programs overseen by health systems or robust medical groups (e.g. likely larger organizations) • Others approved by SMBs
3. Performance in Practice Physicians must demonstrate accountability for performance improvement in their practice.	Physicians should use a variety of methods that incorporate reference data to assess their performance in practice and guide improvement. 3rd party attestation of participation will satisfy this component. As a result of completion of Component Three, licensees may address areas for improvement via Component One as part of a continuing cycle of improvement. Licensees successfully engaged in ABMS MOC or AOA-BOS OCC automatically fulfill Components One, Two and Three.	Assessment tools could include but are not limited to: • 360-degree/multi-source evaluations (self evaluation, peer assessment and patient surveys) • Patient reviews, such as satisfaction surveys • Performance Improvement CME • Collection and analysis of practice data such as medical records, claims review, chart review and audit, case review and submission of a case log • Participation in Registries • American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) Clinical Assessment Program • An approved American Board of Medical Specialties (ABMS) MOC Part IV Practice Improvement activity • An approved American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) OCC Practice Improvement activity • Medical professional society/organization clinical assessment/practice improvement programs • Centers for Medicare and Medicaid Services (CMS) and other similar institutional-based measures • Other performance improvement projects such as the Surgical Care

		Improvement Project (SCIP), American Medical Institute (AMI), Institute for Healthcare Improvement (IHI), Improving Performance in Practice (IPIP), Healthcare Effectiveness Data and Information Set (HEDIS) • Other tools approved by the state medical board

COMPONENT ONE: REFLECTIVE SELF-ASSESSMENT

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

- ABMS member board MOC Part 2 activities, such as Lifelong Learning and Self-Assessment modules which require a physician to review articles from the medical literature and take an open-book quiz on which the physician must achieve at least a passing score to receive a certificate of completion.

- AOA-BOS Osteopathic Continuous Certification Part 2 activities, which center on lifelong learning and self-assessment.

- Performance Improvement (PI) CME offered by medical professional societies that provide for: assessment of current practice using evidence-based performance measures and feedback to physicians comparing their performance to national benchmarks and to their peers; implementation of an intervention based on the performance measures; and reevaluation of performance in practice resulting from the Performance Improvement CME activity.

- Webinar, podcast, online home study or traditional printed CME activities. A majority of the content of the CME selected by the physician should be germane to his/her actual professional practice. These activities should include self-assessment tools such as pre- and post-tests that will assist the clinician to better understand their baseline knowledge before and retention of key elements after completion of the learning experience.

- Live didactic activities such as lectures at medical conferences, professional society meetings, hospital-based programs, group practice lectures, etc. There are many benefits to the in-person education and the related exchange of ideas between the lecturer and students. The content of these activities should also be germane to the physician's actual professional practice and include pre- and post-event assessments similar to those outlined above.

- Participation in organized practice assessment and improvement efforts (Institute for Healthcare Improvement, Improving Performance in Practice, or local Practice-Based Research Network quality improvement projects or similar collaborative.)

COMPONENT TWO: ASSESSMENT OF KNOWLEDGE AND SKILLS

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

- Self-assessment modules, like those of the American Board of Family Medicine, test core competencies and require physicians to correctly answer eighty percent (80%) of the questions in each competency. If they are not initially successful, physicians enter a review mode that offers an opportunity to read a critique and reference for each incorrectly answered question before inputting new answers to the missed questions. This process offers the physician to assess their knowledge, learn from their mistakes, and successfully complete the component.

- Standardized patient assessments. These assessments can provide the physician with feedback on their communication and language skills, as well as other competencies.

- Computer-based clinical case simulations. These evaluation tools can provide the physician with simulated experience working through clinical scenarios to arrive at a diagnostic impression and treatment plan. Such assessments can offer the physician insight into both his/her factual knowledge base as well as his/her clinical problem-solving skills.

- Practice relevant multiple-choice exams (e.g., ABMS MOC and AOA-BOS OCC exams, National Board of Medical Examiners (NBME) subject exams, National Board of Osteopathic Medical Examiners (NBOME) Comprehensive Osteopathic Medical Achievement Tests (COMAT), the Special Purpose Examination (SPEX) and the NBOME Comprehensive Osteopathic Medical Variable-Purpose Examination for the United States of America COMVEX-USA) and activities such as these provide the physician with a structured examination experience designed to test their factual knowledge based on a specific topic(s).

- Mentored or proctored observation of procedures and/or hospital procedural privileging. For skill-based evaluation, the physician may benefit from the direct observation and professional feedback of a fellow physician trained in the same procedure(s).

- Others approved by SMBs. The fundamental objective in Component Two of MOL is for a physician to submit him/herself to an objective or 3rd party assessment of his/her knowledge and /or skills. The results of these assessments will serve at least two purposes: 1) assist the physician in the selection of future MOL Component One educational opportunities to enhance and improve his/her professional practice, and 2) serve as objective 3rd party evidence to the SMB that the physician has successfully completed (this includes "passing" the assessment with a sufficient "score") validated knowledge and/or skill assessments in areas germane to his/her professional activities.

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

COMPONENT THREE: PERFORMANCE IN PRACTICE

Some examples of Component Three activities include:

- Registry participation. There are numerous and increasing numbers of patient care registries available. For example, the Society of Thoracic Surgeons operates a highly regarded registry for cardiothoracic surgeons. Similarly, the American College of Cardiology operates a registry for cardiovascular care. The American Osteopathic Association's Clinical Assessment Program (CAP) includes similar registries for diabetes, coronary artery disease and women's health screening. Through their participation, physicians submit data to the registry on their own patient care activities and outcomes and, subsequently, receive reports that summarize the individual physician's outcomes and place those outcomes in the larger context of the performance of other physicians/patients. In this manner, the physician is able to identify personal successes as well as opportunities for further improvement in his/her own medical practice. To fulfill Component Three of MOL, registries should:

    1) be administered by a credible third party;
    2) collect individual physician data and aggregate data from numerous individual physicians to create a comparative database;
    3) provide reporting of individual physician performance in a comparative manner to peer-matched aggregated data;
    4) provide additional comparison of individual physician performance relative to evidence-based guidelines when available;
    5) define clear criteria for "successful" physician participation in the registry, such criteria to include: a) expectations for consistent submission of required data over time, and b) active acknowledgement of receipt and review of individualized comparative reports by the participating physician; and
    6) upon participating physician request, provide formal documentation to SMBs that the physician is successfully participating in the registry.

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

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

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

- External quality reporting initiatives. Activities such as the Center for Medicare and Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI) and similar activities can provide physicians with data similar to registry participation and/or practice data analysis. Engagement in these activities is in concert with the spirit of Component Three of ABMS MOC and Practice Performance Assessment of AOA-BOS OCC.

- Participation in organized practice assessment and improvement efforts (Institute for Healthcare Improvement, Improving Performance in Practice, or local Practice-Based Research Network quality improvement projects, or similar collaborative).

- 360-degree/multi-source evaluations. Comprehensive personal assessments of the physician can be rigorous and enlightening. Such evaluation processes can provide the physician with robust and actionable feedback on the strengths and weakness of their professional efforts through the use of a number of subjective and objective assessment tools.

- Other tools approved by the SMB. The key concept behind Component Three of MOL is the physician's use of valid quantitative and/or qualitative tools to assess the results/outcomes of the physician's professional activities and for the physician to subsequently use this data to further improve his/her professional practice. It is not possible to fully anticipate the full array of tools that will be available to physicians in the future. As such, the MOL Implementation Group recommends that SMBs accept 3rd party attestation of a physician's successful participation in activities deemed by the SMB to substantially comply with this component.