**MAINTENANCE OF CERTIFICATION SUMMIT**
**Philadelphia County Medical Society**
**March 6, 2015**

On March 6, 2015, representatives of fifteen state and local medical societies [including the Medical Society of the District of Columbia], the American Board of Medical Specialties (ABMS), the American Board of Internal Medicine (ABIM), the American Medical Association (AMA), and the American College of Physicians (ACP), attended a summit hosted by the Pennsylvania Medical Society (PAMED) at the Philadelphia County Medical Society to discuss concerns with Maintenance of Certification (MOC) and identify possible future action steps to address those concerns.

**Key takeaways**

Attendees identified several issues and possible action items (see *next steps*, below), and also coalesced around the following principles:

- Board certification should be lifelong for physicians, as it is for virtually all other professions
- Testing organizations' boards need to be constituted with, at a minimum, 50% of their members engaged in active practice - defined as actively seeing patients for more than 50% of their professional time in practice.
- Minimum CME requirements need to be set and used as a replacement for the current proposed modules, enabling physicians to self-direct their learning.
- Any assessment tests should be used to guide physicians' self-directed CME study, and should never be punitive, eliminating the need for a "secure exam"
    - specific content-based feedback should be provided in a timely manner so physicians know what they got wrong and why
    - There should be multiple options for how an assessment could be structured to accommodate different learning styles
- ABIM Foundation funds need to be mobilized for use by the physicians that funded it
- The AMA should be urged to be more engaged in the monitoring of Board/testing stakeholder organizations to assure they are supporting physician practice not impeding it
- State medical societies' leadership should work with ABIM to help identify those specialty organizations that got MOC right and determine why physicians embrace these groups

**Welcome and review of PAMED actions**

PAMED president-elect Scott Shapiro, MD, began the meeting by reviewing many of the widely held concerns with the current MOC process, including its burdensome and onerous characteristics, the time and expense involved, the Part III exam's punitive nature, and its disconnect from actual practice. He then summarized PAMED's actions to date in responding to those concerns. Those actions include:

- Issuing a Statement of Principles
- Issuing a Statement of Concern
- Surveying Pennsylvania physicians regarding their views of MOC
- Seeking, and obtaining, AMA action on reform of MOC

**Introductions and initial thoughts**

Attendees, both in person and those participating by phone, then introduced themselves and shared some of their concerns regarding MOC. Those concerns included:

- Cost
- Usefulness and relevance to actual practice
- Quality
- Possible link to Maintenance of Licensure (MOL)
- Is MOC the best way to learn?
- Not conducive to sustaining learning
- MOC-related physician stress
- Psychometric measurement v. clinical validity

**Presentation by ABMS**

Mira Irons, MD, Senior Vice President for Academic Affairs at the ABMS, presented an overview of the 2015 ABMS Standards for MOC. During her presentation, Dr. Irons indicated that the ABMS Standards allow the use of "Board-approved resources" and that some Boards are piloting some efforts in this direction. She also made positive reference to the Multi-Specialty MOC Portfolio Approval Program (Portfolio Program), which offers a single process for healthcare organizations to support physician involvement in quality improvement and Maintenance of Certification (MOC) across multiple ABMS specialties.

**Presentation by ABIM**

Furman McDonald, MD, MPH, Vice President for Graduate Medical Education (GME) at the ABIM, reviewed the actions announced by the ABIM on February 3, 2015, and discussed the organization's plans for improving its MOC process.

According to Dr. McDonald, "the plan is to listen," and the goal is, "in collaboration with the community, ABIM implements standards." A key element of that process will be to identify and clarify the roles of stakeholders, including:

- Academic centers
- Professional societies
- Hospitals and health systems
- Government
- Payers
- The ABIM itself

**Q & A with Drs. Irons and McDonald**

Following Dr. McDonald's presentation, he and Dr. Irons responded to questions from attendees. Issues discussed included the following.

In response to a question regarding the specifics of how collaboration with stakeholders might take place, Dr. Irons offered that the ABMS could act as a "convener." Dr. McDonald indicated that the ABIM would be happy to hear from state medical societies.

A suggestion was made that daily evaluation of practice is important, while an examination after ten years is far less so, to which Dr. Irons responded that there is good evidence that the *initial* examination correlates to good care.

Replying to a concern that MOC has eliminated "floor to ceiling" credentialing, Dr. McDonald stated that there has not been a complete convergence, but in his view convergence would be reflective of the value of MOC.

Dr. Irons replied to a concern of the possible linkage of MOC to Maintenance of Licensure (MOL) by stating that the ABMS has no policy on a MOC/MOL link. However, she said that if MOL does come, if physicians were participating in MOC, then that should substantially meet the requirements of MOL.

A concern was raised regarding the lack of transparency regarding the cost of MOC, and that it is not well understood and almost prohibitive. Dr. Irons responded that each board is independent, but the average cost across boards is $300/year/diplomate. She did note that some boards do own Part II CME and charge for it. One reason for doing this is that this would allow diplomates to satisfy Part 2 requirements as part of their MOC fees, and NOT have to pay additional fees for Part 2 MOC. Some Boards have accredited their Part 2 literature reviews for CME and there is an additional charge if the diplomate would like the CME credit, but there is no additional charge for getting MOC credit for the activity.

Dr. McDonald recognized that ancillary costs, including board review courses and lost office days, are big. He said the ABIM understands this and is looking for ways to mitigate that cost. He said, "We want to find answers."

In answer to a comment that MOC should be evidence-based, Dr. Irons said the ABMS is now focused on this, certainly more so than in the past. Dr. McDonald said there have been some studies, and there will be more to come.

A suggestion was made that ABMS boards should offer multiple modules, allowing physicians to choose the ones that are relevant to their practice. Dr. Irons stated that three boards – Otolaryngology, OB/GYN, and Pathology – currently offer modules.

Dr. McDonald responded positively to a concern that there are few, if any, actively practicing physicians on many ABMS boards, stating that addressing that concern was part of the ABIM's restructuring.

Dr. Irons concluded the session by suggesting that state medical societies identify issues of concern and take them to the various boards. She also suggested that more use be made of the Portfolio Program.

**Stewardship**

Charles Cutler, MD, vice president of PAMED, made a presentation outlining high salaries and spending at the ABIM, reflecting the need for oversight and improved stewardship of ABMS member boards' resources. A question was raised as to whether the ABIM is incorporated in Pennsylvania, and whether the Pennsylvania Attorney General could investigate. Participants expressed a belief that the ABIM and its Foundation are incorporated in Iowa.

**Next steps**

The meeting concluded with a discussion of questions to be resolved and possible action items to be addressed going forward. Issues raised included the following:

- Define the role of state medical societies in this discussion, for example being able to link to all physicians in a state and get feedback or help direct learning projects on health issues that are important statewide
- Define the appropriate role of the AMA; AMA should protect physicians and assure that the processes and business practices of the Boards are above board and "by the book"
- Bring voice of physicians in each state to their Board; identify local/regional issues and corresponding best practices to take to boards
- Future listening session with ABIM
- MOC changes should include physicians who are working in clinical practice; certain percentage should be practicing physicians
- MOC process should be relevant to actual clinical practice
- Modules – why is there a 10 year cycle if learning is continuous? Targeted daily improvement and evaluation is better
- Education should be on modules that are available online and low cost
- Reduce the overall cost of the program, including time out of the office, etc.
- Stress this is about lifelong learning and not just MOC
- Get specific feedback on exams from physicians – and share results (what we got wrong and why)
- Replace the exam with a lifelong learning process
- Exam should be educational; remove punitive consequences
- Exams should be open book, reflecting practicing physicians' ability to access materials when treating patients
- What makes good connection between the Board and their physician groups?
- Change the name of MOC to something that more accurately reflects what we want the process to be
- Work to bring other states on board with our efforts
- Expand use of the MOC Portfolio Approval Program
- Task force across the states to give feedback on process/exams

- Do a needs assessment on how physicians learn and tailor exam/learning methods to that
- Identify co-projects between Boards and state societies
- CME should be needs-based, and geared toward MOC-identified areas for improvement/deficiencies
- Establish a timeline for action