The Evolving Paradigm – Tying Physician Demonstration of Continuing Competency to Maintenance of Licensure: What Minnesota Learned

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ABSTRACT

The Minnesota Board of Medical Practice formed a taskforce in 2006 to study the issue of maintenance of competency by physician licensees and the possibility of tying enhanced demonstration of such competency to maintenance of licensure (MOL) in the state of Minnesota. The taskforce was comprised of representatives of major stakeholder

groups including the board, the state medical society, the state hospital association, major professional societies, the university medical dean, payers, and the American Board of Medical Specialties (ABMS).

The taskforce reviewed currently available literature on competency, current CME programs in Minnesota, the ABMS Maintenance of Certification program (MOC), and the peer program used in Canada. Demographic data regarding physicians licensed at present in Minnesota was also reviewed, particularly in regard to age, specialty and time-limited versus lifetime board certification.

The data revealed that 25 percent of physicians in Minnesota are not board certified. In several very critical specialties, including pathology and radiology, the vast majority of physicians hold lifetime board certification. At present, no program, including the ABMS Maintenance of Certification program, has demonstrated that physician participation results in improved patient outcomes. Because evidence is lacking and because of the concerns about physician workforce issues if additional requirements are implemented for maintenance of licensure in Minnesota, the taskforce recommended no changes be implemented at this time. Further, the taskforce recommended Minnesota board members should continue to closely monitor and influence any recommendations made by the Federation of State Medical Boards (FSMB) and strongly encourage any changes to be evolutionary, not revolutionary.

INTRODUCTION

Over the past decade there has been heightened awareness of the less than optimal medical care that Americans are receiving at the same time the cost of care is increasing. The Institute of Medicine report in 1999, “To Err is Human,” followed by its subsequent reports, played a major role in focusing health care systems, physicians, insurers, government and other stakeholder groups on this problem. The Joint Commission’s patient safety initiatives and the Institute for Healthcare Improvement‘s “100,000 Lives” campaign are two of several programs meant to address this problem.

Systems errors, rather than physician incompetence, has been felt to be the major cause of errors resulting in patient harm. Indeed, none of the reports or initiatives has physician incompetence as its major focus nor has identified physician incompetence as a major problem. Rather, these reports and initiatives focus on developing systems that help physicians and all other members of the care team do their jobs to the best of their ability.

In spite of the absence of data showing there is a problem with widespread physician incompetence, there is a perception that physicians should now be required to more regularly demonstrate their competence and that the state medical boards’ current

standards for maintenance of a medical license are inadequate. Most state medical boards now require only a certain number of continuing medical education credits for renewing a state medical license in addition to the licensee answering questions regarding any health issues or chemical use that could impair his or her ability to safely practice medicine.

The FSMB House of Delegates, during its 2003 annual meeting, authorized a Special Committee on Maintenance of Licensure to study what the requirements should be for state medical boards renewing physician licenses. Working with the American Board of Medical Specialties (ABMS), the FSMB also started the Physicians Alliance for Physician Competence in 2005. The alliance, which has since been renamed the National Alliance for Physician Competence (NAPC), consists of multiple organizations, including the AARP, the National Board of Medical Examiners, the American Medical Association, some state medical boards and others. The alliance holds summits annually to make recommendations regarding how physicians can best demonstrate their competency.

In this setting, the Minnesota Board of Medical Practice made the decision in 2005 to form a taskforce to study the topic of maintenance of physician competency and maintenance of licensure. Their charge was to report back to the board with recommendations of changes, if any, to Minnesota licensing requirements. This paper outlines how the taskforce was constituted and worked, what was learned, and the recommendations forwarded to the board.

FORMATION OF THE TASKFORCE

Because the maintenance of competence taskforce was charged with the possibility of recommending changes to the requirements for maintaining a medical license in the state of Minnesota, we felt that major stakeholders who would be impacted by such decisions needed to be part of the taskforce. These groups included the state medical society, the state hospital association, private medical insurers, our state medical school, and the two professional specialty societies representing the largest physician membership -- family medicine and internal medicine. Each of these organizations had a representative on the taskforce, with most being represented by a senior vice president or higher level person. The University of Minnesota medical school was represented by the dean.

We also had at least three physician members from the board of medical practice and one public member on the taskforce at any one time. Our executive director and the associate director staffed the taskforce. Finally, we were privileged to have Stephen Miller, M.D., MPH, then chief executive officer of the ABMS, on our taskforce.

The taskforce met eight times between August 2006 and October 2008. Each meeting

lasted several hours, often taking up the majority of a day.

The medical board directed the taskforce to determine whether the current requirement of 25 Accreditation Council for Continuing Medical Education (ACCME)-certified continuing medical education credits per year is an adequate demonstration of continuing competency. If not, the taskforce was asked to recommend an alternative way for licensees in Minnesota to demonstrate continuing competency. Any new requirements developed by the taskforce should have the following characteristics:

- Available to all licensed physicians and osteopaths, with all eligible;
- Acceptable to the public, regulators, and physicians;
- Practice-relevant, fair and validated;
- Non-punitive;
- Not onerous or duplicative of what physicians are already doing; and
- Not dissuade physicians from practicing in Minnesota.

HOW THE TASKFORCE EDUCATED ITSELF

The taskforce reviewed existing literature regarding maintenance of competency. The American Board of Medical Specialties board certifies most allopathic physicians in the country and has developed time-limited certificates requiring recertification using a Maintenance of Certification model. Therefore, members of the taskforce reviewed this program in detail. The presence of Stephen Miller, MD, MPH, on our taskforce gave us the benefit of an expert presenter. We also looked for programs, if any were in use by other organizations, states, or countries, assessing competency of all their licensed physicians, rather than only those licensees whose competency had been called into question via a formal complaint to their medical board. Using our computer database, we also reviewed what information we had regarding ages of our physician population and specialty in relationship to their board certification status and whether they held lifetime or time-limited certificates.

The taskforce discussed the issue of physicians who had been away from practice for an extended period and needed a reentry program that was more comprehensive than a maintenance of licensure program. Such a program does not currently exist in Minnesota. Dr. Richard Allen, who directs such a program at the University of Oregon Health Sciences, made a presentation to the taskforce. During his visit to Minnesota he was also able to spend a significant amount of time at the university medical school, meeting with the dean and associate deans to help them explore developing a similar program in Minnesota. The task force felt such a program needed to be in place as part of any MOL initiative.

WHAT THE MINNESOTA TASKFORCE LEARNED

We learned that the CME offered in Minnesota at present, although ACCME-certified, does not include post-presentation testing of knowledge gained. Published studies have shown that traditional CME may not improve knowledge base. The CME community is evolving to include practice-improvement modules, point-of-care CME, and other modules that should enhance learning.

An often quoted article, published in 2005 by Choudhry and associates, purports to show that the quality of health care provided by a physician has an inverse relationship with the number of years in practice. A systematic review of the literature by these authors, which is presented in this paper, concluded that 32 of the 62 (52 percent) studies showed decreasing performance with increasing years in practice for all outcomes assessed. However, the only consistent negative-associated outcome was scores on secure exams. Only six studies reviewed by the authors looked at patient outcomes and the results were mixed with several showing no association with time in practice.

We learned that the 24 component boards of the ABMS now have recertification using maintenance of certification programs in place as of 2007, with full implementation planned by 2016. The ABMS Maintenance of Certification program includes four parts:

- Professional standing with an unrestricted license;
- Lifelong learning and self-assessment using CME modules;
- Cognitive expertise demonstrated by taking a secure exam; and
- Practice performance assessment.

Some of the boards, such as pathology, radiology, and otolaryngology, have just recently implemented time-limited certificates, whereas other specialties such as family medicine have always had time-limited board certificates. Approximately 60 percent of ABMS certificates are currently time-limited, but vary widely depending on the specialty. Diplomates with lifetime certificates can volunteer to participate in maintenance of certification, but most have declined. The literature showing that board certification results in improved patient outcomes is very limited and applies only to specific aspects of care, such as percentage of patients who qualify for mammograms receiving regular exams. No literature exists showing that board recertification results in maintenance of competency or improved patient outcomes. In Minnesota, the majority of board-certified physicians in all specialties, with the exception of family medicine, hold lifetime certificates at present. We were surprised to learn that 25 percent of licensed physicians in Minnesota are not board-certified. Literature from the ABMS repeatedly states that 85 percent of physicians in the United States are certified by ABMS boards.

Dr. Sheldon Horowitz, the lead physician for the ABMS Maintenance of Certification program, presented the patient safety MOC module to our taskforce. In an article

published in *Neurology* in 2008, Dr. Horowitz stated that "linkages of participation in maintenance of certification to improved physician performance and patient outcomes are not yet available" and that "part 4 is the heart and soul of the program as it involves looking directly at patient care and patient outcomes." He went on the state that "as MOC established links to other programs, such as maintenance of licensure, pay-for-performance, and recognition programs, diplomates with non time-limited certificates will be more likely to participate in MOC."

We learned that we have some data for our Minnesota physicians regarding their ages, board certification status, practice specialty and place of practice. This is critical data for uncovering the impact implementation of additional MOL requirements could have on our physician workforce. However, we learned that we are missing some important data, such as whether or not a licensee is currently engaged in clinical practice and, if so, how many hours per week. As long as a physician participates in CME and pays his or her license fee, we have no way of knowing if they are practicing. Further, the medical board would need to obtain permission from the state legislature to ask these additional questions.

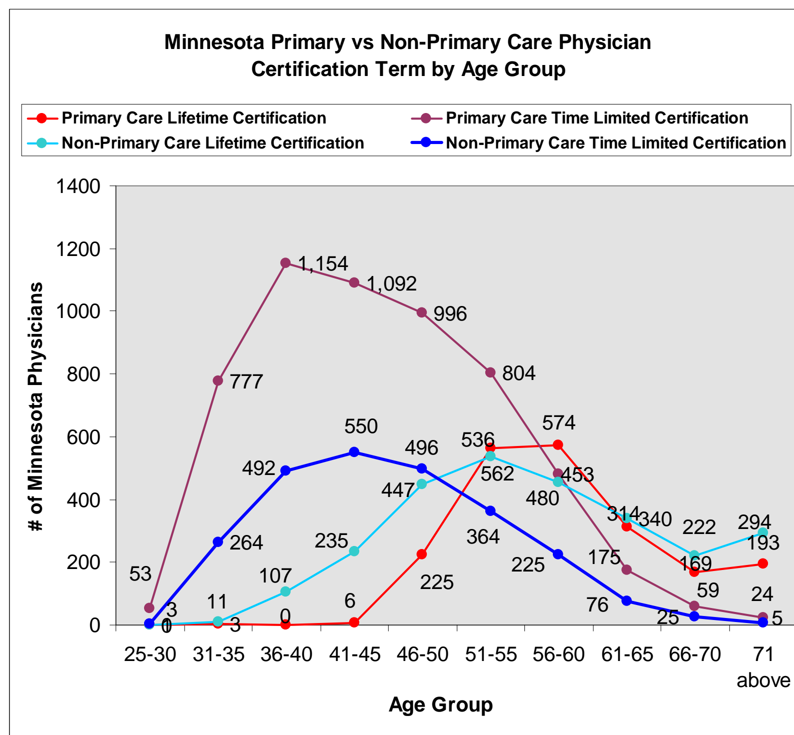
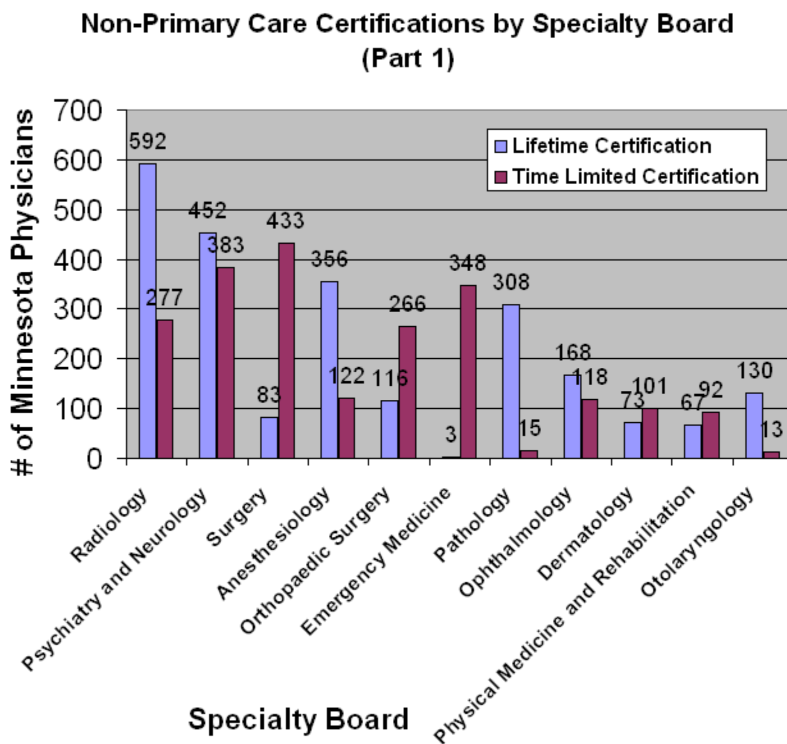


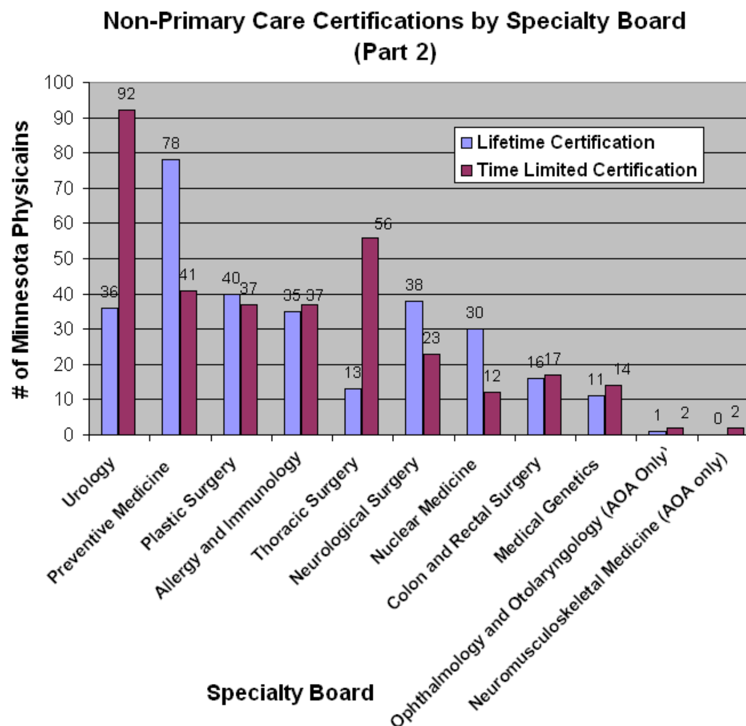
Table 1: Number of Minnesota licensed physicians holding board certification stratified by age, specialty versus primary care (includes family medicine, pediatrics, and general internal medicine), and time-limited versus lifetime certification.

As shown in Table 1, we found that most physicians age 50 and older hold lifetime board certificates. The majority of licensees younger than 50 that hold time-limited board certifications and therefore are already engaged in MOC programs of the ABMS. These efforts include completing learning modules, practice improvement modules, and taking a secure exam every seven to 10 years.

Tables 2 and 3, however, show that in some very critical specialties, only a very small number of physicians hold time-limited certificates regardless of their age. Some of these specialties, such as pathology and radiology, are highly reimbursed and, thus, could allow physicians to choose to leave practice earlier than a standard retirement age rather than participate in any increased requirements for maintenance of licensure. This could leave the state with severe shortages of physicians in these critical specialties.



Tables 2 and 3 (Part 1): Number of Minnesota licensed physicians holding lifetime versus time-limited board certification in certain specialties.



Tables 2 and 3 (Part 2): Number of Minnesota licensed physicians holding lifetime versus time-limited board certification in certain specialties.

Dr. Daniel Klass presented the Ontario and Quebec model of revalidation process used to assure continuing competency of physicians in those provinces. The program consists of audits of physician practices by trained peers. They make on-site observations of how the physician interacts with patients, uses diagnostic tools, makes decisions and keeps records. If the review raises concerns, additional evaluation and education can be ordered. Ten percent of physicians are reviewed each year, as well as all practicing physicians past the age of 70. Currently, all physicians in Canada are engaged in maintenance of competency programs using learning modules from the Royal College or the family medicine association. Neither program requires a secure exam.

INTERSECTION OF THE MINNESOTA TASKFORCE AND BOARD WITH THE FSMB

The Special Committee on Maintenance of Licensure of the FSMB issued its draft report

to state medical boards in late November 2007 to solicit feedback. The proposed standards for maintenance of licensure included:

- Participation in an ongoing process of reflective self-evaluation, self assessment, and practice assessment including learning modules, CME, etc.;
- Demonstration of medical knowledge through a secure exam at least once every 10 years; and
- Accountability for performance in practice through 360-degree evaluations, patient satisfaction surveys and collection and analysis of practice data.

Because the Minnesota board and its taskforce had been studying this topic since 2006, we were able to provide a number of responses and suggestions reflecting what we had learned in Minnesota. The board spent its entire January 2008 public meeting discussing the report. The Minnesota taskforce then received an update from Carol Clothier of the FSMB, on the now "restructured" report in February 2008. At the FSMB's annual meeting in May 2008, members of the Minnesota board spoke frequently during the discussion of this report. The FSMB House of Delegates voted to adopt the recommendations of the report, but recommended no implementation until additional study of the implications of implementation could be completed with a report back to the House of Delegates at the 2009 Annual Meeting.

The Minnesota taskforce reviewed the FSMB House of Delegates report during the summer of 2008. I was invited by the FSMB to participate in the sixth summit held by the National Alliance on Physician Competency, along with another member of the Minnesota board, Dr. Rebecca Hafner-Fogarty. During this summit the draft of the *Guide to Good Medical Practice-USA*, version 1.0, was reviewed and released for comment. The guide outlines recommendations for physician demonstration of competency and mimics those requirements developed by ABMS and the FSMB. In the fall of 2008 the Minnesota taskforce reviewed the *Guide* and forwarded comments to the FSMB. The author also attended the maintenance of licensure implementation taskforce meeting held by the FSMB in October 2008. Representatives of 13 medical boards attended this meeting to discuss the impact any requirements would have on their medical boards.

OUTCOMES AND RECOMMENDATIONS OF THE MINNESOTA TASKFORCE

A very important outcome of the taskforce is that the major stakeholder groups in Minnesota, including the board, physicians, and payers now share a common body of knowledge and understanding of the current limitations and obstacles to moving to enhanced demonstration of continuing competency of physicians at this time. The taskforce recommended that no changes should be made at present to the requirements for licensure in the state of Minnesota. Rather, the Minnesota board should closely

monitor and influence the ongoing MOL initiatives at the FSMB. Because no body of data currently exists showing that board recertification results in improved patient care and outcomes, any changes to MOL requirements should be evolutionary, not revolutionary.

SOME FINAL THOUGHTS FROM THE CHAIR

At present, the FSMB has proposed that MOL use a model very similar to that currently used by the ABMS for maintenance of certification, including a secure exam. The FSMB is, however, now taking a very careful look at the possible implications and unintended consequences of implementation of the current proposed MOL model and reviewing what changes, if any, should be made to the current model, including eliminating the requirement for a secure exam as has been done in Canada. Any definition of competency and requirements for demonstrating such competency must translate into improved patient outcomes.

As demonstrated by the article recently published in *Circulation* by Turchin and colleagues, the current model used for maintenance of certification by the ABMS and the similar proposed MOL model from the FSMB may not result in the desired improved outcomes. In the article the authors looked at intensification of antihypertensive treatment in diabetic patients whose blood pressure was too high at the time of an office visit. Only 6.9 percent of physicians who had been board-certified at least 31 years before the visit increased or changed the antihypertensive medication, whereas 26.7 percent of physicians who were board-certified the previous year increased the medication. The authors concluded that these findings support mandatory recertification. And yet, even the newly board-certified physicians provided the right treatment for only one of every four patients. Is this the level of quality we are trying to achieve? Or should we be going down a different path that will allow physicians to provide the correct care to their patients during the majority of episodes of care?

The right path might very well be one where physicians, hospitals, health systems, and regulatory bodies, including medical boards, focus more on quality improvement initiatives to help all physicians provide appropriate care. This could include:

- **All physicians completing educational modules on a regular basis.** Such modules should be relevant to their practice and include practice-improvement content.
- **Systems need to evolve that will provide feedback loops to physicians in their practices** regarding how well they are performing on patient outcomes such as diabetic care, chronic heart failure, and percentage of eligible female patients receiving mammograms.
- **Patient identifiers should be included so the physician can contact these patients to enhance compliance.**

- **Electronic health-record technology should be harnessed to help physicians improve episodes of care.** This could include using pop-up screens that alert the physician during the patient visit that the patient's blood pressure is outside recommended guidelines, as well as the use of drug interaction alerts.

We should put the focus on problems with systems since few physicians practice in isolation at present, but rather are part of a care team with shared responsibility for patient outcomes. We need to focus on helping all licensed physicians who are currently providing patient care perform better. This will be achieved only by developing a positive, non-punitive quality improvement model for maintenance of licensure.

AUTHOR AFFILIATIONS

Linda L. Van Etta, M.D., FACP, Past President, Minnesota Board of Medical Practice and Past Chair, Minnesota Taskforce on Maintenance of Licensure.

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