

Value of the Continuing Certification Modules and Challenging the Status Quo

Amy Capoocia, DO

A previous draft of this article was written by Dr Capoocia as part of the requirements of the American Association of Colleges of Osteopathic Medicine Health Policy Fellows 2018.

Financial Disclosures:
None reported.

Support: None reported.

Address correspondence to
Amy Capoocia, DO,
Access Health Care
Physicians, LLC, 0494
Northcliffe Blvd, Spring Hill,
FL 34609.

Email: drred2003@yahoo.com

Submitted
September 15, 2018;
revision received
March 22, 2019;
accepted
May 8, 2019.

The need for lifelong learning is inherent to the medical profession. Historically, there was limited oversight on physician training and no clear way to distinguish whether a physician had achieved proficiency in medical assessments and treatments. In the early 20th century, groups of physicians came together to promote advancements in medical science and to identify the boundaries that define specific specialties. In 1917, ophthalmology became the first officially incorporated board, followed by the American Board of Medical Specialties (ABMS) in 1933 and the Bureau of Osteopathic Specialists (BOS) in 1939.¹

Board certification has long been held as the traditional measure of professionalism, the highest standard of care, and an indicator that a physician is committed to excellence. However, over the past 30 years, increased supervision, regulation, and mandates from medical certification bodies have grown in scope and intensity. For example, the ABMS developed Maintenance of Certification (MOC) modules along with standardized testing in 1990. The American Board of Internal Medicine (ABIM) replaced lifelong board certification with a 10-year MOC in 2000. But as the requirements for certification and associated costs have continued to rise, have these requirements been proven to be beneficial to overall quality of patient care?

Despite limited data on improved quality of care associated with periodic testing for board recertification and MOC or Osteopathic Continuing Certification (OCC), board certification or board eligibility is now the standard for employment. Their requirement contributes to increased costs associated with medical care and decreased time physicians are available to care for patients.² Physicians are concerned that the modules are costly and cumbersome, and they are burdened by data entry sets.³ Furthermore, as national and state continuing medical education (CME) requirements meet or exceed those of the MOC and OCC modules, the modules have become redundant. The fact that these modules are tied to board certification also allows them to potentially be tied to licensure, hospital privileges, and insurance payments.

Other specialty boards, such as the National Board of Physicians and Surgeons (NBPAS), the National Board of Osteopathic Physicians and Surgeons, the Association of American Physicians and Surgeons, and the American Board of Physician Specialties (ABPS), arose in response to or have pushed against these added requirements. The discourse and competition from these entities has led to closer scrutiny of existing medical examination boards and has spurred greater scrutiny from the certifying boards themselves.

This article examines the process of MOC and OCC, the impact of MOC/OCC on physician performance and patient care, potential changes to MOC/OCC, and the impact of emerging boards on the process of certifying professional excellence and improving patient care.

Process of Specialty Board Certification

In addition to being in good standing with national and state specialty chapters, the requirements for board certification include up to 150 hours of CME, maintaining full state licensure requirements, and the successful completion of a written examination every 6- to 10 years. The ABMS and the BOS have now abandoned singular, periodic, comprehensive tests in favor of periodic testing plus modules and medical record review updates along with CME requirements to maintain certification.^{5,6}

The physician must also engage in continuous quality improvement through comparison of personal practice performance measured against national standards for the given medical specialty.⁵

The cost of MOC and OCC runs over \$2000 per physician per 8- to 10-year certification cycle, and over \$7000 when including subspecialty and osteopathic principles and practice testing.⁸ In addition to financial cost, significant investment of time is required for participating in examination preparation and continuing education courses. Furthermore, there are additional CME requirements for state and national colleges and state licensure requirements that must be met.

Impact of MOC/OCC on Patient Care and Outcomes

There are limited nonindustry-sponsored data on board certification and outcomes. Two often-cited studies^{9,10}

were written by physicians who are on the Board of Directors for the ABIM and were funded in part by the ABIM; even these papers fail to show a significant benefit to board recertification regarding patient outcomes and reduction of cost.

The MOC and OCC modules were developed to help with the fourth component of ABMS certification: “assessment of performance in practice” (or quality improvement). However, now that medicine is regulated by many entities, these components and requirements are redundant, as patient data analysis is already performed by many hospitals, insurers, and employers. Physicians are already being scrutinized and held to local and state standards, and hospitals are being evaluated by national standards committees. There are no data to support the additional, redundant certification modules.^{11,12}

However, of note, a meta-analysis²⁵ on the effectiveness of CME found that “CME does improve physician performance and patient health outcomes”²⁵ and that CME activities that “are focused on outcomes that are considered important by physicians lead to more positive outcomes.”²⁵

Stakeholders

Support for MOC/OCC

Several prominent boards support MOC and OCC (Table). The ABMS states that specialty boards “are instrumental to the integrity of medical specialty care. They provide a trusted credential that is important to patients and relevant to physician practice.”²⁷

Table.
List of Stakeholders That Support and Oppose Maintenance of Certification and Osteopathic Continuing Certification

Support	Oppose
American Board of Family Medicine	Accreditation Council for Continuing Medical Education
American Medical Association	American Board of Physician Specialties
American Osteopathic Association Bureau of Osteopathic Specialists	Association of American Physicians and Surgeons
American Osteopathic Board of Family Medicine	Change Board Recertification Doctors 4 Patient Care
Centers for Medicare and Medicaid Services	Multiple state and county medical societies
National Board of Osteopathic Medical Examiners	National Board of Osteopathic Physicians and Surgeons
National Committee for Quality Assurance	National Board of Physicians and Surgeons

The American Board of Osteopathic Family Physicians² stated in 2012 that the “single examination model for certification is no longer the standard demanded by the public. [Osteopathic Continuing Certification] [W]ill help Osteopathic Physicians meet and exceed industry and regulatory standards [and] [W]ill be accepted for Maintenance of Licensure (MOL).”

However, in July 2018, the Vision Initiative²¹ hosted 21 hours of testimony from physicians, patients, and other stakeholders and distributed a survey to stakeholders. From the survey results,²² which comprised a convenience sample pulled from more than 34,000 physician responses, it was found that:

While a small percentage of physicians value MOC, a larger portion (of stakeholders) has either mixed views or do not value MOC.... Respondents want continuing certification to include a focus on relevant CME opportunities, self-assessment delivered at regular intervals, open-book testing, and an assessment of the quality and safety of the care provided.²²

Despite this conclusion, it appears ABMS will continue to use the existing modules.

Opposition to MOC/OCC

While most physicians agree that CME in their specialties is important, they disagree with the method of achieving certification.²⁵ Physicians are adapting to utilize real-time information through podcasts, electronic textbooks, and various online resources to stay current with evolving best practices. Rote examination and entering patient data sets with self-assessments fails to help physicians remain current with the literature and advancements relevant to their fields.¹⁶

There are also concerns regarding the financial links between the ABMS and, to a lesser degree, the BOS, and funding institutions such as hospital organizations, pharmaceutical companies, and credentialing organizations. For example, the ABIM is nonprofit, but its financial counterpart, the American Board of Internal Medicine Foundation, is not.¹⁷ Likewise, the nonprofit

ABMS is associated with the for-profit arms ABMS Solutions, LLC, and ABMS International, LLC, which are the primary sources of verifying physician certification and offering training to other countries on licensure and certification, respectively.^{14,15}

Multiple independent physicians and physician organizations are raising concern that these boards are adding onerous projects while benefiting financially. They argue that although lifelong education is necessary, the modules do not improve patient care or outcomes.¹⁸ In a survey of physician attitudes about MOC, Cook et al¹⁹ found that only 15% agreed that MOC was worth the time and effort and 81% found it burdensome. Less than 40% of respondents felt MOC activities contributed to professional development, and the perceived relevance of MOC was noted throughout physician specialties.

After hosting a dialogue on the MOC requirement, the American Academy of Neurology issued a position statement calling MOC Part IV “an unnecessary, onerous requirement” and urged the American Board of Physicians and Neurologists to repeal it.²⁰ The academy further noted that MOC programs “have become so unpopular that state legislatures are moving to limit the significance of MOC and some physicians are opting out of the predominant recertification system entirely.”²⁰

Certification Competition

Two major competitors, the NBPAS and the ABPS, assert that MOC and OCC are cumbersome and ineffective. According to a 2015 article in MDedge,¹³

The launch of the NBPAS’ program occurred just weeks before the [ABIM] announced drastic changes to its MOC process. In a frank announcement, ABIM apologized to doctors for an MOC program that “clearly got it wrong,” and pledged to make the program more consistent with physicians’ practice and values.

Both of the NBPAS and ABPS offer their own board certification. They still recommend board certification; however, they push for streamlining the certification process and eliminating re-certification testing in favor

of focused CME in specialty-specific areas.^{28,29} The focus is on continued lifelong learning instead of performing case logs and quality improvement projects.

Improving Certification

Perhaps because of the emergence of competitive credentialing boards, the Accreditation Council for Continuing Medical Education and the American Medical Association acknowledged in February 2018 that the current structure of MOC was rolled out prematurely and is not user friendly or beneficial to the participants or patients. They are seeking to restructure certification and CME to use technology, provide specialty-specific CME, and offer more options and less regulation.²⁴

Recommendations

While the regulatory boards are contemplating changes, recommendations should be made to continue with certification examination for initial board certification, end the 6- to 10-year mandated examinations in favor of more frequent and more focused online testing, and have physicians complete mandatory hours of specialty-specific CME.

Specialty colleges should require online lectures and posttesting in dedicated topics as determined by each college in addition to broad-based CME. Because requiring MOC and OCC with CME hours is redundant, the fourth component, quality metric modules, should be eliminated. By doing so, this will better use physician time while promoting continued improvement in patient care and outcomes. (doi:10.7556/jaoa.2020.025)

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