began requiring diplomats to complete four sets of activities—including taking and passing an exam every 10 years—in order to renew their board certification.

The pushback never stopped, however, and today, some specialties have changed their approach to the maintenance of certification (MOC) exams to make them less onerous for the physicians taking them and, more important, a better measurement of a physician's knowledge and ability.

Years of controversy over MOC exams and fees have yielded myriad studies, articles, surveys, state laws and alternative professional boards with their own certification standards. A 2016 survey published in the Annals of the Mayo Clinic showed that of the 988 physician respondents, 40 percent or less agreed that MOC activities contribute to their professional development. Only 24 percent (200 of 842) found that MOC activities are relevant to their patients and 15 percent (122 of 824) felt they are worth the time and effort. A full 81 percent said MOC activities are a burden and only 9 percent said that patients care about their MOC status.

Lead researcher David Cook, MD, MHPE, a Mayo Clinic physician, doesn’t find the results particularly surprising, based on the responses of focus groups of Minnesota and Wisconsin physicians and sentiments expressed at informal and formal public forums.

“Part of the problem is that MOC is an add-on to the already-overwhelming workflow of a physician,” Cook says. “Physicians are feeling burned out, and MOC is just one more thing on a physician’s to-do list. To the extent that MOC becomes integrated with physicians’ workflows, and offers tangible benefits (e.g. help to identify and remedy gaps in knowledge and skill), the cost-benefit ratio will probably change.”

Some physicians opted to retire rather than take one more once-a-decade, multiple-choice exam, often in a location that meant time off work and travel expenses. A few refused to take the exam or pay the fees and moved to positions that didn’t require re-certification. Most did what they need to in order to stay in their positions—some through gritted teeth.

Faced with continuing complaints, some of the boards that make up the ABMS have begun changing recertification requirements. One by one, they’ve taken the physician’s workload into consideration, breaking down the tests into more manageable chunks to be completed on a laptop or even a smartphone over a few years. Some allow short periods of time during a test for physicians to look up information, and offer limited flexibility for them to choose categories that best reflect their current practice. Some provide immediate feedback on responses and more information on the topics.

The American Board of Anesthesiology was the first to pilot an alternative to the once-a-decade exam in 2014. The anesthesia board applied adult-learning theory, which posits that cramming for a once-a-decade exam might help adults pass a test, but doesn’t help them retain that knowledge.

“What our board has done is, it said, ‘Look, we want to make this fun. We want it to be educational. We don’t want it to be punitive. Let’s set this up for adult learners,’” says Mike Wall, MD, a MOCA Minute Committee member and head of the anesthesiology department at the University of Minnesota Medical School.

The longitudinal assessment, known as MOCA Minute, requires anesthesiologists to answer 30 questions each quarter and allows one minute to answer each question. Anesthesiologists in subspecialties receive a percentage of questions geared toward those subspecialties.

The questions have evolved, too, with “a boatload of new questions every year,” Wall says. Many are topical and change as guidelines are updated. “The cool thing is, as new guidelines come out, we can get the questions out to every anesthesiologist across the country, and if they get it wrong, they’ll get it again. It’s not minutiae; it’s good stuff.”

The anesthesiology board gave the ABMS the results of its pilot in hopes of having the MOCA Minute replace a high-stakes exam taken every 10 years. When ABMS approved transitioning the pilot to a permanent part of the ABA’s MOCA pro-
Physicians are feeling burned out, and MOC is just one more thing on a physician’s to-do list. To the extent that MOC becomes integrated with physicians’ workflows, and offers tangible benefits, the cost-benefit ratio will probably change.”

— David Cook, MD, MHPE, Mayo Clinic

“Changes for pediatricians

The American Board of Pediatrics (ABP) also followed in the anesthesiology board’s footsteps after hearing about the new model at their 2015 Future of Testing conference. One of their main complaints was that the closed-book, highly secure exam did not reflect their daily practice, in which physicians frequently look up information about particular conditions and treatments on their smartphones and computers.

Like many other specialists, the pediatricians also complained that the 10-year exams were inconvenient, time-consuming and ineffective for learning. The two-year pilot of MOCA-Peds launched in 2017 and the official version begins this year.

ABP’s MOC cycle runs every five years, but the board does not expect its diplomates to answer questions every year for five years, according to Linda Althouse, PhD, vice president of assessments for the board. Instead, the ABP scores each diplomate’s answers at the end of their fourth year. Those who are not passing after four years do not lose their certification but must take the proctored exam. Under the old system, diplomates who didn’t pass lost their credentials and had to wait to re-take the exam. Those who pass after four years have the fifth year “free,” with no required questions to answer.

“You’ll know how you’re doing as you’re going along,” Althouse says. “We are also dropping the lowest four quarters for diplomates each cycle, since this is an ongoing activity and we know that there can be life interruptions.” If a diplomate is performing high enough at the end of three years, they can drop all of the fourth year. ABMS also developed CertLink, a platform to help seven of its smaller boards develop and provide a longitudinal assessment program, according to Mira Irons, MD, senior vice president for academic affairs at ABMS. Physicians receive questions online two to four times a year with references to more information.

“It addresses the relevance concern that physicians have had and addresses the burden concern,” Irons says. “It’s convenient. People can take it at their home, on their laptop.”

As an alternative to the once-a-decade exam, other boards have opted for a once-a-year assessment that physicians can...
take at home. Still others, including the American Board of Obstetrics and Gynecology, have asked their physicians to read a specified number of articles that relate to their specialty and answer questions based on those articles.

While taking MOC exams is getting easier, some physicians chafe at the notion that their employment may be tied to recertification. A family medicine physician for 34 years, Joe Van Kirk has taken the MOC exam five times since 1984. He’ll be 70 when his next 10-year exam comes around and would rather retire than take the test again. That would mean losing clinic privileges at his workplace, Ridgeview Clinic Chanhassen. “It is a roadblock because it does require more time and effort and preparation and money,” he says.

Why certification matters
Maintaining certification is crucial for most physicians; Without it, hospitals and clinics may cut off a physician’s privileges, payers may cease covering the care they provide, potential patients could decide to go elsewhere and current patients might change to other physicians.

Recertification shows patients, hospitals, clinics and payers that physicians have exceeded the standard and are up-to-date with clinical and evidence-based knowledge, says Rahul Koranne, MD, MBA, FACP, chief medical officer for the Minnesota Hospital Association. He considers Minnesota physicians to be high-achieving and exacting when it comes to standards.

“If patients are looking or not looking, physicians in Minnesota are looking at ourselves,” Koranne says. “We take this responsibility of always exceeding the current knowledge base, knowing the evidence base, very seriously. I believe patients are looking, and being board-certified is on everybody’s website.”

Fairview Health Services acknowledges that using the MOC process as a requirement of employment is not perfect, according to Beth Thomas, DO, Fairview’s chief quality officer. And while board certification doesn’t necessarily correlate with providing excellent patient care, “it’s the only real proxy we have at this time that’s objective to say, ‘Yeah, you’re qualified,’” she says.

Blue Cross Blue Shield Minnesota requires in-network providers to be board-certified, with some exceptions. For example, if a provider is serving an underserved population or in the process of securing board certification, the credentialing committee may include that provider in the Blue Cross network following the application and credentialing process.

HealthPartners requires continuous board certification of the physicians and other clinicians who work within its care delivery system. For non-employed physicians and other clinicians whose care is covered by the HealthPartners health plan, board certification is one of the criteria the health system’s credentials committee reviews when a practitioner applies for credentialing and re-credentialing.

Most health systems in Minnesota require board certification for employment, according to Stelter, who says that’s not the ABFM’s fault. “Board certification was never meant to be a surrogate marker for professional credentialing or employment,” he says. “It’s actually for mastery of the individual physician to prove that they are staying up-to-date in the field of family medicine.

“There should be ways for a health system to assess a physician other than board certification,” he says. “We never sold it to the health plans or the large health systems in the country as the means to credential physicians for employment.”

The ABFM resisted having its certification made a condition of employment, Stelter says, “but health systems said, ‘It’s here, so let’s use it.’”

Stelter says there should be another pathway for potential employment and insurance credentialing for those physicians who choose not to participate in ABMS Board Certification, a pathway created by insurers and employers. “They could also come up with their own measure of physician competence for those who aren’t board-certified,” he says.

“They’ve not done that part, and board certification is rigorous—it’s meant to be that way,” he says. “It is a good surrogate marker if you can keep up with it, but it shouldn’t be the only way. You shouldn’t be denied employment based on that. That was not our intent.”

The American Medical Association (AMA) agrees. “The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation,” the AMA states on its website.

The AMA’s State MOC Legislation Tracker shows that four state legislatures have passed what it calls full MOC laws, which mandate that a physician’s MOC status must not affect licensure, employment or insurance coverage. Seven other states have banned MOC ties to medical licensure. Legislators in 18 more states, including Wisconsin and Iowa, have introduced MOC legislation. Minnesota could be among the next, according to State Rep. Scott Jensen, MD, who is considering introducing a bill in the 2019 legislative session.

Jensen has been a family medicine physician for 34 years. In private practice in Carver County, he treats adults but gave up offering OB/GYN care in the 1990s and does not work in hospitals. He calls the 10-year MOC exam “outmoded” and “onerous.” Jensen’s proposed legislation would ban denying credentials to a physician who is in good standing and maintains the requisite CME credits.

As MOC exams are changing, Althouse of the American Board of Pediatrics sees resistance to taking them beginning to ease. “People are more hopeful,” she says. “They want to give this a shot. The mood has definitely swung.”