Overview of Activities Related to Physician Continuing Competence and Continuous Professional Development

In recent years a number of medical regulatory agencies have implemented initiatives that seek to instill principles of quality and performance improvement within the medical profession. Provided below are overviews of activities by the American Board of Medical Specialties (ABMS), Accreditation Council for Continuing Medical Education (ACCME), the Joint Commission, the American Osteopathic Association (AOA) and the Federation of State Medical Boards (FSMB), as well as the Physician Accountability for Physician Competence (PAPC) summits.

American Board of Medical Specialties Maintenance of Certification

In 2000, the 24 member boards of the ABMS endorsed the principles behind Maintenance of Certification (MOC), a program designed to continuously and comprehensively assess the ongoing competence of physicians certified by each of the 24 ABMS specialty boards. This initiative will replace the recertification requirements that ABMS boards began utilizing in the late 1970s. All ABMS member boards received approval of their MOC programs in 2006.

A PowerPoint presentation regarding MOC is available on the ABMS website at: http://www.abms.org/Who_We_Help/Member_Boards/MOC_Communications_Zone/powerpoint.htm

The MOC program requires specialists to demonstrate evidence of the following: professional standing; a commitment to lifelong learning and involvement in a periodic self-assessment process; cognitive expertise; and evaluation of performance in practice. Each of the four areas has associated standards in place specifying what is considered acceptable evidence for meeting that requirement:

1. Professional standing (licensure)
   - Hold a valid, unrestricted medical license
2. Lifelong learning and self-assessment
   - Evidence of participation
   - Diplomates are expected to conform to general and specialty-specific standards
3. Cognitive expertise (examination)
   - Covers the scope and range of the discipline
   - Is clinically relevant
4. Practice performance assessment
   - Proven scientific, educational and assessment methodology
   - Reflects patient care and should result in quality improvement

Physicians who are certified through the ABMS MOC program will be expected to demonstrate competence in six core areas: patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning, and systems based practice. The ABMS is using these competencies, which were developed by the ACGME for use with physicians in training, because it believes they have relevance to physician practice regardless of area of specialty.
Physicians who have certificates without time limit are not required to participate in MOC. Permanent certificate holders who elect to voluntarily participate in MOC activities will not lose their permanent certification should they fail to meet the MOC requirements.

**Accreditation Council for Continuing Medical Education**

In 2005, in an effort to strengthen the role of CME in physician performance improvement and lifelong learning, the ACCME proposed a model for CME based on practice-based, self-directed physician learning and change. Subsequently, in September 2006, the ACCME released new standards for the accreditation of CME providers that focus on learning and change for both CME providers and learners. The new standards aim to improve physician practice and, thus, the quality of patient care by requiring CME providers to develop and implement CME programs that focus on improving physician competence, physician performance and/or patient outcomes. CME providers will be asked to evaluate their success in meeting this goal.

Additional information about the new accreditation criteria is available on ACCME’s website at [www.accme.org](http://www.accme.org). Links to tools to support implementation of the criteria are available directly at: [http://www.accme.org/dir_docs/doc_upload/de070ccf-f614-4f83-8659-837e4318aeb3_uploaddocument.htm](http://www.accme.org/dir_docs/doc_upload/de070ccf-f614-4f83-8659-837e4318aeb3_uploaddocument.htm)

A presentation about the evolution of continuing medical education in the US over the past 60 years is available at: [http://www.fsmb.org/annualMeetingSessions/friday/Maintenance_of_Competence/Kahn_Final_FSMB_050208.ppt#256,1,The Evolution of Continuing Medical Education in the US](http://www.fsmb.org/annualMeetingSessions/friday/Maintenance_of_Competence/Kahn_Final_FSMB_050208.ppt#256,1,The Evolution of Continuing Medical Education in the US)

**The Joint Commission**

The Joint Commission, as part of its accreditation process for health care organizations and programs, evaluates health care organizations' compliance with Joint Commission standards, including those for credentialing and privileging of physicians. In 2003, the commission, prompted by deficiencies in the existing system, began revising its credentialing and privileging standards to focus on the proactive evaluation of physicians' competence and to move beyond privileging decisions based primarily on an evaluation of physicians' technical skills.

The new standards, which were implemented in January 2007 and January 2008, are intended to make the credentialing and privileging process more objective and evidence-based by facilitating continuous monitoring of physicians' performance and by providing a basis for intervening when quality of care concerns are identified. Under the new standards, organizations are required to implement a Focused Professional Practice Evaluation as well as an Ongoing Professional Practice Evaluation as part of the credentialing and privileging process. The Focused Professional Practice Evaluation standards apply to the evaluation of currently privileged practitioners who are seeking new privileges they have never performed before in the organization and to situations in which the competence of a practitioner with existing privileges comes into question. The Ongoing Professional Practice Evaluation standards enable the continuous, rather than periodic, review of practitioners' performance.
The new standards also require organizations to evaluate physicians on multiple competencies, such as the six core competencies developed by the Accreditation Council for Graduate Medical Education (i.e., medical knowledge, patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice). Finally, the new standards address hospital-based education and require that such activities relate, at least in part, to the type of services offered by the organization and be based on the findings of performance improvement activities.

**American Osteopathic Association**

In 2007, the American Osteopathic Association Bureau of Osteopathic Specialists (AOA BOS) approved a schedule for implementation for continuous certification. All osteopathic certifying boards were required to submit a plan for continuous certification to the BOS by November 2008, and plans will be implemented by 2012. The American Osteopathic Board of Emergency Medicine (AOBEM) already has implemented a continuous certification program to replace traditional recertification. As part of this process, diplomates are required to provide evidence of meeting criteria in four components on a continual basis: Professional Status, Continuous Osteopathic Learning Assessment, Formal Re-Certification Examination, and Practice Status.

In addition to discussions regarding continuous certification by the AOA BOS, the AOA Clinical Assessment Program (CAP) is a quality improvement tool for osteopathic physicians to evaluate the effectiveness and safety of patient care in their clinical practice during residency programs and in physician practices. The goal of the CAP is to improve patient outcomes by providing valid and reliable assessments of current clinical practices. Using evidence-based guidelines to evaluate clinical practices and track patient outcomes, the data in CAP is compared to national benchmarks and the performance of other participants to determine whether their treatment protocols are consistent with the best standards of practice. CAP provides evidence-based measurement sets on eight clinical conditions including diabetes, coronary artery disease, hypertension, women’s health screening, asthma, COPD, childhood immunizations, and low back pain. CAP measurements of quality can be used as a component of board certification and osteopathic continuous certification to meet the requirement of practice performance assessment.

**Council of Medical Specialties**

In 2008, the CMSS released a primer on *The Measurement of Health Care Performance*, which summarizes recent discussions and interest in quality improvement, outcome measures, practice measurement and physician performance. The intent of the primer is to “create a common background of terminology, approaches, and rationale regarding physician practice measurement and quality improvement.” The primer is available on the CMSS website at: [http://www.cmss.org/images/Primer.pdf](http://www.cmss.org/images/Primer.pdf)

**FSMB Special Committee on Maintenance of Licensure**

The Special Committee on Maintenance of Licensure was convened in May 2003 to study the role that medical boards should play in ensuring the ongoing competence of physicians and to develop recommendations for use by state medical boards in implementing maintenance of licensure initiatives. In 2004, the FSMB's House of Delegates adopted the official policy statement that state
medical boards are responsible to the public for ensuring the ongoing competence of physicians as a condition of relicensure.

In fall 2007, the committee disseminated a draft of its final report to interested parties for comment. Responses from state medical boards, individual physicians and affiliate medical organizations indicated mixed support for the committee’s recommendations, citing concerns about both implementation issues and impact on practicing physicians. Acknowledging the concerns raised by state medical boards, the FSMB Board of Directors deferred acting on the committee’s report and instead, recommended to the FSMB House of Delegates that it direct FSMB to study how medical boards and other stakeholders might be impacted by implementation of MOL requirements and report back to the House of Delegates. The Board of Directors also recommended the following five principles be adopted as a framework for guiding future FSMB activities related to MOL:

- Maintenance of licensure should support physicians’ commitment to lifelong learning and facilitate improvement in physician practice.
- Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing maintenance of licensure requirements should remain within the purview of state medical boards.
- Maintenance of licensure should not be overly burdensome for the profession and should not hinder physician mobility.
- The infrastructure to support physician compliance with maintenance of licensure requirements must be flexible and offer a choice of options for meeting requirements.
- Maintenance of licensure processes should balance transparency with privacy protections.

Both recommendations were adopted by the FSMB House of Delegates in May 2008.

In January 2009, the FSMB released a draft report analyzing how state medical boards and other stakeholders would be impacted if states implemented maintenance of licensure policies as recommended by the Special Committee on Maintenance of Licensure. To carry out the analysis, representatives from 13 boards, as well as “content experts” from the continuing medical education, assessment and practice communities, were convened to participate in a two-day meeting in October 2008 to identify relevant issues and assess the implications of implementing MOL policies. The impact analysis report is available on the FSMB’s website at: [http://www.fsmb.org/m_mol_reports.html](http://www.fsmb.org/m_mol_reports.html).

A report on maintenance of licensure will be presented to the FSMB House of Delegates in 2009.

Physician Accountability for Physician Competence

In March 2005, the FSMB hosted the first in a series of national summits to engage a broad array of stakeholders in discussions about how the health care system will measure, determine and assure the public of a physician’s competence through the course of his or her career. To date, six summits have been held, with representatives from over 75 organizations participating. The seventh summit is scheduled for February 23-24, 2009. Documentation of all the PAPC meetings is available at [www.innovationlabs.com/summit](http://www.innovationlabs.com/summit).
This dialogue has resulted in agreement on several important principles: 1) the medical regulatory system is fragmented and in need of change; 2) such change or improvement will require collaboration between the organizations along the continuum of medical education, training, licensure and certification; 3) the medical profession must be responsive to calls for increased accountability for the competence of its members, both at the point of entry to practice as well as throughout a physician’s professional career; 4) efforts to measure, determine and assure competence should be non-punitive, non-duplicative, coordinated as much as possible, and should encourage continuous improvement and professional development.

Through the course of the summits, several streams of work have emerged that summit participants believe will prove to be useful to the national medical community. One is a document entitled Guide to Good Medical Practice-USA that describes desirable characteristics of competent physicians licensed to practice medicine in the United States. As presented in the document’s preamble, the intent behind development of Guide to Good Medical Practice – USA is to provide common language and a common framework for how organizations responsible for educating, training and regulating physicians think about competence. The document uses as its framework the six core competencies developed by the Accreditation Council for Graduate Medical Education and embraced by the American Board of Medical Specialties for purposes of maintenance of certification: patient care, medical knowledge, interpersonal and communication skills, professionalism, systems-based practice and practice-based learning and improvement. Summit participants believe that if the document is widely embraced, it could serve as a guide or framework for how physicians are educated, trained and regulated in the future.

Guide to Good Medical Practice 1.0 was distributed to all summit participants in September 2008, who were asked to distribute the document to their organizations’ constituents for reaction and feedback. The document has also been posted for comment on the GMP website set up by the NBME: https://gmpusa.org/.

In addition to Guide to Good Medical Practice-USA, summit participants are exploring concepts to facilitate data-sharing between the different organizations that have or are developing databases containing information relevant to determining a physician’s competence. As part of these discussions, participants have explored the “Trusted Agent” initiative and what such a virtual interface means to secure sharing of data. Participants have also explored the idea of developing common standards for electronic learning portfolios, or e-Folios.

PAPC participants have also become increasingly cognizant of the need for efficient and effective linkage between the organizations comprising the medical regulatory system. In August 2007, representatives from state medical boards met with representatives from specialty certifying boards to begin a conversation about how to improve the interface between licensing and certifying boards. Sponsored by the American Board of Internal Medicine (ABIM) Foundation, the meeting was viewed as an opportunity to demonstrate the value of cross-organizational collaboration aimed at “fixing” gaps in the current system of medical regulation. A number of opportunities were identified by the group as well as preliminary action plans for potential solutions.

As the PAPC dialogue has progressed, participants have expressed strong interest in formalizing the relationships that have developed between the organizations working on these issues. Participants have consistently voiced support for creating a National Alliance for Physician
Competence, acknowledging that there is an informal alliance already exists and should be allowed to evolve naturally over time. Participants have coalesced around the idea that the summits provide a “commons” or a place for participants to openly share and discuss issues of mutual interest and concern.

Several new streams of work emerged at the July 2008 summit. The first is a “shift document” that summarizes the patterns of change taking place in how the profession of medicine views competence. There was broad consensus that, when finalized, the shift paper could be commissioned for publication in a national medical journal. The second “new” stream of work is a preliminary attempt at describing the systems conditions that would need to exist in order for physicians to provide good medical care. It is envisioned that this “conditions” document could serve as a separate publication or as an appendix to Guidelines for Good Medical Practice.

At the July 2008 summit there was tangible progress made towards creating an infrastructure to support the work of the Alliance. Participants approved an Alliance participant agreement that articulates the mission, purpose, values, and rules of engagement to which organizations that participate in the Alliance would be expected to abide by. A steering committee was formed to guide work between summits, and a basic framework for a website for the Alliance was approved. The group also agreed on a process for managing conflicting or alternate opinions about how to move forward on a particular matter. The process fundamentally respects the wishes of the majority while acknowledging and recording the opinions of the minority.