

ABMS

“In the News”

January/February/March 2010



American Board
of Medical Specialties

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Press Clips, Media & Releases

January/February/March 2010

Part of ABMS' strategic mission is to communicate to appropriate external stakeholders that board certification is known as a major marker of quality for physician practice performance and that ABMS is recognized as the organization that establishes standards and criteria.

Shown in this book are the numerous mentions that ABMS has received in the press and media from January/February/March 2010.

If you have any questions or come across other mentions of ABMS in the media, press or on the Internet, please direct all copies to Lori Boukas, Director of Marketing and Communications so this information can be published back to the boards.

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Relevant Media

NEJM

“American Board of Internal Medicine Maintenance of Certification Program”

Drazen, J. M.

March 11, 2010

“American Board of Internal Medicine Maintenance of Certification Program”

Drazen, J. M.

A 55-year-old physician, who graduated from medical school in 1979, completed his internship and junior residency in internal medicine in 1981. He did 3 years of fellowship training in endocrinology, followed by a third year of residency in internal medicine. He then completed and passed the American Board of Internal Medicine (ABIM) qualifying examinations in internal medicine and endocrinology; the ABIM issued to him certificates of unlimited duration, specifying that he held board certification in internal medicine and endocrinology. For the past 24 years, he has been in the practice of general internal medicine with an emphasis on endocrinology. He estimates that about half of his patients see him for endocrine problems exclusively and the remainder see him for issues regarding general internal medicine. He is on the faculty of the medical school from which he graduated, but he spends most of his time caring for patients in an outpatient setting. For 6 months of each year, he has third-year residents, training in internal medicine, shadowing him at his outpatient practice. For one 3-week block each year, he serves as an attending physician on the general medical service of the hospital where he has inpatient privileges, a minor teaching hospital of his medical school at which he trained. During this 3-week period, he has two medical students, two interns, and a senior medical resident under his direct supervision.

He attends the grand rounds lecture series regularly. Once a year, he leaves his practice to attend a weeklong postgraduate course, alternating between internal medicine and general endocrinology. He has never considered enrolling in the maintenance of certification (MOC) program in either internal medicine or endocrinology. His reasoning is that he is up to date in his practice, that he makes frequent use of point-of-care reference services to check on the latest diagnostic or therapeutics practices when he encounters a condition that he does not see frequently, and that the money and time needed to undertake MOC would not be well spent. He has received a communication from the ABIM urging him to undergo the MOC process. He consults you, as a friend and colleague, for advice about what to do.

Which recommendation would you find most appropriate for this physician? Two recommendations are outlined, and each is defended in a short essay by experts; read the essays and then cast your vote.

Like our colleague in the vignette, approximately 69,000 diplomates of the American Board of Internal Medicine (ABIM) have time-unlimited certification, often called "grandfather" status. We are among the less than 1% of such physicians who have chosen to become recertified by participating in the maintenance of certification (MOC) program. As members of the ABIM Board of Directors, we were required to participate in MOC. We found that participation in MOC fit with our commitment to lifelong learning and gave us more confidence (and tangible evidence) that we are up to date in our fields.

Many physicians question the value of MOC, and — we must confess — so did we. We used to believe that years of practice build knowledge and competence and that ongoing participation in continuing medical education (CME) reinforces a basic understanding of clinical concepts. But the evidence does not bear that out.^{1,2}

Considerable research shows that traditional CME does not deliver when it comes to improved physician performance and knowledge.^{1,2,3} However, MOC, as a structured assessment process, is more likely to stop the decline over time in a physician's skills, knowledge, and performance⁴ than more passive CME. MOC requires physicians to complete a self-assessment of their knowledge, participate in practice-based quality-improvement activities, and pass a secure, knowledge-based examination.

Initial ABIM certification and MOC have both been associated with better care.^{5,6,7,8,9,10} Physicians who are certified in their field provide higher-quality care — such as in the management of acute myocardial infarction^{7,8} and delivery of preventive services⁹ — than noncertified physicians. Similarly, physicians who participate in MOC have better clinical outcomes.^{5,6,10} For example, internists scoring in the top quartile on the ABIM MOC examination were more likely to provide better care for patients with diabetes than physicians with scores in lower quartiles; those who did not pass the examination performed least well in terms of benchmarks of quality care.⁶

What physicians think they know and do in practice does not match what they actually know and do. In fact, physicians are not good at assessing their own skills — fewer than 30% of physicians examine their own performance data,¹¹ and physicians' ability to independently and accurately assess and evaluate themselves has been shown to be poor.³ Furthermore, physicians typically overestimate their compliance with quality standards.^{10,12}

Physicians with grandfather status may need the recertification process more than their younger peers do. A systematic review⁴ of 62 studies showed that most found declines in physician performance with greater numbers of years in practice⁴: decreasing medical knowledge; less adherence to the standards of appropriate diagnosis, screening, preventive care, and therapy; and worse actual health care outcomes. Also, clinical skills tend to decline over time, and more clinical experience does not necessarily lead to better outcomes or improvement of skills.^{3,4}

Although participation in MOC is not required by the ABIM, physicians with grandfather status are being called on to enroll in the program by external stakeholders. Patients are becoming more sophisticated in seeking information that will help them to select physicians who provide high-quality care. Hospitals are required by accreditation bodies, like the Joint Commission, to routinely attest to physicians' competence. Payers are interested in assessing the quality of care so they can distinguish "high-quality physicians." We believe the MOC process, developed and continually refined by physicians, is a better program than those developed by payers or by the government.

The biggest concerns we hear from physicians about becoming recertified relate to cost, time, relevance, and fear.^{13,14} The physician in the vignette should understand that the ABIM recommends that physicians maintain the certifications that best reflect their practice; in his case, we would recommend that he maintain his endocrinology certification. We believe that the one-time fee, although considerable (\$1,570 to \$1,720), is reasonable, since certification lasts for 10 years, resulting in a cost of about \$160 per year. The cost of his annual weeklong postgraduate course is much more than that — approximately \$1,000 per course per year. Enrollment in MOC provides CME credits for completion of the knowledge self-assessment modules and gives access to performance-improvement modules throughout the 10-year period — at no additional cost.

The ABIM currently has 19 subspecialties and continues to get requests to create more focus areas; this is reflected in the cost. The process of producing, maintaining, and administering the examinations and

modules is expensive. Teams of physicians in practice and academia create the examinations and approve all MOC products. Furthermore, to ensure quality, accuracy, relevance, and security, questions for the secure examination and self-assessment modules are updated continually.

In our experience, MOC requires a time commitment, to prepare for the examination and to complete the performance-improvement modules. The fact that the assessment is meaningful to patients, physicians, and other stakeholders requires the ABIM to create a program that is rigorous and robust and that requires real effort by the participant. Indeed, completing the performance-improvement modules can take hours, because the test taker has to gather data, develop and implement a quality-improvement plan, and remeasure performance. For us, preparing for the examination had the added value of providing a means of continuous learning.

Physicians express concern that the examination is about recall but does not give them the chance to use the resources they would use in their practice. The questions in the examination are designed to test diagnostic reasoning and clinical judgment — that is, to test what the certified internist or subspecialist is expected to know without access to medical resources. The examination is continually revised by internists, who select the most relevant questions; in the future, the ABIM may provide resources in which test takers can look up information during the examination.

Finally, fear of failure is a hurdle for physicians with time-unlimited certification. The examination is a high-stakes one, and failure can affect a physician's practice (although physicians with grandfather status do not lose their certification if they fail the examination). It is worth noting that 84% of first-time test takers pass and that the ultimate pass rate is around 95% — evidence that learning and feedback are effective.

The ABIM's MOC program is not perfect, and we on the Board of Directors have been working with input from our diplomates to address many shortcomings of the program. We share the topic areas of the examination questions so that physicians know what will be covered. Given physicians' concerns that the secure examination be relevant to their practices, especially for those who are very specialized, the ABIM is exploring plans to implement a MOC track of focused practice. This track will consist of a program that better aligns with what physicians are doing in practice.

In addition, the ABIM is working to make sure that, if appropriate, multiple resources can be used to complete the MOC process. Many tools are being developed to assist physicians in assessing their performance in practice. Physicians can often use the work they are doing within the MOC program to get credit for other programs important to their practice, thereby reducing redundant effort.

We recommend to our colleague that he take up the ABIM challenge and enroll in MOC. In doing so, he can show his patients, peers, and himself that he is up to date in medical knowledge, participates in quality improvement in his practice, and has met a rigorous, external standard. As a faculty member, he can serve as a role model to students and residents, all of whom will be required to participate in MOC throughout their careers. As public expectations increase and as self-regulation is challenged on the basis of high costs of care and gaps in quality,¹⁵ it is time for all "grandfathers" to participate in MOC.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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Do Not Enroll in the Current MOC Program

Lee Goldman, M.D., Allan H. Goroll, M.D., and Bruce Kessler, M.D.

We three "grandfathers," despite having substantially different backgrounds and current roles, strongly support the concept of recertification but cannot advise the physician in the vignette to engage in the American Board of Internal Medicine's (ABIM) maintenance of certification (MOC) program as currently constituted. We express this view with a sense of disappointment but also with hope and expectation that the process will be greatly improved.

From a variety of perspectives, we would be pleased to endorse a recertification process that reasonably and cost-effectively assessed a physician's competence, in terms of knowledge and professionalism, in the skills and tasks appropriate to the physician's specific medical practice. We would be even more confident in this recommendation if there were definitive evidence to show that the actual process of recertification benefitted those who became recertified, as well as their patients. The fact that so few physicians with grandfather status voluntarily choose to be recertified shows that most older, experienced internists do not believe the current recertification process to be a worthwhile method of helping them maintain their competence to care for their patients.¹³

Although nonrandomized data show an association between initial board certification and improved performance,^{8,9,16} there are little or no data showing improved outcomes of care related to recertification. Unfortunately, the logical belief that continuing education will improve a physician's knowledge (and hence, performance) has not been confirmed in randomized trials.^{1,2} Board recertification in internal medicine relies heavily on, and culminates with, physicians' passing a secure examination of knowledge. This strategy is used by many professional boards because of the inconsistency of oral examinations and the psychometric validity ascribed to the written examination.

We do not dispute the correlation of performance on a written examination with other process-performance measures, but we wonder whether the correlation is based on examination scores being a surrogate marker, rather than a definition, of competency. Medicine is replete with surrogate markers that correlate well with an outcome but either are not truly causal or, even if they are causal, may represent misplaced therapeutic targets. Similarly, even if scores on a secure examination are a useful surrogate for overall competence, do the outcomes justify spending tens, if not hundreds, of hours studying to pass an examination that may have little to do with one's practice? Physicians do need a solid knowledge base, but much more importantly, physicians must have a well-developed ability to access and use relevant information resources to support decision making. The question of whether heavy emphasis on increasing personal knowledge will improve outcomes of care can be tested, but so can the question of whether improving one's ability to utilize available information will improve care. In the absence of relevant data, the current approach to recertification relies more on the logical assumption that it may be beneficial than on demonstrated outcomes.

Even if the current approach by the ABIM is correct, we believe that the MOC process falls short in terms of relevance and the time, effort, and expense it requires of candidates. The one-size-fits-all secure examination, which requires many hours of preparation and the review of volumes of material, much of which may be irrelevant to one's daily practice, is a key component of the MOC program. If you fail the examination, you fail to become recertified.

The relevance of MOC should and could be enhanced by customizing the process — by having the candidates identify the most common problems and diagnoses encountered in their practice (e.g., through the review of electronic medical records or billing data) and focusing the study, practice-improvement, and testing materials on the customized practice (presumably from a bank of available material). The customized learning agenda could be supplemented by a limited amount of core material focusing on a small set of must-not-miss diagnoses and management priorities pertinent to all internists, rather than requiring all candidates to reread about all of internal medicine in an unfocused fashion. The "final examination" (which could still be used, if data could show its relevance) should allow candidates to access the information typically available to a practitioner so that real-world skills, not factual recall, are assessed.

We do not oppose tests. Rather, we fear that continued overreliance on factual recall runs the risk that physicians will be inappropriately encouraged to trust their "recertified memories" rather than reminded that they should always consult easily accessible, authoritative resources to make sure they are doing the right thing.

In an ABIM survey of board-certified internists whose certification was expiring, only 38% of respondents felt that the requirements for recertification were appropriate; 41% did not.⁸ Among the respondents, only 53% had completed the requirements for MOC. The major reasons for not participating in the process were the time required, the lack of relevance to their practice, the expense of the process, and the fact that recertification was not required for employment. These results suggest that it might be better for the ABIM to address these issues definitively so as to enhance the legitimacy of recertification for those who must participate, before embarking on a campaign to convince physicians with time-unlimited certification to participate voluntarily.

The ABIM has had, for all intents and purposes, an absolute monopoly on certification and recertification in internal medicine and its subspecialties. Since the advent of recertification, the financial reserves of the ABIM and the ABIM Foundation have increased substantially; in 2006 and 2007, the ABIM transferred \$13 million to its foundation.¹⁷ Reserves of this magnitude create a responsibility both to reduce the costs of recertification and to fund research and development to improve the certification and recertification processes. We contend that this goal should become the stated priority of the ABIM, pursued explicitly and aggressively in a manner that the public can trust and the profession should endorse.

It can be argued that recertification captures the high ground and helps forestall more onerous and capricious external regulation; we hope this can be made the case. However, the low rate of voluntary recertification confirms that physicians with grandfather status are not convinced of the value of the process. We believe that the true success of recertification will be defined not by whether physicians with time-limited certification maintain their certification but by whether the ABIM can improve and reform the process of recertification sufficiently so that all physicians will choose to become recertified in a truly voluntary fashion. Our view is that the entire internal medical community would be delighted to work with the ABIM to make recertification a more relevant, evidence-based, cost-effective process.

In its current form, recertification is great in theory but disappointing in practice. As a result, we would reluctantly advise our colleague to spend his time and money elsewhere.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

Journal of the American Board of Family Medicine

"Future of Board Certification in a New Era of Public Accountability"

Kevin B. Weiss, MD

March 2010

"Future of Board Certification in a New Era of Public Accountability"

Kevin B. Weiss, MD

The American Board of Medical Specialties and its member boards have been serving as a key foundation for professional self-regulation for the past century. During this time the standards for specialty board certification have evolved to meet the public's needs. Recent major changes have included time-limited certification status, the adoption of 6 core competencies, and the multifaceted recertification program termed Maintenance of Certification. During the past decade there has been a dramatic increase in the public's interest in improving the quality, safety, and efficiency of the US health care system. This article describes some of the milestones in the evolving public demand for physician accountability. The public's growing need for better health care delivery is, in turn, creating the need for the American Board of Medical Specialties and its member boards to evolve to meet the public's expectations of the profession of medicine to maintain its privileged status in specialty certification through self-regulation.

Evolution of Board Certification and Professional Self-Regulation in the United States

In the United States there has been a long tradition of shared responsibility for physician performance through a combination of state regulation and professional self-regulation. Dating back to the 1760s, the United States and territories have held the authority to license the practice of medicine. Although this authority has been the backbone of US physician regulation, it is broad in scope and serves as an overall safety net for medical care.¹ To provide greater assurance of the quality of physician practice, the medical profession launched the specialty board movement to assist the public in the identification of highly qualified health professionals in specialty-based practice. The Board of Ophthalmology was the first of the specialty boards to be created in 1917, with other boards soon following. In 1933, the boards joined together to form the Advisory Board of Medical Specialties, which was later renamed the American Board of Medical Specialties (ABMS), a national self-regulatory organization established for the purpose of credentialing physicians in specialty-based medicine. In 1939 the ABMS published the Directory of Medical Specialists and the United States had its first comprehensive source for identifying physicians who had undergone consistent training and standardized assessment in specialty practice. The ABMS is currently composed of 24 member boards.

The process of self-regulation through voluntary specialty board certification has been quite successful; more than 750,000 US physicians currently hold one or more certificates from ABMS member boards. Certification's value is demonstrated by the ongoing public interest in seeking out board-certified physicians and by the number of hospitals and other health care organizations that make board certification a key qualification for medical staff privileges.

The medical profession's awareness of the need for public accountability has continued during the many decades since the start of the specialty board movement. When the American Board of Family Medicine

was established in 1969,² lifetime certification gave way to the concept of a time-limited certification process, which required periodic recertification. Since then, all of the ABMS member Boards have adopted time-limited certification.

At first, time-limited certification was primarily composed of passing a knowledge-based examination. However, in the late 1990s the ABMS and the Accreditation Council for Graduate Medical Education designed a new competency-based training model based on 6 mutually agreed-upon core competencies, including patient care, medical knowledge, professionalism, practice-based learning and improvement, interpersonal and communication skills, and systems-based practice.³ Such a complex set of core competencies made it clear that a medical knowledge examination by itself would be insufficient for the recertification process.

In 2000, the 24 member boards of ABMS agreed to evolve their recertification programs to one of continuous professional development known as ABMS Maintenance of Certification[®] (ABMS MOC[®]).⁴ The program is designed to assure that participating physicians are committed to a process of lifelong learning and evaluation of competency by requiring ongoing measurement of the 6 core competencies. Although the assessment tools vary by specialty, all member board MOC programs adhere to a 4-part process that is designed to keep certification continuous. As of 2006, all member boards have received approval of their programs and are in varying stages of implementation. In 2009, ABMS adopted further standards for MOC that include new developmental standards for assessing patient safety, patient experience of care, and peer-to-peer evaluation.

ABMS MOC is designed to provide the public with assurance of high-quality health care. Yet, as the specialty board movement in the United States approaches its 100th year, questions exist as to whether or not ABMS MOC is sufficient to meet the public's current needs and how it should grow and evolve to meet the needs of the future. To better understand the answers to these questions it is useful to examine the recent evolution of public and market needs for physician and health systems accountability.

The Public's and Marketplace's Needs for Health System and Physician Accountability

Although the public has always had a deep interest in the quality of care provided by physicians, both the marketplace and the government have, to a large extent, left it up to the medical profession to regulate itself. Although they operate in view of the public and often have some public member representation, the state and territorial licensing authorities are largely physician dominated activities. Similarly, the ABMS specialty boards are largely physician-run organizations. Within hospitals, functions of medical staff also are overseen principally by the profession. This is of little surprise considering the technical and complex nature of clinical practice. To a certain degree, the physician's role in self-regulation would go largely unchallenged were it not for some very important emerging public concerns. There are 2 major sets of issues: (1) concerns about health care safety and quality, and (2) concerns with the overall rising costs of care. Taken together, it seems inevitable that the public and marketplace are seeking greater accountability from the profession.

It is unclear exactly when the concept of patient safety began to emerge as a broad concern in the public's eye. During the past 10 years there have been a series of cases that have drawn attention to issues of health care safety. Some of the sentinel cases include that of Libby Zion, who in 1984 died at the age of 18 within 8 hours of her emergency admission—her death was probably caused by medication error⁵; the artist Andy Warhol, who died in 1987 from sudden cardiac arrhythmia after a

routine cholecystectomy⁶; and the 1994 case of Betsy Lehman, a 39-year-old health reporter for the Boston Globe newspaper who died from a complication of a chemotherapy overdose at the Dana Faber Cancer Institute, one of the leading hospitals in the country.⁷ These high profile cases and others sent a repeated message to the public that the health care system may not be safe.

While evidence was mounting for the need to examine patient safety, other evidence was emerging about variability in the quality of health care. As early as 1973, Jack Wennberg and Alan Gittlesohn⁸ began publishing on the high degree of variability in health care delivery and outcomes. In their first study of a population-based health data system in Vermont they reported wide variations in resource input, utilization of services, and expenditures for some common medical and surgical conditions among neighboring communities. During the 1980s and 1990s hundreds of studies built on that seminal report by demonstrating variations in care that cannot be explained by underlying sociodemographic or other epidemiologic characteristics. In 2003, McGlynn and colleagues⁹ reported on quality measures and the poor performance of primary care in a sample of US physician practices. The evidence from this body of literature that has amassed over the decades has not gone unnoticed by the public.

Although a series of untoward, high-profile events have raised concerns about patient safety and a body of scientific literature has emphasized the need to examine quality, a very different concern about the cost of health care in the United States has been driving public demand for improved health system performance and professional accountability. The issues related to the rising costs of health care are well known. The United States is a country with a population of more than 40 million uninsured and health care costs that are some of the highest per capita in the world, yet the United States has similar if not worse outcomes on many health indices as compared with other countries.¹⁰ Health care costs equal >14% of our nation's gross national product, and without significant efforts to control costs, it is estimated that the Medicare program will be insolvent by 2017.¹¹ In addition, the rising costs of health care in a primarily employer-sponsored health insurance system may be placing American businesses at a strategic disadvantage in terms of the international competitiveness. Any one of these concerns would warrant the attention of the public sector and marketplace; collectively, these cost concerns signal the need for much closer scrutiny of health care performance and the value it delivers.

The Response to the Emerging Public and Marketplace Need for Health System and Professional Accountability

Although it is not possible to define just where the response to concerns for greater accountability in the health care sector began, one of the first reactions was the emergence of large-scale efforts aimed at performance measurement of health systems and hospitals. The 1980s and 1990s saw a series of rapidly evolving efforts toward further accountability among health plans. Organized measurement of health plans was largely prompted by employers' needs to better understand the value of the health care they were purchasing. In 1991, the health maintenance organization Kaiser Permanente worked with its largest purchasers (Towers Perrin, Bull HN, Digital, GTE Corporation, and Xerox) to establish the Health Employer Data Information System (HEDIS) to provide information about health plan performance.¹² Soon thereafter, the HEDIS program was turned over to the National Committee for Quality Assurance (NCQA). Over the years, NCQA has continued to develop the HEDIS program, and many of the measures that were originally designed for health systems performance have become some of the same measures that health plans (and employers) use to directly assess physician performance.¹³ To a large degree, the HEDIS measures have served as the first set of national tools to answer the marketplace's call for physician accountability.

Hospitals have also responded to the call for public accountability. They have a long tradition of regulation and self-regulation. Although there are many organizations that serve to inform the public about hospital performance, none are as influential as the Joint Commission, which has for many years (until recently) enjoyed deemed status from the federal government as the source of accreditation for participation in Medicare. Until recently, the performance measurement efforts of the Joint Commission focused mostly on structural measures of hospitals. However, in response to increased concerns about patient safety, quality health care, and costs, they are now advancing tools to address process and outcomes in health system performance (eg, their ORYNX measures).¹⁴

To date, the public's role (specifically the federal government's role) in hospital, health plan, and physician accountability has been relatively passive. They have principally relied on the tools and programs of The Joint Commission and its provisions for credentialing medical staff, the NCQA and its HEDIS measures, the states and their medical licensing boards, and the ABMS and board certification.

There was one early attempt to use the significant power of Medicare data to provide some transparency to health system performance. In 1984 the Health Care Financing Administration produced a public report of hospital mortality rates across all acute care hospitals in the Medicare program. However, this public reporting program was quickly discontinued in response to cries of "foul play" issued from the hospitals and the medical profession principally based on methodologic concerns about a lack of adequate case mix and severity adjustments.¹⁵

Although much of the early movement toward greater accountability was focused on the performance of health plans, hospitals, and health systems, changes were also taking place at the level of physician accountability. One of the defining moments occurred when several states began issuing reports of mortality outcomes for coronary artery bypass surgery. In the early 1990s, New York, and subsequently Pennsylvania, began publically reporting hospital-based outcomes.¹⁶ These reports, in turn, stimulated the Society of Thoracic Surgeons to design and implement a national registry of performance measures for coronary artery bypass graft and (more recently) valve replacement.¹⁷ Thus the first large-scale, national professional response to the need for transparency in performance measurement of surgical outcomes was created. Since that time, other national registries and databases have begun to emerge.

Broadening the Awareness of the Need for Performance Measurement and the Call for Public Intervention

In 1998, in response to the growing evidence and advancing public awareness of a health system with serious problems, the Institute of Medicine launched a major initiative to examine the health care of the nation. The first activity was a national roundtable about quality of care—an effort that resulted in several major reports, including "To Err is Human"¹⁸ and "Crossing the Quality Chasm."¹⁹ These reports, along with many others, formed the basis for much of the subsequent national effort in the health care quality movement, including the creation of the National Quality Forum. One of the first notable reports from the National Quality Forum involved a strategic framework that defined 2 pathways for quality improvement: one based on intrinsic motivation and another based on accountability and selection.²⁰

The Veteran's Administration: Demonstrating the Value of a Robust Quality-Improvement Program
It is noteworthy that, despite the numerous examples of health systems problems, there are also organizations in the United States that serve as reminders that it is possible to dramatically improve quality and value in health care. Perhaps the most notable example comes from the federal government

itself. The Veteran's Administration proved that a public health system that seemed to be failing could reinvent itself. Today, the Veteran's Administration is a high-performance health system committed to comprehensive performance measurement of its hospitals and physicians.²¹

The Marketplace's Ventures into Physician Accountability through Value-Based Purchasing

The market has been the first to respond to the need for greater accountability from the health system and physicians. The market has used a number of tools at their disposal to identify what they define as high quality and efficient care. The most recent, well publicized, and controversial efforts have involved the use of strong financial incentives to reward physicians based on some type of performance measurement. This effort, commonly called "pay for performance," has been in use by health plans for nearly a decade. There have been several large-scale efforts by purchasers to demonstrate the merit of "value-based purchasing" models. The results of these demonstrations are mixed; to date no definitive link between incentive payments and clinical outcomes has been demonstrated. However, it is clear that, because of the increasing demands of the big health care purchasers, the health insurance industry will continue to explore ways to advance the concept of "value-based purchasing" for the foreseeable future.²²

Congress Begins Using its Power to Advance Physician Accountability

To date, Congress has continued to support the notion of self-regulation of the medical profession. However, in recognition of a faltering health care system, the 2006 Tax Relief and Health Care Act (PL 109 to 432) required the establishment of a physician quality reporting system,²³ including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries. The Centers for Medicare and Medicaid Services (CMS) initially called this program the Physician's Voluntary Reporting Program and subsequently renamed it the Physician Quality Reporting Initiative (PQRI).

The PQRI required the creation of a broad range of physician performance measures to be able to make the program available to all health care providers. The American Medical Association responded to this need by funding the Physician's Consortium for Performance Improvement²⁴ to design and promote condition-specific quality of care measures. In addition, the medical profession joined with other national organizations with a stake in health care to form a coalition called the AQA for purposes of reviewing and approving physician performance measures that could be used in the PQRI program.

To date, the CMS PQRI program remains voluntary, with incentives based on bonus payments. However, it is not hard to envision that, given the financial constraints on the Medicare program, in time voluntary participation could give way to required participation and bonuses could give way to payments based on performance rather than reporting, or it could even result in withholds for nonparticipation.

The Public Demand for More Information

This overview would be incomplete without noting the growing demand of the public and the increasing capacity for consumer movement to drive physician accountability. The combined efforts of national consumer organizations such as the AARP and the Consumer's Union along with national business coalitions have contributed significantly to the strength and capacity of the National Quality Forum. Another coalition between the Consumer and Purchaser Disclosure Project and the Attorney General's Office of the State of New York has resulted in an initiative focused on improving health plan reporting of physician performance.²⁵ In addition, numerous public and consumer web sites are beginning to

provide physician practice-level data, often free to the public, and many new web-based companies have made it a business to rank physicians in response to the public's desire to identify high-quality physicians.

2010: National Health Care Reform and Physician Accountability

At the time of the writing of this document, a national health care reform debate is requiring the country to rethink all of the major elements that make up our health care system. Although it is too soon to know the final outcome, the early legislative language from both the US House of Representatives and the Senate signal that they are supportive of the CMS plan to continue the advancement of physician accountability through PQRI. Although PQRI today is a voluntary program based on bonuses, a Congress focused on fiscal constraint could easily reverse this positive incentive, making participation voluntary in name only. Furthermore, although the current program is a pay-for-reporting model, it could easily be converted into a public reporting program in response to pressures from public stakeholders. This is very likely to happen in the next few years as CMS gains enough experience with the PQRI data to produce valid public reports.

The Future of Professional Self-Regulation and Voluntary Board Certification in Light of the Emerging Public and Market Drive for Increased Physician Accountability

Specialty-based care seems to be the incontrovertible bedrock in the landscape of the American health care system both now and for the foreseeable future. Although it is clear that there is a need for a larger primary care physician workforce, it would be difficult to imagine the devolution of our system into one of non-specialty-based care. In that light, the public and the marketplace will continue to need the type of accreditation that is provided by the ABMS boards. There is also little doubt that specialty-based physician certification will remain a self-regulatory function.

While it is theoretically possible that the 70 states and territories that make up the system of U.S. physician licensing authorities could evolve into a specialty based licensing system, this would require a level of public intervention that would be difficult to envision. Therefore, it is not clear if board certification will be sufficient to meet the broader public and market demand for physician accountability.

However, recent discussions with multiple stakeholders—ranging from consumer groups and health plans to national and regional employer coalitions as well as leaders in the federal government—suggest that that ABMS boards are, theoretically, well positioned to influence quality.²⁶ However, these many stakeholders are uncertain that current board certification and MOC programs will meet their needs for physician accountability.

Some of the principle critiques include:

The program is not patient centered. Very little of the board certification and MOC processes reflect the patient's voice and concerns. Although physician communication skills are one of the ABMS's core competencies, they are not yet routinely assessed. Nor are continuity and transitions of care or the ability to assist in shared decision making. Assessment of service needs, such as accessibility and timeliness, are also absent from the certification process.

Lack of transparency. The public has only a very small window from which to view the board certification and MOC processes and outcomes. There are currently very few public seats in the governance and leadership of ABMS and its 24 member boards. There is also very little public information available about the processes and assessment methods that comprise board certification. Approximately 80% to 95% of all physicians who apply eventually attain board certification status, and nearly all of those who enroll in MOC are able to successfully complete the program. The result is that 85% of the US physician workforce has a self-regulation credential into which the public has little insight.

No assessment of the appropriateness of care. One of the biggest concerns about the US health care system is the continuous and rapid escalation of the costs of care in both the public and private sectors. Much of this rise has been attributed to the unrestrained use of new technologies, unnecessary diagnostic services, unwarranted duplication of tests, and the use of new expensive therapeutics when less expensive therapeutics would be equally efficacious. To date, board certification and MOC provide little in the way of assessing physician performance in relation to these concerns.

Insufficient public input. As noted above on the topic of transparency, only a few members of the public have seats in governance within the board environment, and there are currently no common pathways for public input to the board certification and MOC processes.

Insufficient system-based evaluation. During the past few decades, health services research has clearly proven what many an astute observer would conclude: that physicians, although central to patient care, work within systems of care. Physicians working within different systems of care probably have very different capacities to deliver care. Patient care is, therefore, a combination of physician competency and health system performance. This is clearly evident in the use of health information technology, where the use of computerized order entry, electronic prescribing, and electronic medical records can enhance patient safety and improve clinical care. Currently, the board certification and MOC programs have identified system-based practice as a core competency. However, to date there has been little assessment of physician knowledge and practice in this area.

The Future of Board Certification in the United States

It is very likely that physicians will continue to participate in a board certification and MOC process both to demonstrate their chosen scope of practice and to be credentialed to practice in many health care settings. More specifically, hospitals, nursing homes, health plans, and academic institutions all need a certification process that they trust to credential physicians claiming to have specialty-based training. As such, ABMS and its member boards currently represent the most respected and subscribed to specialty-based certification program in the United States. Furthermore, the evolution of the ABMS specialty board certification program from that of an initial evaluation to recertification to the current MOC program has to a large extent ensured that the ABMS credential will be secure for the foreseeable future.

In this light, the key question before the ABMS and its member boards is not how it will meet the needs of the credentialing environment, but rather to what degree will it seek to be relevant in addressing the larger public concerns related to health care and physician accountability. Currently, board certification and MOC are aligned only modestly with the public's desire for physician accountability and the need for a safer and higher quality of care.

To meet the latter requirement, specialty-based board certification increasingly will have to focus on addressing the above-noted concerns of patient-centeredness, transparency, appropriateness, public input, and system-based practice. It is through enhanced public input that additional issues will emerge and evolve over time, thus supporting the need for increased public representation in the board certification enterprise.

Further evolution of the ABMS specialty board enterprise toward an alignment with a public accountability framework will not be easy. There is no single public organization or voice that speaks for all; rather, gaining public input will require the inclusion of a number of stakeholders. The many voices of the "public" will not necessarily share common priorities for physician accountability, and at times will probably be conflicting. Finding the right partnership(s) with the public will need to take shape over time.

If one takes the perspective of the public as the primary customer of board certification, it would seem that the choice of whether or not to broaden the scope of certification processes to address the widening definition of public accountability is straightforward. The need of the public is great and they are expressing this need in their drive for increased reporting of physician performance both in the public (ie, PQRI and regional public reporting efforts) and private markets (value-based health care purchasing).

Alternatively, if one takes the perspective of the physician as the primary customer for board certification, it would seem that the choice of whether or not to pursue enhanced public accountability is more nuanced. In support of this evolution is the ethereal or lofty goal of improving health care in the United States. In addition, any alignment of board certification and MOC with value-based purchasing would probably result in multiple benefits, including financial rewards for participation in ABMS programs. Counterbalancing these benefits are the challenges that would come with participating in a more intensive and transparent board certification program—a potentially real burden given the other demands on the practicing physician.

For most of the 20th century the profession of medicine has sought to provide assurance to the public about the quality and safety of physician care through self-regulation, which has been led by the specialty board certification movement. During the past decade, increased awareness of the need to improve health care quality and efficiency, as well as patient safety, has presented new challenges to self-regulation. The certifying boards of the ABMS have sought to address this changing environment by establishing ABMS MOC. With an ever-increasing public interest in a more effective and efficient health care system, ABMS and its member boards will need to continue to evolve to meet these increasing needs and expectations.

The ABMS and its member boards are left with a choice to design their future. The safe pathway is to stay focused on the credentialing environment; however, this may not meet the larger needs of the public or build their trust in the profession. Alternatively, ABMS and its member boards may continue to embrace the larger public need to address the role of the physician in a complex and troubled US health care system that is struggling to improve. This latter and more challenging role of the certifying boards seems the best pathway to better health care outcomes and to assure the public's future trust in our profession.

<http://www.jabfm.org/cgi/content/full/23/Supplement/S32?ck=nck>

Archives of Internal Medicine

“Patient-Centered Comparative Effectiveness Research”

Essential for High-Quality Care

Jean R. Slutsky, MSPH; Carolyn M. Clancy, MD

March 8, 2010

**“Patient-Centered Comparative Effectiveness Research”
Essential for High-Quality Care**

Jean R. Slutsky, MSPH; Carolyn M. Clancy, MD

Most physicians implicitly define high-quality care as the application of scientific knowledge to patient care, tailored to each individual's unique characteristics, circumstances, needs, and preferences. Fulfilling that aspiration today is more challenging than ever because of chaotic practice environments, many new options, and informed patients who have done their own research online, but there is precious little comparative information. Patient-centered comparative effectiveness research (CER) is essential for high-quality care, because it focuses on filling gaps in evidence that is needed by clinicians and patients to make informed decisions. It also promises to help clinicians identify which patients are most likely to benefit from breakthrough innovations and to accelerate innovation uptake into practice. The purpose of this commentary is to review recent developments in CER and their implications for clinicians and patients.

Patient-centered CER has received a great deal of attention in the United States since the term was described in a small section of the 2003 Medicare Prescription Drug, Improvement, and Modernization Act. Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act authorized the Agency for Healthcare Research and Quality (AHRQ) to conduct and support research with a focus on outcomes, comparative clinical effectiveness, and appropriateness of pharmaceuticals, devices, and health care services. The legislative language includes 3 components: (1) clear direction to set priorities based on broad input from all stakeholders in health care; (2) authority for research and syntheses on a broad array of health care services; and (3) a mandate that the results be made accessible to multiple audiences. Since 2005, the AHRQ's CER program has invested \$125 million focused on 14 priority conditions ranging from cancer and cardiovascular disease to mental health disorders, diabetes, and infectious diseases. Investments have included systematic literature reviews, observational studies using databases with clinical electronic detail, support for enhanced methods and training, and a growing library of guides for clinicians and consumers. To enhance the credibility of the results with all parties, the AHRQ has established opportunities for broad input from diverse stakeholders on overarching priorities, specific research questions, and review of draft reports.

In 2009, an investment of \$1.1 billion for CER was made through the American Recovery and Reinvestment Act (Recovery Act), creating an unprecedented opportunity to develop a vital enterprise through the development of unbiased and timely evidence to inform important decisions facing clinicians and patients. Patient-centered CER also emphasizes the importance of innovation and responsiveness of the research enterprise to the needs of patients, their caregivers, and their providers. Even though there is a relatively new public interest in understanding the relative benefits of different treatment options, the need for this information has been around for a long time.

In 1996, Andy Grove, cofounder of Intel Corporation, authored an article in *Forbes Magazine* titled "Taking on Prostate Cancer." Grove chronicled his very personal story and experience with the

uncertainties about his diagnosis and treatment of prostate cancer. He eloquently described the frustrating ambiguity regarding the opinions and literature on the use and interpretation of the prostate-specific antigen test. He described the treatment options he was presented with, each with attendant adverse effects, but little evidence about what represented the best, most effective option. However, one of the most prescient comments made in the article was about his frustration that medical researchers were unlike researchers in his own field of semiconductors. In his field, a researcher is always comparing his data with his competitors' data. However, after trying to evaluate the research behind prostate-specific antigen testing and treatments for prostate cancer, he concluded that the comparison of treatment effectiveness was not routinely done by the research field, and, thus, he had to do it himself. Grove survived his diagnosis of prostate cancer but subsequently went on to develop Parkinson disease, another disease for which there are many diagnostic and treatment uncertainties.¹

Fast forward 13 years to 2009. In June, the Institute of Medicine published a report outlining the priorities for CER.² In the first quartile of 100 recommended priorities, an Institute of Medicine panel included a recommendation for comparative studies on the effectiveness of management strategies for localized prostate cancer. A year earlier, the AHRQ came to a similar conclusion and commissioned a comparative effectiveness review, *Comparative Effectiveness of Therapies for Clinically Localized Prostate Cancer*, which was published in February 2008 (http://effectivehealthcare.ahrq.gov/repFiles/2008_0204ProstateCancerExecSum.pdf). Therefore, for this very common condition—almost a quarter of a million men are diagnosed as having prostate cancer each year—we still know little about what management strategy works best, which course of treatment has the most troublesome adverse effects, and how best to advise patients regarding choice of treatment.

In short, a focus on CER reflects a mismatch between the uncertainties that clinicians and patients confront each day and the research enterprise. The preeminence and leadership of the United States in biomedical science has resulted in an abundance of diagnostic and treatment options for multiple conditions, but there is far less guidance regarding which option represents the best fit with an individual's needs and preferences. Also, the limited external validity of many clinical trials further constrains both effective application of science to patient care and identification of approaches to develop innovative treatments and study designs to evaluate their effectiveness in different populations. For example, what happens to the frail elderly woman with diabetes? Do we treat her the same as a 45-year-old obese man? If we are treating a grandfather for angina, how do we know whether a meaningful outcome for him is freedom from pain or mortality?

As researchers, clinicians, and funders of research, this is an opportunity to reexamine and reevaluate how we approach patient-centered research. Not only does the research need to be innovative and valid, it also has to be timely and, most importantly, focused on the needs of patients. Furthermore, it needs to focus increasingly on the patients for whom the research enterprise has been the least responsive. In the United States, we have shown an amazing capacity to innovate. We need only to compare how peptic ulcer disease was treated 30 years ago with how it is treated now. We have moved from ineffectual diet restriction to relatively cheap and effective pharmaceutical therapies. The change in patient lives has been dramatic. At the same time, it is widely recognized that new discoveries are not distributed effectively. Today, the use of β -blockers to reduce mortality among patients who have had a myocardial infarction is so routine that health plans are no longer "scored" with this quality measure.³ However, this achievement occurred 25 years after the landmark clinical trial was published.⁴ At its core, CER has to link the production of relevant research with strategies for delivering evidence to the

point of care. The Recovery Act funding will support testing novel dissemination strategies as well as incentives and technical assistance to promote the broad adoption of health information technology.

Health information technology has created many opportunities for streamlining patient registries and other clinical studies, clinical decision support, electronic health records, prescribing, and more. However, a surge in patient use of electronic communication is growing in ways that would have seemed improbable a decade ago. Patients with rare diseases who are difficult to study in traditional clinical trials are voluntarily submitting patient reports to disease-specific Web sites in hopes of identifying strategies and treatments that seem to have promise. Patients want to know what works best for them as individuals and are increasingly using electronic means to create communities around their conditions. Health information technology offers the potential of linking practice and research in unprecedented ways, the foundation of what has been referred to as a learning health care system, one in which care delivery offers both a platform for discovery and a rapid, effective translation of new findings to patient care.

Taking full advantage of these incredible opportunities will require new kinds of collaborations between researchers, clinicians, patients, and caregivers. Some aspects of this journey will be exciting, while others will be more challenging. Researchers will need to develop streamlined protocols that do not add burdens to practice, and clinicians may have to struggle with health information technology systems that are not always intuitive. Together with our patients, we need to identify approaches for longitudinal follow-up to learn more about longer-term outcomes.

But the payoff will be fantastic. As we continue our exploration of health care reform and the role of comparative effectiveness research, keeping patients front and center is essential. If we lose sight of their personal needs, concerns, values, and uniqueness, we will fail to improve health outcomes and quality of life. If we accept the challenge to be creative and dynamic, patient-centered CER can and should take into account the very things that we all hold dear: individuality, values, innovation, and equity.

<http://archinte.ama-assn.org/cgi/content/full/170/5/403>

Annals of Internal Medicine

“Pay for Performance Through the Lens of Medical Professionalism”

Amir Qaseem, MD, PhD, MHA; Vincenza Snow, MD; Alice Gosfield, Esq; David Gregg, MD; Keith Michl, MD; David Wennberg, MD, MPH; Kevin B. Weiss, MD, MPH; and Eric C. Schneider, MD, MSc
March 16, 2010

“Pay for Performance Through the Lens of Medical Professionalism”

Amir Qaseem, MD, PhD, MHA; Vincenza Snow, MD; Alice Gosfield, Esq; David Gregg, MD; Keith Michl, MD; David Wennberg, MD, MPH; Kevin B. Weiss, MD, MPH; and Eric C. Schneider, MD, MSc

Lagging quality of care in the U.S. health care system has been a persistent problem and challenge. In the past, medical professionalism and professional certification have served as cornerstones for improving quality in health care. Among newer efforts to improve quality, pay for performance has been proposed to propel better results, but many observers are concerned that pay for performance is at odds with medical professionalism. The authors examine the potential conflicts between pay for performance and medical professionalism and conclude that properly designed pay-for-performance models can support professional objectives.

As the costs of health care and the number of uninsured Americans have increased, reform of health care payment systems has become an urgent national imperative. Pay for performance (P4P) has been proposed as one physician payment model. Under P4P, part of a physician's payments is earned on the basis of the quality of care, assessed by using explicit performance measures. The label “pay for performance” is applied to various financial incentive programs that differ in eligibility requirements, selection and scope of measures, formula for determining payment, and magnitude of payments (1, 2).

For most of the past century, professionalism and professional certification, rather than payment incentives, have served as cornerstones for improving quality in health care (3). Some commentators have called for a renewal of professionalism as a framework for quality improvement (4, 5). Professionalism, renewed recently in the form of a Charter on Medical Professionalism (6), defines a code of conduct that under ideal circumstances is adhered to by all professionals. Professionals are expected to improve the quality of care to better serve the patient's interests through lifelong learning. The professional model is silent about how payment for services should be allocated among professionals. In contrast, the P4P model is built on the premise that differences in the quality of care delivered by individual physicians are measurable and that higher-quality providers should be paid more than those who produce lower quality (7).

The compatibility of P4P with professionalism is controversial, but this is not unique to P4P. All payment models for physicians create incentives that may conflict with individual tenets of professionalism (3). The Charter itself states that “market forces, societal pressures, and administrative exigencies” must not compromise the principle of “primacy of patient welfare” (6). However, a considerable body of research (8) demonstrates that physicians respond to financial incentives in ways counter to the charter statement.

Our goal is to assess the extent to which these approaches are compatible or in conflict with one another. To accomplish this assessment, the American College of Physicians convened an advisory board of experts in clinical medicine, law, management, and health policy at 6 in-person meetings, during which it conducted a detailed examination of the relationship between medical professionalism and P4P incentive programs and used the Charter on Medical Professionalism as the framework for the analysis.

Professionalism: A Physician Charter

The Charter on Medical Professionalism (6) discusses 3 fundamental principles of professionalism and delineates 10 professional responsibilities of a health professional. The 3 principles are patient welfare, patient autonomy, and social justice. To simplify and clarify our analysis of the relationship between medical professionalism and P4P, we organized the 10 professional responsibilities around 4 themes especially pertinent to P4P (3). We then systematically considered the interaction between P4P and each of the themes.

1. The application of scientific evidence to deliver and improve care: Maintaining competence, relying on scientific knowledge, and engaging in improving the quality of care.
2. Ethically appropriate interactions with patients and the public: Being honest with patients, preserving patient confidentiality, maintaining appropriate relations with patients, and maintaining trust by managing conflicts of interest.
3. Promoting equity in health care delivery: Ensuring access to care and promoting the just distribution of resources among patients.
4. Commitment to the profession and its members: Promoting the ideal of the profession with voluntary efforts and offering voluntary assistance to other professionals to ensure that all professionals perform at a high level.

Interactions of P4P and Medical Professionalism

The Table summarizes the relevant potential interactions of P4P and medical professionalism. Below, we summarize the interactions and the P4P program design recommendations that emerge from the consideration of these interactions.

Themes and Attributes of Medical Professionalism and Threats and Opportunities of Pay for Performance

Theme 1: Application of Scientific Evidence

Medical professionalism rests on the integrity of scientific standards grounded in research evidence and the translation of evidence into practice guidelines, which define the proper use and implementation of diagnostic testing and therapeutics. The scientific evidence must be protected from inappropriate influence by nonprofessionals or others who have a direct financial interest in a particular definition of a standard or guideline or in a performance measure based on one. As a corollary, professionals are expected to remain current in the scientific evidence relevant to medical practice through lifelong learning. The “new professionalism” increasingly recognizes that quality improvement skills, including team management skills, are among the important competencies that physicians must have in the 21st century (4, 5). However, under current payment systems, physicians have few financial incentives to make such investments.

Quality measures selected for P4P programs should be based on scientific knowledge (3, 9). Where a single scientific standard of practice has been established, a single set of quality measures that reflect that standard should be used so that P4P programs based on these quality measures reward scientifically based medical practice. In the absence of strong evidence, rigorously developed consensus measures grounded in science may also be appropriate. If P4P programs use nonstandardized or

proprietary quality measures, they may promote non–evidence-based care, thereby undermining professionalism.

Professionalism should guide the allocation of P4P incentives across the domains of quality—process, outcomes, access, and equity. Professionalism asserts that access to care is a critical component of high quality. A P4P incentive should be linked to carefully specified, evidence-based measures of the process of care (10), because such measures can drive the delivery of care to conform to scientific evidence. Inadequately risk-adjusted measures that do not recognize the severity or complexity of a patient's condition may lead physicians to avoid patients with severe or complex illness (cherry-picking). Incentives based on both outcome and patient experience measures can also be useful as part of a comprehensive P4P program.

Theme 2: Ethical Interactions Between Physicians and Patients

Ethical interactions encompass honesty with patients, maintaining the confidentiality of patient information, avoiding improper relationships that take advantage of the patient's vulnerability, and avoiding conflicts of interest. Pay-for-performance programs that offer large amounts of money or that require public reporting may tempt clinicians to fall short of ethical obligations. The inclusion measures of outcomes, resource use, and cost-efficiency may also be problematic. The need for data to conduct valid performance measurement may pose risks to patient privacy and confidentiality. The financial incentives introduced by P4P may also create powerful conflicts of interest for physicians and lead them to maximize their financial results at the expense of their patients (gaming). Gaming might include such behavior as subtly modifying documentation or coding in ways that may not directly affect patients, subjecting patients to screening procedures when clinical judgment would suggest that they should not receive screening, or denying access to care for seriously ill patients who might be at high risk for poor outcomes (11–13).

In contrast, transparency of quality measurement and disclosure of payment incentives may enhance patient trust. The point of P4P programs is to create a financial incentive that aligns the interests of physicians and patients, and this can often motivate both increased use of preventive services and improved care management. The incentives (such as those that encourage guideline-based care) can strengthen the fiduciary aspect of the physician–patient relationship (3, 9).

Theme 3: Achieving Equity

Medical professionalism envisions an equal standard of care for all patients (3). Pay-for-performance programs typically do not address access; however, a program is unlikely to foster the equitable distribution of care unless it includes measures of access to care and adequate case-mix and risk adjustment strategies (14). For example, programs that ignore variability in a physician's patient population may create a powerful disincentive to provide care to complex patients or those who are sociodemographically disadvantaged. Programs that aggregate reporting to the level of larger groups of physicians reduce the risk for a financial penalty for individual clinicians who specialize in the care of these patients. Measuring variability in the allocation of patients among providers enables adjustment of scoring and performance rewards on the basis of the complexity of patient socioeconomic and clinical case-mix of a provider group (9).

Theme 4: Commitment to Professionalism

Pay-for-performance programs that are predicated on competition among individuals create a fundamental tension with the assertions of the Charter on Medical Professionalism, which envisions

individuals acting collectively to promote professional goals. Those programs that pay only on the basis of the top tier of performance put physicians in competition with each other.

By promoting competition, P4P programs might encourage secrecy among physicians about their methods for achieving high performance. However, P4P programs could be designed to encourage the sharing of knowledge, scientific evidence, and information—a principle of professionalism. Professionalism can also be fostered by recognizing the importance of team-based care that involves generalist physicians working with specialists and other professionals (3, 9). Measuring and rewarding the performance of specialties in isolation from one another (such as rewarding internists or family physicians separately from cardiologists or gastroenterologists) ignores the importance of team care, discourages active collaboration between specialists and primary care physicians, and may deter efforts to more effectively coordinate care. It can also lead to redundant testing and treatment if the primary care physician cannot obtain records from the specialist or vice versa.

Concerns about the conflicts between P4P and medical professionalism have been based primarily on theories about the tension between external motivation and self-interest and the internal motivation and self-restraint that characterize professional expectations. Our analysis of P4P incentives and the central themes of professionalism suggests that these theoretical conflicts are not inevitable. Rather, P4P programs could be designed to encourage many of the aspirations reflected in the Charter on Medical Professionalism.

To date, evidence about the effects of P4P in health care has been mixed (15–19). In addition, little research has evaluated the cost of improving quality of care in relation to the incentives offered by P4P programs. We believe that physicians should play a key role in defining and evaluating P4P programs that are compatible with professionalism. For example, the payment rewards proposed as part of the patient-centered medical home (20) may foster appropriate implementation of performance measurement and strengthen the physician–patient relationship. Rewarding performance of specialties together with primary care could improve the coordination of care.

Our analysis suggests that P4P programs should emphasize the collection of better scientific evidence about their effect on the quality of care, attend carefully to the ethical implications for the physician–patient relationship, ensure disclosure and transparency of payment incentives to patients, monitor whether P4P incentives produce greater equity in the care of patients, and support the development of professionals engaged in collective learning and improvement. Bearing these principles of professionalism in mind, P4P programs should be able to strengthen the relationship between the physician and the patient and increase the likelihood that all physicians will deliver the best possible care to every patient.

<http://www.annals.org/content/152/6/366.full.pdf%20html?sid=2a45e6f5-9a38-4965-a123-e944a6001102>



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Press Clips



American Board
of Medical Specialties

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ABMS Monthly Media Report January/February/March, 2010

Following is a summary of media coverage identified during the months of January/February/March related to the American Board of Medical Specialties (ABMS). A brief description of each story, along with an excerpt is provided as well as available links for complete articles. For other articles contact lboukas@abms.org.

ABMS Mentions

Story 1

Health Day

“Health Tip: Selecting a Surgeon”

Nancyann Rella

Feb. 19, 2010

This article offers tips for consumers who are considering surgery. According to the article, it is important to find a surgeon who is board certified and a Fellow of the American College of Surgeons, and to check that the hospital or surgery center is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

This article was also picked up today by *Business Week* and the *Palm Beach Post* (links are included below).

ABMS Mention: “A good indication of a surgeon’s competence is certification by a surgical board that is approved by the **American Board of Medical Specialties (ABMS)**.”

<http://www.healthday.com/Article.asp?AID=636174>

<http://www.businessweek.com/lifestyle/content/healthday/636174.html>

<http://www.palmbeachpost.com/health/health-tip-selecting-a-surgeon-253139.html>

Story #2

New York Times

“A Child’s Allergies Are Serious But Can Be Treated Effectively”

Walecia Konrad

March 5, 2010

An interview with Dr. Kevin Weiss is included in this article about advancements in treating children's allergies.

ABMS Mention: “You think your little one is getting a cold, but the cold never comes while the runny nose seems never to leave. ‘That could be a sign of allergies,’ says **Dr. Kevin Weiss, an expert on allergies and president of the American Board of Medical Specialties....** ‘Mild allergies can be treated without a lot of testing,’ **Dr. Weiss** said.”

<http://www.nytimes.com/2010/03/06/health/06patient.html?pagewanted=print>

Story #3

Modern Healthcare

“Clinical informatics moves toward certification”

Joseph Conn

Wednesday, March 10, 2010

The American Board of Medical Specialties (ABMS) and ABMS Member Board, the American Board of Preventative Medicine (ABPM) are mentioned in a *Modern Healthcare* article about the move towards certification for clinicians.

ABMS Mention: “If all goes well, according to Detmer's estimates, final approval of the clinical informatics subspecialty initiative could come from **American Board of Medical Specialties** as soon as this fall with development of the initial certification examination to be completed by the summer of 2012 at the earliest and by that fall at the latest. The first exams might be administered by the fall of 2012 and the first subspecialty certificates issued in January 2013, again, by Detmer's estimates.”

ABMS Member Board Mention: “There are **24 medical specialty boards** overseeing as many primary medical specialties and 121 medical subspecialties. The **American Board of Preventive Medicine** agreed last summer to become the home medical specialty board for the clinical informatics subspecialty, with AMIA serving as its designated adviser. Under the program envisioned by AMIA, each of the 24 primary medical specialties should be able to create a clinical informatics subspecialty.”

<http://www.modernhealthcare.com/apps/pbcs.dll/article?AID=/20100310/NEWS/303109960/1153#>

Story #4

The following media picked up information from the ABMS press release distributed March 23, 2010, on the inclusion of ABMS MOC in the health care reform measure passed by the House of Representatives on March 21 and signed into law yesterday by President Obama. The list is arranged by date and then alphabetically:

Ad Hoc News

March 23, 2010

<http://www.ad-hoc-news.de/abms-moc-included-in-health-care-bill-as-option-to--/de/Unternehmensnachrichten/21148950?tfindex=LUS-Tec>

Benzinga.com
March 23, 2010

<http://www.benzinga.com/press-releases/b188539/abms-moc-included-in-health-care-bill-as-option-to-assess-physician-quality>

dBusinessNews
March 23, 2010

<http://chicago.dbusinessnews.com/viewnews.php?article=bwire/20100323006972r1.xml>

Earth Times
March 23, 10

<http://www.earthtimes.org/articles/show/abms-moc-included-in-health,1217879.shtml>

Enhanced Online News
March 23, 2010

http://eon.businesswire.com/portal/site/eon/permalink/?ndmViewId=news_view&newsId=20100323006976&newsLang=en

EuroInvestor.co.uk
March 23, 2010

<http://www.euroinvestor.co.uk/news/story.aspx?id=10955061&bw=20100323006972>

FinanzNachrichten.de
March 23, 2010

<http://www.finanznachrichten.de/nachrichten-2010-03/16450881-abms-moc-included-in-health-care-bill-as-option-to-assess-physician-quality-004.htm>

iStockAnalyst
March 23, 2010

<http://www.istockanalyst.com/article/viewiStockNews/articleid/3970475>

Pharmacy Choice
March 23, 2010

http://www.pharmacychoice.com/News/article.cfm?Article_ID=553332

SmartBrief
March 23, 2010

<http://www.smartbrief.com/news/aaaa/industryBW-detail.jsp?id=902184F8-922E-4FF0-8809-4A83AEEF6A3B>

StockNod.com
March 23, 2010

<http://quotes.stocknod.com/stocknod/?GUID=12418673&Page=MediaViewer&ChannelID=3191>

Twitter.com/PatientSafety
March 23, 2010

<http://twitter.com/PatientSafety01/statuses/10939818220>

World Market Media
March 23, 2010

<http://www.worldmarketmedia.com/1876/section.aspx/157820/abms-moc-included-in-health-care-bill-as-option-to-assess-physician-quality>

Yahoo Finance
March 23, 2010

<http://finance.yahoo.com/news/ABMS-MOC-Included-in-Health-bw-161933582.html?x=0&.v=1>

NPR Topics
March 24, 2010

<http://topics.npr.org/quote/08ymam69RRfxW>

The Medical News
March 24, 2010

<http://www.news-medical.net/news/20100324/New-provision-in-health-care-bill-ensures-physicians28099-participation-in-PQRI-program.aspx>

Story # 5

ASTRO News

“The American Board of Radiology MOC Program in Radiation Oncology: 15 Years of Experience”

Paul E. Wallner, D.O., FASTRO, David Laszakovits, M.B.A., Donna E. Breckenridge, M.A.
March 23, 2010

This article looks at how the American Board of Radiology's (ABR) board certification and maintenance of certification (MOC) programs have evolved starting back in 1934 when lifetime certificates were issued to today's current ABR-MOC program.

ABMS and Specialty Member Board Mentions: “Ultimately, the **American Board of Medical Societies (ABMS)** initiated its **Maintenance of Certification (MOC)** process, which has now been adopted by all 24 of its Member Boards. By 2002, the **ABR** issued only 10-year, time limited certificates, and by 2007, the **ABR-MOC** program was fully established.”

<http://cs.astro.org/blogs/astronews/pages/astronews-the-american-board-of-radiology-moc-program-in-radiation-oncology-15-years-of-experience.aspx>

Story #6

The following media picked up information from the ABMS press release distributed March 24, 2010, announcing appointments to its Board of Directors. The list is arranged by date and then alphabetically:

dBusiness News
March 24, 2010

<http://chicago.dbusinessnews.com/viewnews.php?article=bwire/20100324006682r1.xml>

Earth Times
March 24, 2010

<http://www.earthtimes.org/articles/show/abms-board-of-directors-appointments,1219999.shtml>

Enhanced Online News
March 24, 2010

http://eon.businesswire.com/portal/site/eon/permalink/?ndmViewId=news_view&newsId=20100324006688&newsLang=en

Forbes
March 24, 2010

<http://www.forbes.com/feeds/businesswire/2010/03/24/businesswire137209183.html>

Genetic Engineering News
March 24, 2010

<http://www.genengnews.com/news/bnitem.aspx?name=78581278>

TMC.net
March 24, 2010

<http://www.tmcnet.com/submit/2010/03/24/4691174.htm>

UPI
March 24, 2010

<http://www.upi.com/finance/?GUID=12439493&Page=MediaViewer&ChannelID=3191>

Story #7

Modern Healthcare

“Some Back It, Some Smack It”

Andis Robeznieks

March 29, 2010

This article is about how passage of the healthcare reform bill will impact on various physician groups. The article cites ABMS and the MOC/PQRI initiative, and quotes Dr. Weiss at the end of the article.

ABMS Mention: “The **American Board of Medical Specialties** spoke in favor of an obscure provision in the bill that links the specialties board's maintenance of certification program with the CMS's Physician Quality Reporting Initiative, or PQRI. **Kevin Weiss, the specialties board's president and CEO**, said about 200,000 physicians participate in the maintenance program, with 30,000 and 40,000 added each year. As opposed to physicians cramming for a board exam every several years, the maintenance program calls for continuous learning and self-assessment, and **Weiss** believes linking it to the PQRI and offering a bonus of about 0.5% of Medicare Part B allowable charges will promote more growth of the program. **‘It’s going to be real useful and a driving force for quality,’ Weiss** said.”

<http://www.modernhealthcare.com/apps/pbcs.dll/article?AID=/20100329/MAGAZINE/1003299>
[60](#)

Health Day/Business Week/Palm Beach Post

Health Tip: Selecting a Surgeon

<http://www.healthday.com/Article.asp?AID=636174>

<http://www.businessweek.com/lifestyle/content/healthday/636174.html>

<http://www.palmbeachpost.com/health/health-tip-selecting-a-surgeon-253139.html>

By Nancyann Rella, Feb. 19, 2010

(HealthDay News) -- Your doctor suggests you have an operation. But how do you go about finding a qualified surgeon?

If you or someone you know is considering surgery, The American College of Surgeons recommends that you screen for the following qualifications:

- **Board Certification.** A good indication of a surgeon's competence is certification by a surgical board that is approved by the **American Board of Medical Specialties (ABMS).**
- **Association with an accredited hospital or outpatient surgery center.** Your surgeon will arrange for your operation to be performed in a hospital where he or she has staff privileges. It is a good idea to make sure that the hospital has been accredited by the Joint Commission on Accreditation of Healthcare Organizations.
- **Fellowship in the American College of Surgeons.** The letters FACS after a surgeon's name indicate that he or she is a Fellow of the American College of Surgeons (ACS). Fellows of the College are almost always board-certified surgeons whose education, training, professional qualifications, surgical competence, and ethical conduct have been approved by the College.

New York Times

A Child's Allergies Are Serious but Can Be Treated Effectively

<http://www.nytimes.com/2010/03/06/health/06patient.html?pagewanted=print>

By WALECIA KONRAD, March 5, 2010

It starts with a telltale snuffle, itchy eyes and an occasional [cough](#). You think your little one is getting a cold, but the cold never comes while the [runny nose](#) seems never to leave.

“That could be a sign of [allergies](#),” says **Dr. Kevin Weiss, an expert on allergies and president of the American Board of Medical Specialties**. Not a surprising diagnosis when you consider that more than 40 percent of children (and 20 to 30 percent of adults) suffer from [allergic rhinitis](#), often simply called allergies. With spring pollen season just around the corner, parents are bound to hear more of those tell-tale sniffles.

Allergies are no trivial matter. Each year, allergic rhinitis accounts for two million missed school days and \$2.3 million in health care costs for children younger than 12. It's not unusual for allergy sufferers to spend thousands of dollars each year on doctor visits, medications and other products, says Dr. Linda Cox, an allergist practicing in Ft. Lauderdale, Fla., and former chairwoman of the [American College of Allergy, Asthma and Immunology](#)

What's more, Dr. Cox said, allergies left untreated in children can often lead to [asthma](#), a chronic and debilitating pulmonary disease.

For the purposes of this article I'll focus on allergic rhinitis, particularly among children. (The subject of food allergies may warrant a separate, future column.) The condition can be set off by outside elements like pollen from ragweed, grasses and trees and indoor allergens like dust mites and pet dander.

Combating allergies often requires a multipronged and sometimes costly approach. Here's what you can do to make sure your child gets the best results.

THE RIGHT DOCTOR Most allergies can be identified and treated by a pediatrician or [family doctor](#). The doctor will use blood tests and your child's symptoms to come up with an educated guess on what is causing the problem.

“Mild allergies can be treated without a lot of testing,” **Dr. Weiss** said. New nondrowsy prescription and over-the-counter medications make it easier to treat symptoms, he added. Your child's doctor should know which drugs are appropriate for children.

That's good news, because allergists aren't always part of an insurer's network or covered under high-deductible plans.

Nevertheless, an allergist can best treat your child if symptoms become moderate to severe. If your child is extremely uncomfortable, losing sleep or missing a lot of school, and the current medications he or she is using aren't working, you may need to take the next step. An allergist will most likely do a skin test to pinpoint exactly what your child is allergic to. This is often more precise than the blood tests and is usually covered by [insurance](#).

To find an allergist, ask your pediatrician or family doctor for a recommendation or log onto the [doctor locator](#) sponsored by the American College of Allergy, Asthma and Immunology. If you're covered by an H.M.O. or other health network, you'll need to ask your primary physician for a referral.

ELIMINATE THE SOURCE After you and your child's doctor have narrowed down the possible culprits, it's time to reduce or remove the troublemakers. Many of the most effective ways to do this are labor-intensive but low in cost, said Dr. James Sublett, an allergist in Louisville, Ky., and professor of pediatric allergy and immunology at the [University of Louisville](#) School of Medicine.

Keep your pet away from carpeted rooms, sleeping areas, upholstered furniture and other places where it becomes difficult or impossible to remove dander. Cats are the animals that cause the most allergy problems, and cat allergen can remain in a house for an average of 20 weeks after an animal is removed.

If you and your doctor suspect dust mites are a problem, remove drapes, stuffed animals, pet bedding, upholstered furniture and even carpeting from the bedroom. Wash linens frequently. Dust with a moist cloth or an electrostatic fabric duster. Both do a better job of actually collecting dust rather than just stirring it around. Remember: dust takes a couple of hours to settle after cleaning and vacuuming.

Tumble-drying stuffed animals on high heat for 20 minutes will also kill dust mites.

Get rid of any pest problems, like roaches or mice. Both can be huge allergy triggers. In addition, keep windows closed during peak allergy season.

CONSIDER IMMUNOTHERAPY Even after you've identified and tried to eliminate the source of your child's allergies, he or she may still be suffering. If that happens, you may have to go for the shots.

Allergy shots have come in for criticism over the years because, well, they are shots and require repeat visits to the doctor's office — two things children really don't like.

And many parents may wonder — in some cases, rightfully, alas — whether the allergy doctor is overdiagnosing allergies and overtreating their children. Dr. Cox argues that allergists get to the root of the cause instead of just treating symptoms. General practitioners can prescribe medicines to treat symptoms without easing the condition, she

says. In any case, it is important to get a referral from a pediatrician or family doctor whom you trust to do what's right for your child.

A new study published last month in the peer-reviewed *Annals of Allergy, Asthma and Immunology* found that allergy shots, also known as immunotherapy, could actually help eliminate allergy symptoms after only 18 months. What's more, shots may help save you money in the long run. Among the children with allergic rhinitis studied, shots helped to reduce total health care costs by a third, and prescription drug costs by 16 percent, said Dr. Cox, who was a co-author of the study.

In immunotherapy, an allergist injects a small amount of the allergen into a patient. This prompts the body to make natural [antibodies](#), which naturally increase one's [immunity](#) to the culprit. "It is the only therapy that doesn't just treat allergy symptoms but tries to get at the cause," Dr. Cox said.

But because the allergist personally mixes the allergens according to a patient's needs, the shots are not considered [pharmaceuticals](#) and are sometimes not covered by insurance.

The first year of allergy shots, which includes a three-month build-up period during which a child receives injections as often as twice a week until the proper dosage is found, would cost a bit less than \$1,000 for the year, according to Dr. Cox. The next year, with twice-a-month injections, would total an estimated \$350.

For parents who are uninsured and cannot afford shots for their children, Dr. Cox suggests contacting the state allergy society for a list of allergists and clinics that may offer low or no-cost treatments. (Because there is no clearinghouse for such information, you'll probably have to do your own Web sleuthing.)

AVOID THE UNNECESSARY There's no end to the number of products marketed to allergy sufferers, including air filters, humidifiers, dehumidifiers, ozone machines, mattress and pillow encasements, special breathing masks and more. Many of these products are expensive and some are ineffective. Ozone, for instance, can be a pollutant and actually worsen allergies, Dr. Sublett said.

Several studies show that there are no significant improvements from using mattress and pillow encasements and other allergy-fighting products. The best thing to do is to take the necessary steps to remove allergens like the ones discussed above.

Modern Healthcare/Healthcare IT Strategist

Clinical informatics moves toward certification

<http://www.modernhealthcare.com/apps/pbcs.dll/article?AID=/20100310/NEWS/303109960/1153#>

By [Joseph Conn / HITS staff writer](#), posted March 10, 2010, 11 a.m.

The role of medical informatics in healthcare is rapidly expanding, as is the use of information technology itself. What is not moving rapidly—at least to an outside observer—is an already 5-year-old effort by institutional medicine that has perhaps another three years to go before creating a program of subspecialty board certification in clinical informatics.

To insider Don Detmer, however, what would appear to some as a glacial pace is actually “moving amazingly fast, as far as these things go” given that medical boards and medical education organizations “move very, very slowly.”

A recent eight-page article, “Clinical informatics board certification: History, current status, and predicted impact on the clinical workforce,” which appears in the online journal, *Applied Clinical Informatics*, gives an update on the effort. Detmer, the past president and former CEO of the American Medical Informatics Association, is its lead author.

If all goes well, according to Detmer's estimates, final approval of the clinical informatics subspecialty initiative could come from **American Board of Medical Specialties** as soon as this fall with development of the initial certification examination to be completed by the summer of 2012 at the earliest and by that fall at the latest. The first exams might be administered by the fall of 2012 and the first subspecialty certificates issued in January 2013, again, by Detmer's estimates.

The training programs for the required fellowship in clinical informatics will be accredited by the Accreditation Council for Graduate Medical Education.

For the first five years of the program, however, experienced medical informaticists could be grandfathered out of the training requirements, but would have to apply for, sit and pass the exam to receive certification in their clinical informatics subspecialty. After five years, the training and testing components would apply to everyone, Detmer said.

There are **24 medical specialty boards** overseeing as many primary medical specialties and 121 medical subspecialties. The **American Board of Preventive Medicine** agreed last summer to become the home medical specialty board for the clinical informatics subspecialty, with AMIA serving as its designated adviser. Under the program envisioned by AMIA, each of the 24 primary medical specialties should be able to create a clinical informatics subspecialty.

The ABPM is going to sponsor it and manage it for all the boards, but there will be collaborative

and cooperative agreements between that board and all the other boards, Detmer said. Surgeons, for example, will be issued a subspecialty by the American Board of Surgery, not the ABPM, he said.

“Almost every single board is interested in making sure that their people will be able to be certified if they underwent training and sat for the exam,” he said.

Details of the training programs have yet to be worked out, but Detmer said he envisions a curriculum with a subject matter core that would be universal across all training programs and informatics elements specific to the subspecialty.

There are a number of reference marks in the history of medical informatics for the ongoing clinical subspecialty effort, but Detmer, now a senior adviser to the AMIA, wrote in the article that a launching point was the goal set by then-President George W. Bush in 2004 that most Americans would have access to an electronic health record in a decade.

Detmer observed that the informatics community quickly recognized “that the U.S. healthcare system was sorely lacking the informatics savvy workforce sufficient in number and knowledge to accomplish this goal.”

The article said these growing workforce demands “dictated that it was time for clinical informatics to evolve from an avocational or part-time activity of self-identified informaticians to a fully professional career track with training, standards, codes of ethics and certification.”

Work by AMIA toward a board certification program in clinical informatics can be traced back to a town hall discussion at the AMIA annual meeting in 2005, when a group conclusion was reached that social benefits could be derived from formal training and certification, according to history of the effort in an [earlier article by Detmer that appeared in the AMIA journal](#).

The AMIA board began hunting for funding for the program and in 2007 obtained a grant from the Robert Wood Johnson Foundation to develop guidelines on core content and training program requirements, which were subsequently drafted and approved by the AMIA board in late 2008.

William Hersh is a physician, professor and chairman of the Department of Medical Informatics and Clinical Epidemiology in the School of Medicine at Oregon Health & Science University, which has a certificate program in clinical informatics with about 200 enrollees and a full master's degree program in clinical informatics with typically 30 to 40 enrollees.

While a formal degree in medical informatics is “still not an absolute requirement” for placement in positions in clinical informatics—Hersh volunteers he does not have one—and experience remains the most common passport in the informatics field, “there is no question that interest is increasing, that more and more hospitals are interested in hiring people like this.”

Hersh said medical college informatics programs should have little difficulty in adapting to the formal educational requirements of the new clinical informatics subspecialties.

In his keynote speech last week to the Healthcare Information and Management Systems Society convention in Atlanta, David Blumenthal, head of the Office of the National Coordinator for Health IT at HHS, talked about federal funds under the American Recovery and Reinvestment Act of 2009, also known as the stimulus law, going toward health IT workforce development. Much of the money will be used to train 40,000 or more health IT workers through community college certificate programs, “but we are also training at a higher level as well.”

That includes [\\$32 million in grants](#) “to establish university-based certificate and advanced degree health IT training programs and \$6 million dollars to develop a health IT competency examination program.”



March 23, 2010 1804 +0000 UTC</DIV

ABMS MOC Included in Health Care Bill as Option to Assess Physician Quality

CHICAGO--(BUSINESS WIRE)-- A provision in the health care reform measure passed by the House of Representatives Sunday and signed into law today by President Barack Obama includes participation in the American Board of Medical Specialties Maintenance of Certification ® (ABMS MOC ®) as an option for the nation's physicians to fulfill requirements of the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI). The bill enhances PQRI by opening up an additional pathway for physician participation in quality reporting starting in 2011, and provides an increased incentive payment beyond the PQRI bonus to physicians who choose to voluntarily participate. It represents the first time MOC is an option within the Federal accountability framework.

"ABMS MOC was developed to ensure physician commitment to lifelong learning and competency in his or her specialty and/or subspecialty," said Kevin B. Weiss, MD, ABMS president and CEO. "MOC reporting will give patients, health plans and others the information they need to choose physicians based on performance and other key qualifications, including diagnostic acumen, clinical reasoning and medical knowledge. This bill's approval is a significant step forward in recognizing the value of MOC in advancing health care quality for the benefit of patients."

Now celebrating its 10th anniversary, MOC was enacted by ABMS and its 24 Member Boards to enhance the physician certification process, moving from once in a lifetime, or once every six to 10 years, to an ongoing commitment to continuous maintenance of high quality clinical competencies. ABMS MOC ensures that a participating physician is committed to lifelong learning and ongoing self-assessment in six areas of competency. While measurement of these competencies may vary according to the medical specialty, this multi-faceted assessment is carried out by all 24 Member Boards using a four-part process, including practice-based learning and improvement.

"Practice performance assessment required by ABMS MOC involves real-world evaluation of clinical practice and quality improvement," said Christine Cassel, MD, president and CEO of the American Board of Internal Medicine (ABIM), a Member Board of ABMS. In MOC, physicians must perform a quality improvement intervention, a process that, by its very nature, calls for continuous improvement for the benefit of patients, physician practices and the broader health care community.

PQRI is a physician quality reporting system established by the CMS. The program includes an incentive payment for physicians who satisfactorily report data on quality measures for professional services provided to Medicare beneficiaries.

Each of ABMS' 24 Member Boards will now determine if and how to participate within the PQRI program leveraging this new MOC pathway.

About ABMS

For more than 75 years, the American Board of Medical Specialties has been the medical organization overseeing physician certification in the United States. It assists its 24 Member Boards in their efforts to develop and implement educational and professional standards for the evaluation and certification of physician specialists. ABMS Member Boards provide physician certification information to ABMS for its certification verification service programs. ABMS is recognized by the key healthcare credentialing accreditation entities as a primary equivalent source of board certification data for medical specialists. Patients can visit www.abms.org or call toll-free 1-866-

ASK-ABMS to see if their physician is board certified by an ABMS Member Board. For more information about ABMS visit <http://www.abms.org> or call (312) 436-2600.

The 24 Member Boards that make up the ABMS Board Enterprise cover more than 145 medical specialties and subspecialties and include: American Board of Allergy and Immunology, American Board of Anesthesiology, American Board of Colon and Rectal Surgery, American Board of Dermatology, American Board of Emergency Medicine, American Board of Family Medicine, American Board of Internal Medicine, American Board of Medical Genetics, American Board of Neurological Surgery, American Board of Nuclear Medicine, American Board of Obstetrics and Gynecology, American Board of Ophthalmology, American Board of Orthopaedic Surgery, American Board of Otolaryngology, American Board of Pathology, American Board of Pediatrics American Board of Physical Medicine and Rehabilitation, American Board of Plastic Surgery, American Board of Preventive Medicine, American Board of Psychiatry and Neurology, American Board of Radiology, American Board of Surgery, American Board of Thoracic Surgery, and American Board of Urology.

Astro News

ASTRONews: The American Board of Radiology MOC program in radiation oncology: 15 years of experience

<http://cs.astro.org/blogs/astronews/pages/astronews-the-american-board-of-radiology-moc-program-in-radiation-oncology-15-years-of-experience.aspx>

By Paul E. Wallner, D.O., FASTRO, David Laszakovits, M.B.A., and Donna E. Breckenridge, M.A.

When it was founded in 1934, the American Board of Radiology (ABR) began issuing lifetime certificates based entirely on a body of knowledge that candidates could demonstrate proximate to completion of their postgraduate training. With the passage of time and increasing concerns regarding the quality and value of care being provided, it became evident that a process that concluded at the time of completion of training was inadequate to keep pace with the rapidly changing nature of disease diagnosis and management.

In 1994, the trustees of the ABR determined that, beginning the following year, candidates in radiation oncology who passed the initial certification examination would be given a 10-year, time-limited certificate. Recertification examinations were to be computer-based and not oral. Time-limited certificates in diagnostic radiology and radiologic physics would follow (1).

Subsequent to the 1994 ABR decisions, the Institute of Medicine published two reports highlighting the urgent need for a safer healthcare system: *To Err Is Human* in 1999 (2) and *Crossing the Quality Chasm* in 2001 (3). These reports, and others, suggested an unsustainable growth in U.S. healthcare expenditures accompanied by a decline in America's ranking among industrialized nations in several healthcare outcome metrics, including infant mortality and life expectancy. Stakeholders began to question the current healthcare system and to seek methods to improve quality and value.

Ultimately, the American Board of Medical Specialties (ABMS) initiated its Maintenance of Certification (MOC) process, which has now been adopted by all 24 of its Member Boards (4). By 2002, the ABR issued only 10-year, time-limited certificates, and by 2007, the ABR-MOC program was fully established. The ABR hopes these programs will assure the public about a diplomate's fund of initial knowledge and continued competency.

The Maintenance of Certification program

All ABR diplomates with time-limited certificates are automatically enrolled in the MOC process. Currently, those with lifetime certificates are strongly encouraged to participate as a demonstration of their commitment to the best interest of their patients and practice.

The MOC program helps facilitate and document continuous professional development through its focus on six essential competencies of quality care, as agreed to by all ABMS Member Boards: medical knowledge, patient care, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice. Based on these competencies, the radiation oncology MOC process has four required components to be completed over a 10-year cycle.

- **Part I - Professional Standing:** Diplomates must maintain current and unrestricted licenses in all locations of practice.
- **Part II - Lifelong Learning and Self-Assessment:** Diplomates must complete 250 continuing medical education (CME) credit hours approved by the Accreditation Council on Graduate Medical Education (ACGME) (Category 1) and eight ABR-qualified self-assessment modules (SAMs).
- **Part III - Cognitive Expertise:** Diplomates must successfully complete a computer-based exam once during the last three years of the cycle.
- **Part IV - Practice Quality Improvement (PQI):** Diplomates must complete three PQI projects over the 10-year cycle. Diplomates have the option to select projects in which they work individually, with a group or through a specialty society like ASTRO, but at least one of the projects must be society-based with a national database.

Now in their second decade, significant changes are on the horizon for MOC programs. Many of these changes have been developed by staff and board trustees with the intention of making the programs more convenient and efficient for diplomates. Other changes are part of a larger national effort to improve demonstration of physician competency, increase transparency in the licensure and certification of physicians, improve public access to information regarding their providers, and improve the ability of the public to provide input into the entire process.

Over the next 12 to 24 months, the ABR plans to make available additional SAMs and CME opportunities. Diplomates in the MOC programs will have greater access to their own data and an enhanced ability to transfer information among multiple organizations, all feeding into individual personal databases (PDBs). More frequent timeline notification will be developed.

Although the ABMS member boards, including the ABR, issued lifetime certificates for decades and hundreds of thousands of lifetime certificate holders continue to serve in clinical practice, over the past several years there has been increasing pressure from legislators, state medical boards, and other regulatory and oversight organizations such as the Joint Commission to initiate programs that serve to “assure” maintenance of competency rather than to simply test a body of knowledge and skills at the completion of postgraduate training. For this reason, the Federation of State Medical Boards, the Joint Commission, various hospital and health systems, government agencies, and many payers are considering active participation in MOC programs to be a sine qua non for maintenance of licensure and participation on hospital medical staffs and payer panels (5,

6).

Similarly, the various health reform bills being considered by Congress may allow for use of MOC credentials as an alternative pathway to PQRI bonus payments. As these evolve, lifetime certificates will remain valid, but participation in MOC programs may be necessary for continued active medical practice. With increasing impact of the MOC programs on professional activities, there will be a parallel increase in need for transparency to the public and other interested stakeholders. The ABMS is developing a way for public reporting of MOC participation and activities on an individual practitioner level and is considering reductions in the 10-year MOC cycle. In addition, to improve public accountability regarding maintenance of competency, the ABMS is encouraging member boards to develop pilot projects in focused practice (FP) initiatives for MOC. The ABR is currently exploring the potential of a FP initiative in brachytherapy that diplomates could pursue in addition to their general MOC.

Currently, only about 45 percent of practicing radiation oncology ABR diplomates are enrolled in MOC, with the overwhelming majority representing individuals with time-limited certificates. This pattern may certainly change in the future as more entities consider MOC as having deemed status to fulfill a portion of their credentialing requirements. Despite concerns raised regarding a potential drop-off in performance on the Part III cognitive examination as diplomates are further removed from training and may see fewer general oncology patients if they limit their practices to specific sites, passage rates have been extremely high.

The ABR recognizes that, as with many new and evolving programs, implementation at the individual practice level may be difficult. To avoid confusion and delays, communication methods have been developed and will be improved over time. MOC-related articles and presentations will be provided to all radiation oncology organizations, and e-mail communication with diplomates will update program status. ABR staff is also available to answer specific questions at an MOC hotline at 520-519-2152 and by e-mail to abrmocp@theabr.org.

Dr. Wallner is senior vice president for medical affairs, 21st Century Oncology, L.L.P., and associate executive director for radiation oncology, ABR. Laszakovits is division chair for MOC at the ABR. Breckenridge is director of communications for the ABR.



March 24, 2010 1836 +0000 UTC</DIV

ABMS Board of Directors Appointments

CHICAGO--(BUSINESS WIRE)-- The American Board of Medical Specialties (ABMS), the organization that oversees the certification of physician specialists in the United States, announced at its Annual Assembly Meeting today the appointment of John McCabe, MD, FACEP, as the 33rd chair of its Board of Directors, and the appointment of six new members to the Board.

Dr. McCabe joined ABMS in 1999 and most recently served as the vice chair of its Board of Directors. He has been a member of the American Board of Emergency Medicine (ABEM) since 1996, and has held all offices within that organization including president of the board from 2004-2005.

"John McCabe is an outstanding leader in advancing the ABMS mission to improve the quality of medical care through enhanced physician accountability," said Kevin B. Weiss, MD, ABMS president and CEO. "He will be a valuable asset as ABMS moves forward with its commitment to develop and apply rigorous professional and educational standards for the certification of physician specialists and the maintenance of certification throughout their careers."

In addition to his roles with ABMS and ABEM, Dr. McCabe, a renowned emergency medicine physician, is professor of emergency medicine, State University of New York (SUNY) Upstate Medical University in Syracuse, NY and chief executive officer and senior vice president for hospital affairs, Upstate University Hospital. He also was instrumental in the development of the university's Department of Emergency Medicine and its residency program. He served as editor of the journal, Resuscitation. He is past president of the American College of Emergency Physicians.

Dr. McCabe attended medical school at the SUNY Upstate Medical University, Syracuse, completed his internship at the Charles F. Kettering Medical Center in Kettering, Ohio, and his residency in emergency medicine at Wright State University School of Medicine in Dayton, Ohio.

The ABMS Board of Directors (BOD) consists of 31 voting directors - one representing each of the 24 Member Boards, three public members (which will be expanded to six over the next three years) and the ABMS officers (chair, vice chair, secretary-treasurer and president). Other newly elected board members include:

Jo Buyske, MD, adjunct professor of surgery, University of Pennsylvania School of Medicine, Philadelphia, representing the American Board of Surgery, of which she is associate executive director. A prominent surgeon, Dr. Buyske is the incoming president of the Society of American Gastrointestinal Endoscopic Surgeons and serves on the editorial board of Archives of Surgery. She is a recipient of numerous awards, including the Physician Mentor Award of the American Medical Association's Women Physician's Congress.

Bruce J. Gantz, MD, professor and head of the department of otolaryngology, head and neck surgery, University of Iowa Hospitals and Clinics, Iowa City, representing the American Board of Otolaryngology. Dr. Gantz's research interests include: cochlear implant clinical research, management of facial paralysis, hearing preservation in acoustic tumor surgery, and management of chronic otitis media with cholesteatoma. He is the principal investigator of the Iowa Cochlear Implant Clinical Research Center, funded by the NIH since 1985.

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Modern Healthcare

March 29, 2010

Cover Story

Some back it, some smack it

Doc groups take polar opposite positions on reform

By Andis Robeznieks

Depending on which physician group's news release you read, the recently passed healthcare reform legislation represents a "monumental moment," "half-baked" legislation that will be a "budget buster" for Medicaid programs or "aspirin dispensed for the treatment of cancer."

Many doctors, meanwhile, are still struggling to find out what reform will mean for them and what effect it will have on their daily lives and the operation of their practices. Also, there are aspects of the bill—such as restrictions on physician hospital ownership—that received scant attention during the months of heated debate but now threaten to doom clinically and economically successful enterprises.

"The passage of the healthcare reform bill will have a devastating impact on physician-owned hospi-

tals, the patients they treat and the communities they serve," said Molly Sandvig, executive director of the Physicians Hospitals of America lobbying group, in an e-mail. "The legislation virtually destroys over 60 hospitals that are currently under development, and leaves little room for the future growth of the industry."

John Dietz is an orthopedic surgeon and chairman of Indiana Orthopaedic Hospital, a 37-bed, 10-operating room facility in Indianapolis that Dietz owns with 62 other doctors. He said, despite scoring high on quality and patient-satisfaction measures, it will be tough for the operation to survive within the limits placed on physician-owned facilities by the new reform law because it will limit the hospital's ability to adapt to changing market conditions. As Dietz explained, the new law will severely restrict physician



Weiss: Maintenance program a "driving force for quality."

owners' ability to compete.

"Now we cannot change the percentage of physician ownership, so basically we cannot add or change partners," Dietz said, adding that there are also restrictions on expansion, which will compromise the hospital's construction of a new, three operating-room facility. "We're going to complete the construction because we're already too far down this path."

The law also has "transparency" provisions that call for alerting patients to the hospital's

Physicians

physician-owned status, which Dietz said he doesn't mind one bit.

"We don't object to the requirement that we tell our patients we own our hospital," Dietz said. "We have a sign out front that proudly proclaims it."

The American Medical Association, which called the signing of the new law a "monumental moment," came under fire from some physician groups for supporting its passage. Similar to the PHA, the Chicago-based association also objected to the restrictions on physician ownership contained in the reform legislation.

"Physician-owned hospitals provide high-quality patient care and increase competition and choice in the marketplace—those should be the hallmarks against which these hospitals

are judged,” the AMA said in an e-mail attributed to its president, J. James Rohack. “Restricting physician-owned hospitals is counter to what we are working to achieve—a better healthcare system for patients and physicians.”

Rohack, a cardiologist from Temple, Texas, angered other physicians in his state as the 45,000-member Texas Medical Association—the nation’s largest state physician society—railed against the bill. In a news release, the association’s president, William Fleming III, called the law “a half-baked budget buster.”

Congress “passed a bill that does nothing to fix glaring problems in our current healthcare system,” Fleming said. “Instead, it saddles Texans with higher costs, higher taxes, more red tape and more bureaucracy. We believe the bill’s unaffordable health system reforms, piled on top of a crumbling Medicare foundation, will create even more dire consequences for all.”

Other state associations saw it differently. The Massachusetts Medical Society said it was pleased the reform law was approved, but called it “far from perfect” and classified its support as “qualified.”

“Overall, it’s good for patients, but by no means is it a fix,” said the society’s president, Mario Motta, a Salem-based cardiologist, who added that he read the entire bill. Reform “will



Restrictions on physician ownership are part of the health reform legislation.

affect Massachusetts less than the rest of the country because we’ve already done it.”

Motta said that 96.4% of Massachusetts has insurance coverage, and the federal legislation should add coverage for about 70,000 more people, “getting us closer to 99%.” But what’s unknown is what effect a

new federal provision requiring companies with 50 or more employees to offer health insurance will have on the state law requiring companies with 11 or more employees to do so.

The Physicians for a National Health Program single-payer advocacy group said the new law results in 23 million people remaining uninsured for the next nine years and said the legislation was like using aspirin to treat cancer.

The American Board of Medical Specialties spoke in favor of an obscure provision in the bill that links the specialties board’s maintenance of certification program with the CMS’s Physician Quality Reporting Initiative, or PQRI.

Kevin Weiss, the specialties board’s president and CEO, said about 200,000 physicians participate in the maintenance program, with 30,000 and 40,000 added each year. As opposed to physicians cramming for a board exam every several years, the maintenance program calls for continuous learning and self-assessment, and Weiss believes linking it to the PQRI and offering a bonus of about 0.5% of Medicare Part B allowable charges will promote more growth of the program. “It’s going to be real useful and a driving force for quality, Weiss said. <<



American Board
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Higher standards. Better care.®

Press Releases

News Release



FOR IMMEDIATE RELEASE

ABMS Media Contact: Lori Boukas
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ABMS MOC Included in Health Care Bill as Option to Assess Physician Quality

CHICAGO – Tuesday, March 23, 2010 – A provision in the health care reform measure passed by the House of Representatives Sunday and signed into law today by President Barack Obama includes participation in the American Board of Medical Specialties Maintenance of Certification® (ABMS MOC®) as an option for the nation's physicians to fulfill requirements of the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI). The bill enhances PQRI by opening up an additional pathway for physician participation in quality reporting starting in 2011, and provides an increased incentive payment beyond the PQRI bonus to physicians who choose to voluntarily participate. It represents the first time MOC is an option within the Federal accountability framework.

"ABMS MOC was developed to ensure physician commitment to lifelong learning and competency in his or her specialty and/or subspecialty," said Kevin B. Weiss, MD, ABMS president and CEO. "MOC reporting will give patients, health plans and others the information they need to choose physicians based on performance and other key qualifications, including diagnostic acumen, clinical reasoning and medical knowledge. This bill's approval is a significant step forward in recognizing the value of MOC in advancing health care quality for the benefit of patients."

Now celebrating its 10th anniversary, MOC was enacted by ABMS and its 24 Member Boards to enhance the physician certification process, moving from once in a lifetime, or once every six to 10 years, to an ongoing commitment to continuous maintenance of high quality clinical competencies. ABMS MOC ensures that a participating physician is committed to lifelong learning and ongoing self-assessment in six areas of competency. While measurement of these competencies may vary according to the medical specialty, this multi-faceted assessment is carried out by all 24 Member Boards using a four-part process, including practice-based learning and improvement.

"Practice performance assessment required by ABMS MOC involves real-world evaluation of clinical practice and quality improvement," said Christine Cassel, MD, president and CEO of the American Board of Internal Medicine (ABIM), a Member Board of ABMS. In MOC, physicians must perform a quality improvement intervention, a process that, by its very nature, calls for continuous improvement for the benefit of patients, physician practices and the broader health care community.

PQRI is a physician quality reporting system established by the CMS. The program includes an incentive payment for physicians who satisfactorily report data on quality measures for professional services provided to Medicare beneficiaries.

Each of ABMS' 24 Member Boards will now determine if and how to participate within

the PQRI program leveraging this new MOC pathway.

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News Release



FOR IMMEDIATE RELEASE

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ABMS Board of Directors Appointments *John McCabe, MD, FACEP, to Chair ABMS Board*

CHICAGO – March 24, 2010 – The American Board of Medical Specialties (ABMS), the organization that oversees the certification of physician specialists in the United States, announced at its Annual Assembly Meeting today the appointment of John McCabe, MD, FACEP, as the 33rd chair of its Board of Directors, and the appointment of six new members to the Board.

Dr. McCabe joined ABMS in 1999 and most recently served as the vice chair of its Board of Directors. He has been a member of the American Board of Emergency Medicine (ABEM) since 1996, and has held all offices within that organization including president of the board from 2004-2005.

“John McCabe is an outstanding leader in advancing the ABMS mission to improve the quality of medical care through enhanced physician accountability,” said Kevin B. Weiss, MD, ABMS president and CEO. “He will be a valuable asset as ABMS moves forward with its commitment to develop and apply rigorous professional and educational standards for the certification of physician specialists and the maintenance of certification throughout their careers.”

In addition to his roles with ABMS and ABEM, Dr. McCabe, a renowned emergency medicine physician, is professor of emergency medicine, State University of New York (SUNY) Upstate Medical University in Syracuse, NY and chief executive officer and senior vice president for hospital affairs, Upstate University Hospital. He also was instrumental in the development of the university’s Department of Emergency Medicine and its residency program. He served as editor of the journal, *Resuscitation*. He is past president of the American College of Emergency Physicians.

Dr. McCabe attended medical school at the SUNY Upstate Medical University, Syracuse, completed his internship at the Charles F. Kettering Medical Center in Kettering, Ohio, and his residency in emergency medicine at Wright State University School of Medicine in Dayton, Ohio.

The ABMS Board of Directors (BOD) consists of 31 voting directors - one representing each of the 24 Member Boards, three public members (which will be expanded to six over the next three years) and the ABMS officers (chair, vice chair, secretary-treasurer and president). Other newly elected board members include:

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