



STANDARDS FOR ABMS MOC® (PARTS I-4) PROGRAM
Approved March 16, 2009

COMMOC Principles

The launch of the ABMS 2008-2011 Public Trust Initiative brings an increased commitment to quality healthcare and transparency in diplomate accountability and provides an opportunity to enhance the value of Maintenance of Certification to the public, the diplomates, the Member Boards and the Board Enterprise (24 Member Boards and ABMS). The ability to respond to the needs of the public while keeping pace with the growing field of performance measurement, requires a dynamic MOC process that moves away from periodic re-certification to a continuous process of maintenance of certification. The standards to which we hold diplomates need to be continually evaluated and updated to keep pace with advances in medicine, changes in practice, and local and national efforts in healthcare reform. Yet, if the commitment to change is to be effective, it must be accompanied by an implementation plan that is both feasible and not unduly burdensome to the diplomates and the Member Boards.

To this end, we offer the following set of guiding principles:

- By 2010¹, Boards will develop a process by which new diplomates are automatically enrolled in MOC at the time of initial certification.
- Information regarding continuous participation by diplomates (time-limited and lifetime certificate holders) in the MOC process will be available to the public.
- Linkages among the various MOC parts and opportunities for simultaneous satisfaction of multiple requirements (among the parts) should be encouraged whenever possible.
- Planned major version releases of the MOC Standards Document will not occur more frequently than every 5 years. Specific modifications in response to scientific evidence or regulatory or public requirements may be introduced more frequently as needed.
- Prior to implementing new requirements, ABMS will conduct a review in partnership with each Member Board, to assess impact, determine how the new requirements can be integrated with current processes and explore opportunities for Board Enterprise support (shared platforms, products, technical support, etc)

¹ For all dates mentioned in this document, implementation to commence on or before July 31 of the year unless stated otherwise.

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Structural Elements for Operating MOC

In order to demonstrate public accountability, each Member Board will:

- By 2009, have a process in place to provide oversight and review of the MOC program.
- By 2009, designate a staff person as an MOC coordinator to support the activities resulting from MOC policies and participate in a collaborative network of MOC representatives from all of the Boards.
- Beginning in 2010, submit a brief annual report (i.e., 2-3 pages) to COMMOC for review based on a specified template.
- Beginning with one third of the Boards in 2011, one third of the Boards in 2012 and one third of the Boards in 2013, submit a detailed report of their MOC program (based on a specified COMMOC template) for review by COMMOC every 5 years.
- By 2010, transmit information about diplomate certification status, clinical status (active, inactive or unknown—see attachment 1), dates and participation in MOC to ABMS in a timely manner.²

ABMS will make information about certification status, dates, and participation in MOC available to the public

Standards

Part I: *By 2009, staff of each Member Board will:*

- Receive and review Disciplinary Alert Notification System (DANS) reports at least monthly
- Establish a structured review process (approved by COMMOC) of DANS report
- Provide in the annual report the final outcomes of the DANS review process to COMMOC:
 - Number of DANS reports
 - Number and type of Member Board actions/number of diplomates with license revoked
 - Number and type of Member Board actions/number of diplomates with license suspended

² Initially, participation will be defined by the individual Member Boards. By 2011, COMMOC will develop a standard definition of participation in MOC.

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Part 2:

By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of Board certification, and free of commercial bias and control of a commercial interest as currently specified in the ACCME Standards for Commercial SupportSM.

- Each diplomate will be required to complete CME credits (AMA PRA Category 1, AAFP Prescribed Credit, ACOG cognates, and/or AOA Category 1A).⁹
 - At least an average of 25 credits per year (averaged over 2-5 years, at Member Boards discretion) with the intent that credits are evenly distributed throughout the entire MOC cycle. The usual method of collecting CME credit information is self-reporting.
 - At least an average of 8 of the credits per year (averaged over 2-5 years) should involve self-assessment (e.g. multiple choice exam, or simulation with checklist).
- At their discretion, Member Boards may accept CME credits to meet Part 2 MOC requirements for lifelong learning and self-assessment modules developed by other organizations (e.g., ABMS Boards, medical societies or other healthcare organizations such as academic medical centers, hospitals, and other physician organizations).

Effective 2010, Member Boards will ensure that every diplomate enrolled in MOC will complete a patient safety self-assessment program (the ABMS Patient Safety Foundations or other equivalent program approved by COMMOC)¹⁰ by 2012 and then a minimum of once per MOC cycle. Member Boards will ensure that diplomates who register into MOC after 2010 complete a patient safety module in the first two years of the MOC cycle.

** This is a developmental standard to be piloted, tested for feasibility, and re-evaluated in no more than 5 years. Further definition of developmental standards pending*

⁹ The COMMOC standards are based on a review of the current CME requirements of the Member Boards and State Licensing Boards and efforts to coordinate with activities of Maintenance of Licensure. It is anticipated that many Member Boards will exceed the minimum requirements.
¹⁰ See attachment 2 for policy on equivalency standards for patient safety programs.

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Part 3: *Effective 2010, each Member Board will provide information regarding the exam (to be part of the annual report to COMMOC—see section on structural elements).*

- Reports number of diplomates who took Part 3 exam including pass rate (first time, overall)

Every 5 years (as part of in-depth review)

- Reports psychometric validity of exam(s)
 - Reports criteria for ensuring exam security
 - Member Boards with modular exams will describe the purpose and scope of each exam.
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Part 4:

By 2010, Member Boards will require diplomates to provide evidence of participation in practice assessment and quality improvement every two to five years.¹¹

- Boards should base their requirements on a complete cycle of initial assessment, improvement activity and re-assessment. Currently, the AMA PRA Category I Practice Improvement credits meet this criteria, provided all stages are completed.
- Evidence of participation in assessment of performance in practice and quality improvement includes Member Board approved:
 - Use of a registry with a learning collaborative¹², or
 - Completion of a self-administered module¹³, or
 - Verification through attestation of individual participation in a group quality measurement and improvement activity¹⁴, or

¹¹ The assessment schedule of every 2-5 years was put in place in this version of the Standards document in recognition of the current variation in Part 4 frequency requirements across Member Boards and the logistical burden of changing those requirements by 2010. However, in an effort to align with the national movement towards performance measurement, COMMOC recommends that future versions of the standards move toward an annual assessment of participation in practice assessment and quality improvement.

¹² For example, participation in the Society for Thoracic Surgeons' National Database <http://www.sts.org/sections/stsnationaldatabase/>

¹³ For example, participation in a Practice Improvement Module (PIM)-- <http://www.abim.org/pims/default.aspx>

¹⁴ For example, participation in Improving Performance in Practice (IPIP)

http://www.abms.org/about_abms/ABMS_Research/current.aspx

Boards to submit to COMMOC their standards for defining acceptable group QI activities as part of the in-depth review process every 5 years.

- 178 ○ Other activity judged to be of comparable value in practice assessment and
179 quality improvement.
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181 • Standards and criteria for Part 4 activities include:
182 ○ Each activity should include evidence of analysis of performance measures,
183 changing practice to improve quality measures and re-measurement to determine
184 the effect of a change in process or structure of care.
185 ○ Use nationally endorsed measures (e.g., those endorsed by the National Quality
186 Forum) whenever appropriate.
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190 **Overall:** *By 2010, each Member Board to annually report the number of diplomates enrolled in*
191 *MOC to COMMOC (report based on prior year activity)*
192 • Number of diplomates with time limited certificate (TLC) participating¹⁵ in
193 MOC
194 • Number of diplomates with lifetime certificate (LTC) participating in MOC
195 • Number of diplomates participating in Part 4 of MOC
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197 *By 2011, each Member Board to report on their standards to assess the six core*
198 *competencies (and how often each competency is assessed in the MOC cycle).¹⁶*
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200 *By 2011, each Member Board to report on their MOC policy for lapsed certificates.¹⁶*
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202 *By 2011, each Member Board to report on their strategy for increasing MOC*
203 *participation for lifetime certificate holders.*
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¹⁵ Participation is currently defined by Member Boards. COMMOC to develop standards to define “participation” by 2011.
¹⁶ Submit to COMMOC as part of in-depth review process every 5 years.

214 **GLOSSARY**

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216	AAFP	American Academy of Family Physicians
217	ABMS	American Board of Medical Specialties
218	ACOG	American College of Obstetricians and Gynecologists
219	AMA PRA	American Medical Association Physician Recognition Award
220	AOA	American Osteopathic Association
221	CAHPS	Consumer Assessment of Healthcare Providers and Systems
222	COMMOC	Committee on Oversight and Monitoring of MOC
223	CME	Continuing Medical Education
224	DANS	Disciplinary Alert Notification Service
225	IPIP	Improving Performance in Practice
226	LTC	Lifetime certificate
227	MOC	Maintenance of Certification
228	NQF	National Quality Forum
229	PIM	Practice Improvement Module
230	QI	Quality Improvement
231	TLC	Time-limited certificate

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234 **ATTACHMENT I**

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236 **Recommendations on clinical activity status** (as approved by the ABMS Board of
237 Directors on September 17, 2007)

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1. Clinically active status be redefined as any amount of direct and/or consultative patient care that has been provided in the preceeding 24 months.
2. Clinically inactive status be redefined as no direct and/or consultative patient care that has been provided in the past 24 months.
3. It should be the responsibility of the individual diplomate to inform the certifying board(s) of changes in clinical activity status that relate to any/all certificates held by that diplomate. The public should be informed that this information is self-reported. In addition, certifying boards should routinely, on a regular basis, query certificate holders about their clinical activity status. It is suggested that this be done on a frequency no greater than every 24 months. If information regarding clinical activity status cannot be determined, this should be so stated in public reporting.
4. With respect to reentry, those physicians who have been clinically inactive who wish to reacquire active certification status, must meet the reentry criteria established by their respective certifying boards.
5. With respect to public reporting, it may be appropriate to avoid the terms clinically active and clinically inactive by the use of a more straightforward statement such as: "Dr. X has reported that he or she is (or is not) currently engaged in patient care activities." This approach may e clearer to understand. Also, certificate holders who may be professionally active within the broad scope of their disciplines, but who are not engaged in direct and/or consultative care (eg, those involved in population health, researchers, certain preventive medicine specialists, etc.) may find the label "clinically inactive" unacceptable, but may accept a simple statement indicating whether they are or are not engaged in patient care.

268 **ATTACHMENT 2**

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270 **ABMS PATIENT SAFETY FOUNDATIONS PROGRAM:**
271 **STANDARDS FOR EQUIVALENT PROGRAMS**

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274 **COURSE REQUIREMENTS**

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276 **Equivalent programs will meet several criteria:**

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278 1. Identify key themes of patient safety that cut across disciplines and clinical settings. Key themes
279 shall include, but not be limited to, epidemiology of error, the effect of the system on patient
280 safety, human factors, safety enhancing technology, communication, culture of safety, and
281 methods and tools for evaluating safety events.

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283 2. Provide learners with a high quality content that is free of commercial bias and control of a
284 commercial interest as currently specified in the ACCME Standards for Commercial SupportSM
285 and meets accepted standards for reliability and validity.

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287 3. Present a curriculum that addresses each of the above noted key themes. The curriculum will
288 contain 3-5 learning objectives for each key theme as well as a pre and post-test to evaluate
289 learner progress.

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291 **TESTING**

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293 1. The curriculum will include pre-test(s) and post-test(s) of multiple choice questions drawn from
294 the curriculum content. The number of questions should adequately cover the content.

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296 2. Assessment methods must meet standards for self-evaluation in the field.

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298 3. Content in the curriculum must be completed prior to taking the post-test(s)

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300 4. A passing score of 80% is required in the post-test(s) to complete each section to complete the
301 course and earn *AMA PRA Category 1 credit*

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303 1. The curriculum covers the key themes identified above under Course Requirements.

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305 At a minimum, the following key themes must be incorporated into a program to be deemed
306 equivalent:

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308 **Epidemiology of error**

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310 Core concepts – the Epidemiology of error curriculum should prepare physicians to
311 discuss the key definitions that underpin current patient safety efforts (see key terms) as
312 well as the historical journey of the patient safety movement in the United States, in
313 particular the release of the IOM report, *To Err is Human*. Rates of errors and adverse
314 events should be discussed. The curriculum should include a discussion of the most
315 common types of errors and adverse events, including (1) communication problems, (2)
316 inadequate information flow, (3) human (or performance) problems, (4) patient-related
317 issues, (5) organizational transfer of knowledge, (6) staffing patterns/work flow, (7)
318 technical failures, (8) inadequate policies and procedures. A discussion of latent failures
319 vs. active failures should be included.

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Systems thinking and the affect of the system on patient safety

Core concepts – Physicians should be able to describe the system in which they provide care – the core elements of that system include the providers, patients, support staff, clinical processes, administrative processes, technology, and information that all come together to produce the care. The curriculum should also identify the multiple layers of the healthcare system – for example, the nation, the state, the hospital, the care giving unit -- that influence the ability to improve care. The curriculum should also address how a well performing system can prevent patient harm.

Human factors

Core concepts – Human factors is the study of the interrelationships between humans, the tools they use, and the environment in which they work. The curriculum should discuss specific human factor interventions to improve systems and processes such as simplifying and standardizing procedures, building in redundancy into the system, improving communication within healthcare teams, and redesigning equipment to improve the human-machine interaction.

Safety enhancing technology

Core concepts – The curriculum should address how technology can provide an effective means for preventing and mitigating the effect of some types of errors. The curriculum should also address how technology may have unintended consequences that actually lead to more errors or additional types of errors that weren't anticipated.

Communication

Core concepts – The curriculum on Communication will demonstrate how communication plays a role in achieving patient safety. Several barriers exist that may affect both the physician-nurse and the patient-practitioner communication including safety culture and the authority gradient. Transitions of patient care are a particularly vulnerable time for patients and the curriculum should address the specific transitions that are related to the discipline, including a specific strategy for conducting the transition of care. Disclosure of adverse events should be addressed specifically and should include the strategies for accomplishing the necessary steps in effective disclosure, including: (1) telling the patient and family what happened, (2) taking responsibility, (3) apologizing, and (4) explaining what will be done to prevent similar errors. The curriculum should include a discussion of the SBAR technique to facilitate communication between physicians and other members of the care team.

Culture of safety

Core concepts – The culture of safety curriculum should identify the specific elements – i.e., the beliefs, attitudes, and values about work, and risk that contribute to safety culture. The curriculum should identify the value of learning in creating and sustaining patient safety and recognize the relationship between reporting and learning. The program should make the distinction between errors resulting from deliberate unsafe acts and errors that are a result of system failures. In addition the curriculum should identify the detriments to patient safety from hierarchical gradients among members of the healthcare team.

- 368 Methods and tools for evaluating safety events
369 Core concepts – There are several common tools that are used to assess and evaluate
370 risk as well as adverse events. Methods that should be included in the curriculum
371 included: root cause analysis, failure modes effects analysis, and probable risk assessment.
372 In addition the tools to identify individual safety events and trends such as error
373 reporting systems and national reporting efforts should be discussed.
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376 2. A plan that clearly identifies the method by which the course content and materials will be
377 updated at least every three years
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380 KEY TERMS

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382 At a minimum, the following key terms must be incorporated into a program to be deemed
383 equivalent:
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- 385 • Active Error (or Active Failure)
- 386 • Adverse Drug Event (ADE)
- 387 • Adverse Drug Reaction
- 388 • Adverse Event
- 389 • Authority Gradient
- 390 • Blunt End
- 391 • Close Call
- 392 • Error
- 393 • Failure Mode and Effects Analysis (FMEA)
- 394 • Human Factors (or Human Factors Engineering)
- 395 • Latent Error (or Latent Condition)
- 396 • Medication Error
- 397 • Near Miss (also defined as close call)
- 398 • Patient Safety
- 399 • Potential ADE
- 400 • Root Cause Analysis
- 401 • Safety Culture
- 402 • Sharp End

403 REFERENCES

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405 The following reference is **required** for incorporation into an equivalent program:
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- 408 I. Institute of Medicine. *To Err is Human: Building a Safer Health System*. Washington:
409 National Academy Press; 1999.

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411 The following references are suggested for incorporation into an equivalent program:
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- 414 I. Brennan T, et al. Incidence of adverse events and negligence in hospitalized patients
415 of the Harvard Medical Practice Study I. *NEJM* 1991;324:370-376.

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