



American Board of Medical Specialties

Higher standards. Better care.®

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The Honorable Fred Upton
Chairman, Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Henry A. Waxman
Ranking Member, Energy and Commerce
Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Upton and Ranking Member Waxman:

The American Board of Medical Specialties (ABMS) appreciates this opportunity to contribute to the dialogue surrounding repeal of the physician sustainable growth rate (SGR). ABMS Member Boards are devoted to improving the quality of care provided to patients and facilitating continuous professional development by certified medical specialists. We share your goal of assuring that Medicare policies enable beneficiaries' timely access to high quality, affordable health care.

ABMS is a not-for-profit organization representing 24 Specialty Boards that certify the quality of physicians to practice in a medical specialty or subspecialty through initial medical specialty certification, usually achieved soon after a physician completes residency, and ABMS Maintenance of Certification (ABMS MOC®), a process that continues throughout the medical specialist's professional career.

ABMS MOC® is a system of specialty-specific assessment and professional development activities that require medical specialists to reflect on their practice performance, identify gaps, and adopt new practices to improve care. More than 800,000 licensed US physicians are certified by one of the 24 Boards, and more than half of these medical specialists participate in ABMS MOC® to maintain and deepen their knowledge, skills and professionalism in their medical specialty disciplines.

We appreciate your seeking broad input before taking action and believe our experience offers instructive, practical insight regarding performance assessment and physician engagement. Our comments emphasize three fundamental ideas:

1. Build on clinically meaningful, trusted and proven performance assessment strategies;
2. Keep the focus of reform efforts on improving patient care; and,
3. Foster physicians' intrinsic motivation, as medical professionals, to provide high quality patient-centered care.

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Identify Physician Cohorts that Reflect ABMS Recognized Medical Specialties and Subspecialties

Questions focusing on designation of physician cohorts correctly identify one of the most challenging aspects of measure development: the identification of evidence-based groupings that assure clinically homogenous, practice-relevant comparative measurement. ABMS appreciates recognition in the draft of the ABMS specialty designations as a starting point in the identification of physician cohorts. However, even within the 37 recognized areas of primary specialty practice certified by the 24 ABMS, practices can be quite heterogeneous. These groupings may still be too broad to assure clinically homogeneous cohorts.

ABMS recognizes 123 subspecialties, each of which is supported with an accredited training program, a body of knowledge specific to the sub-discipline and a sufficiently dense clinical practice to justify subspecialty designation.

We encourage the Committee to develop cohorts around the ABMS primary and subspecialty designations. Although it might seem a large number of cohorts, the existing parallel structure of training and assessment programs makes these designations operationally feasible and clinically meaningful.

Base Performance Assessment on the ACGME/ABMS

ABMS appreciates recognition of the ABMS/ACGME (Accreditation Council of Graduate Medical Education) competency domains as a framework for understanding good medical practice (Professionalism; Medical Knowledge; Patient care and technical skills; Interpersonal and communication skills; Lifelong learning and Improvement; System-based practice).

The competency framework, adopted 14 years ago by the ABMS and the ACGME, is integrated into the training and continuous professional development of physicians throughout their careers by our organizations. The six “domains” of competency are fundamental to ACGME residency program requirements and to ABMS MOC® standards. The American Osteopathic Association (AOA) has adopted a parallel set of competencies for Doctors of Osteopathy (DO). The competency domains also frame the Joint Commission’s standards for medical staff assessment and privileging (Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation).

The competency domains encompass performance issues important to patients and essential to quality care. They are consistent with and map to the priorities of the National Quality Strategy and Meaningful Use domains, including patient engagement, safety, care coordination and patient care management, clinical appropriateness and effectiveness, and efficient use of health care resources. Issues of patient experience and patient and family engagement are addressed in the context of the “Interpersonal and Communication Skills.” Issues related to teamwork, transition management, and care coordination are addressed in this domain and in the “System-based Practice” domain. The competency framework is flexible and aligns well with federal quality goals.

Taken together, these six domains are more descriptive of what physicians actually do – and what they are asked to improve throughout their clinical careers – than the discrete performance measures currently in use, which tend to focus on a single domain of patient care and technical skill.

Recognize ABMS MOC® as a Performance Measure

The ABMS Member Boards are committed to raising standards and improving care. Use of ABMS MOC® as a value metric will avoid placing additional administrative burdens on physicians already participating in professional development activities, help to assure that there are practice-relevant options for all specialties and tie quality measurement to a disciplined improvement process. Alignment of federal quality programs with ABMS MOC® has been advocated by the Centers for Medicare and Medicaid Services (CMS), the Measures Application Partnership (MAP), and the National Quality Forum (NQF).¹

Moreover, Sec. 1848(k) (4) of the Social Security Act, as amended by Section 3002(c)(3) of the Affordable Care Act, authorizes HHS to incorporate “participation in a Maintenance of Certification Program and successful completion of a qualified Maintenance of Certification Program practice assessment” both to satisfy PQRS reporting and for use in computing the value-based payment modifier. This should be retained; ABMS is working closely with the CMS to better align with PQRS and facilitate participation across the specialties.

ABMS MOC® Member Board programs lend themselves to several measures:

- 1) Certification;
- 2) Completion of all the professional development activities defined by the certifying boards to maintain certification;
- 3) Completion of a practice performance assessment that includes a performance improvement project;
- 4) As determined through the practice performance project show either
 - a. that performance is consistent with professional norms or
 - b. that care practices have improved

We recommend that ABMS MOC® serve as a reporting pathway in the future for more detailed data on performance across the competencies. Making it possible to report through MOC will reduce administrative burden on physicians participating in voluntary professional development activities, will help to assure that there are practice-relevant options for all specialties and that quality measurement will be tied to a disciplined improvement process.

¹ Measurement Applications Partnership. Coordination Strategy for Clinician Performance Measurement. Final Report. October 2011. See also, Conway, P. and Cassel, C. Engaging physicians and leveraging professionalism: A key to success for quality measurement and improvement. JAMA, September 12, 2012— Vol. 308, No. 10 979-980.

Phase implementation to develop practice-relevant measures and build a supporting quality infrastructure

Measures do not exist today for most specialties and subspecialties. The MAP identified significant gaps in measures, with respect to both specialties and competencies. A period of measure development will be necessary. Even with new, rapid cycle development methods that are now being explored, we will not likely have sufficient measures for three to five years. We suggest that the program be phased to allow for engagement at different levels depending on the maturity of measurement and improvement for the discipline: participation in an improvement activity, reporting data, achievement of a clinical standard, and demonstration of improvement.

Integrate existing federal quality reporting mechanisms and align with private sector assessment programs

SGR reform offers an opportunity to align PQRS, the EHR incentive program, and the Value-based modifier programs strategically and operationally. Measures used in public programs should support the NQS strategy and should be aligned with quality improvement activity in the private sector. Service provision in public programs is almost exclusively through the private sector, and it is vital to send consistent signals through the system about improvement priorities.

Alignment is critical to reducing administrative burden on all health care providers because it frees up doctors to focus on patient care not on collecting and reporting near-identical measures. It also can accelerate progress because it focuses attention on a selected group of improvement targets.

The existing mechanism for achieving this alignment is through the National Quality Forum. ABMS participates with other stakeholders across the public and private sectors in a “National Priorities Partnership” (NPP) convened by the National Quality Forum to develop a common framework for improving the performance of the health system. The priorities identified by the NPP are consistent with the National Quality Strategy (NQS) and are helping to coordinate measurement activity at every level.

Context-and practice-relevant assessment

Current measure sets and measurement priorities focus on the provision of primary care, particularly chronic care. We recognize that these are priorities for the Medicare program and encompass about half of the care provided to beneficiaries each year. Nevertheless, we believe it is important to recognize the diversity of practice across the 24 specialty areas, and the role of all specialties in caring for Medicare beneficiaries. This diversity of practice requires diversity in assessment.

The ABMS Boards’ standards for ABMS MOC® respect this diversity while maintaining a common performance improvement model. ABMS Member Board programs encourage assessment approaches most appropriate to each discipline’s clinical practices:

- Use of a registry with a learning collaborative (which best serves interventional specialties, like the registry maintained by the Society for Thoracic Surgeons)

- Self-administered clinical evaluation modules (a method for abstracting data from medical records on key metrics related to the treatment of specific conditions, which best serves the medical specialties)
- Verified attestation of participation in a group quality measurement and improvement activity (which best serves the hospital-based specialties);
- Simulations (which best serves to assess technical and procedural skills)

Although the approaches to measurement may differ, the basic structure is the same across all the boards: a measure-intervention-measure cycle with feedback and opportunity for reflection and improvement. The identification of performance gaps is followed by additional education or some form of system practice change that is expected to improve capabilities or improve actual performance.

This diversity presents some operational challenges. However, the ABMS Member Board experience demonstrates that it is possible to create a universal assessment program with enough flexibility to allow for important differences in assessment approaches. We believe this approach yields better physician engagement and more improvement in practice.

Measures must be fit for purpose

We need high quality measures in all the specialties if performance-based reimbursement is going to improve care. Certainly, all measures used in public programs need to meet rigorous criteria: They must be important to physicians, patients, and other affected stakeholders; evidence based; shown through testing to be valid and reliable; be feasible to collect and report; and demonstrate through use that they are actionable to change practices and improve care.

However, measurement needs differ for different purposes.

Measures used in public programs also must be “fit for purpose” – measures that are aligned with national quality priorities and that are themselves designed to work through public incentive and accountability programs to achieve national quality goals. When it comes to the selection of measures that will be used in public programs, broad public input is necessary.

Codified in existing federal statute, some form of multi-stakeholder input should continue to be supported in future legislation. Multi-stakeholder input fosters consensus about what elements of performance should be the target of public programs. This is essential to getting to a targeted set of quality, experience and efficiency measures to support health system improvement.

The MAP represents a range of stakeholders to help identify the fitness of measures for use in public programs. The MAP has done more than recommend measures: it has clarified the criteria for selecting measures for use in different programs, developed comprehensive measurement frameworks that describe what good clinical practices entail, clarified how measures align vertically through the health system, and identified measure gaps with priorities for measure development.

Foster a “learning system” of measure evaluation and improvement

As practice and clinical guidelines change, the medical specialty societies and certifying boards are in the best position to determine whether measures need to be reevaluated. The NQF has also established guidelines for reviewing measures to ascertain whether the measures need to be revisited in light of current practice and we are working with them in that effort.

A more empirical approach to the evaluation of measures to determine how well they perform in practice – how discriminating they are with respect to performance differences and how useful they are with respect to improving care – is also needed. The National Quality Forum now recommends feedback from clinicians using measures to improve care to provide an empirical basis for evaluating the performance of measures and their utility for improving care. We believe that putting measures to use in ABMS MOC® could create the opportunity to collect just this kind of ongoing empirical testing to improve the measurement process itself.

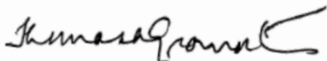
Protect source data from discoverability

Finally, as we have suggested previously, the ABMS Member Boards need legal protection from discovery for sensitive quality data that certifying and accrediting organizations may collect to support professional assessment and development. Currently, these organizations are not eligible for the protections afforded to “Patient Safety Organizations” under current law if they might respond to observed quality issues revealed by the data. Protecting data submitted to the Boards will encourage physicians to participate in and openly share their practice data through voluntary quality improvement activities like ABMS MOC®. We ask that you specifically protect this activity.

As the Committee considers measurement and rewards, we encourage it to build upon the assessment and improvement activities that already accepted by physicians and integrated with their training, education, and professional development. We believe that certification and ABMS MOC® are foundational to physician quality and should be foundational to any future system that seeks to encourage professional development and quality improvement.

We look forward to working with you further as you develop the reform proposal and would be pleased to provide additional information about the certification process and answer any questions you might have.

Sincerely,



Tom Granatir
Senior Vice-President, Health Policy and Strategic Partnerships

cc: Lois Margaret Nora, MD, JD, MBA
President and Chief Executive Officer
American Board of Medical Specialties