Maintenance of Certification 2009 Update
Maintenance of Certification 2009 Update

- Martin Luchtefeld M.D.
- Disclosures: none
Maintenance of Certification (MOC)

- A process designed to document that physician specialists, certified by one of the Member Boards of ABMS, maintain the necessary competencies to provide quality patient care.
Who put us in this position?
How did we get here?
What exactly are we doing?
Maintenance of Certification (MOC)

- A process designed to document that physician specialists, certified by one of the Member Boards of ABMS, maintain the necessary competencies to provide quality patient care.
The American Board of Medical Specialties (ABMS), a not-for-profit organization comprising 24 medical specialty boards, is the pre-eminent entity overseeing physician certification in the United States. For more than 70 years, ABMS’ mission has been to maintain and improve the quality of medical care by assisting its Member Boards in developing and implementing educational and professional standards to evaluate and certify physician specialists. Through its coordination of Member Board activities, ABMS also serves as a unique healthcare industry influencer, bringing focus to issues involving specialization and certification in medicine. ABMS is recognized by the key healthcare accreditation organizations as a primary equivalent source of board certification data on medical specialists for credentialing purposes.
Who put us in this position?
How did we get here?
What exactly are we doing?
MOC History

- March 1998 - Task force on Competence
- September 1999 - Description of Competent Physician
- March 2000 - Member Board Commitment to MOC
- March 2002 - Four Components of MOC
- September 2003 - Board of Directors and ABMS commit to MOC
- March 2009 - ABMS Board of Directors approves MOC Standards
Six (Seven?) Core Competencies

- Medical knowledge
- Patient care
- Interpersonal and communication skills
- Professionalism
- Practice-based learning and improvement
- Systems-based practice
- Procedural/technical skills?
Six (Seven) Core Competencies
- Medical knowledge
- Patient care
- Interpersonal and communication skills
- Professionalism
- Practice-based learning and improvement
- Systems-based practice
- Procedural/technical skills

MOC Four Components
- Professional standing
- Lifelong learning and self-assessment
- Cognitive expertise
- Evaluation of Performance in Practice
How did we get here?
Who put us in this position?
What exactly are we doing?
MOC

- **Professional standing (Every 5 years)**
  - Full unrestricted license
  - Hospital privileges for colon/rectal surgery
  - Recommendations from the chief of staff
- **Lifelong learning and self-assessment**
- **Cognitive expertise**
- **Evaluation of Performance in Practice**
MOC

- Professional standing (Every 5 years)
- Lifelong learning and self-assessment (Every 5 years)
  - 150 hours Category 1 CME credit (which can include CARSEP)
  - CARSEP
  - Patient safety self-assessment module every MOC cycle
    - ABMS Patient Safety Foundations program or a COMMOC-approved alternative (developmental standard)
- Cognitive expertise
- Evaluation of Performance in Practice
MOC

- Professional standing (Every 5 years)
- Lifelong learning and self-assessment (Every 5 years)
- Cognitive expertise (Every 10 years)
  - MOC Cognitive Exam
- Evaluation of Performance in Practice
MOC

- Professional standing (Every 5 years)
- Lifelong learning and self-assessment (Every 5 years)
- Cognitive expertise (Every 10 years)
- Evaluation of Performance in Practice (Every 5 years)
Part IV-Practice Performance Assessment

They are evaluated in their clinical practice according to specialty-specific standards for patient care. They are asked to demonstrate that they can assess the quality of care they provide compared to peers and national benchmarks and then apply the best evidence or consensus recommendations to improve that care using follow-up assessments.
• Evaluation of Performance in Practice
  ■ Communications and interpersonal skills
  ■ Clinical practice data
• Evaluation of Performance in Practice
  ■ Communications and interpersonal skills (in evolution) [developmental standard]
    ● Patient survey
      ■ CAHPS (Consumer Assessment of Healthcare Providers and Systems)
      ■ ABMS Communications Assessment Tool
      ■ ACS survey instrument
      ■ Other validated patient surveys
    ● Peer survey?
  ■ Clinical practice data
Evaluation of Performance in Practice
- Communications and interpersonal skills
- Clinical practice data
  - NSQIP
  - SCIP
  - Practice-based learning system (ACS case log)
Evaluation of Performance in Practice
- Communications and interpersonal skills
- Clinical practice data
  - NSQIP
  - SCIP
  - Practice-based learning system (ACS case log)
• Evaluation of Performance in Practice
  ■ Communications and interpersonal skills
  ■ Clinical practice data
    ● NSQIP
    ● SCIP
    ● Practice-based learning system (ACS case log)
Evaluation of Performance in Practice
- Communications and interpersonal skills
- Clinical practice data
  - NSQIP
  - SCIP
  - Practice-based learning system (ACS case log)
    and maybe an ABMS Surgical Registry
There *is* some good news!

- Reciprocity
  - If you are doing ABS MOC already...all you need to do is CARSEP (q5 years) and MOC cognitive test (q10 years)
ABMS Board of Directors approved new standards for all participating Boards MOC programs - March 2009
ABMS new standards for MOC include two developmental standards

- Communications and interpersonal skills (in evolution)
  - Patient survey
    - CAHPS (Consumer Assessment of Healthcare Providers and Systems)
    - ABMS Communications Assessment Tool
    - ACS survey instrument
    - Other validated patient surveys
  - Peer survey?
- Patient safety self-assessment module every MOC cycle
  - ABMS Patient Safety Foundations program or a COMMOC-approved alternative
• MOC Survey done by e-mail 3/2009
• 272 respondents out of 1307 diplomates
  ■ 25% University setting
  ■ 63% private practice
  ■ 2% military
  ■ 10% other
## MOC Survey

How familiar are you with the components of MOC?

<table>
<thead>
<tr>
<th>Component</th>
<th>Very</th>
<th>Reasonably</th>
<th>No idea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional standing</td>
<td>79 (29%)</td>
<td>118 (44%)</td>
<td>73 (27%)</td>
</tr>
<tr>
<td>Life-long learning</td>
<td>83 (31%)</td>
<td>128 (47%)</td>
<td>60 (22%)</td>
</tr>
<tr>
<td>Cognitive expertise</td>
<td>76 (28%)</td>
<td>121 (45%)</td>
<td>74 (27%)</td>
</tr>
<tr>
<td>Performance in Practice</td>
<td>69 (26%)</td>
<td>118 (44%)</td>
<td>82 (30%)</td>
</tr>
<tr>
<td>How familiar are you with the components of MOC?</td>
<td>Very</td>
<td>Reasonably</td>
<td>No idea</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------------</td>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>Professional standing</td>
<td>79 (29%)</td>
<td>118 (44%)</td>
<td>73 (27%)</td>
</tr>
<tr>
<td>Life-long learning</td>
<td>83 (31%)</td>
<td>128 (47%)</td>
<td>60 (22%)</td>
</tr>
<tr>
<td>Cognitive expertise</td>
<td>76 (28%)</td>
<td>121 (45%)</td>
<td>74 (27%)</td>
</tr>
<tr>
<td>Performance in Practice</td>
<td>69 (26%)</td>
<td>118 (44%)</td>
<td>82 (30%)</td>
</tr>
</tbody>
</table>
### How familiar are you with the components of MOC?

<table>
<thead>
<tr>
<th>Component</th>
<th>Very</th>
<th>Reasonably</th>
<th>No idea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional standing</td>
<td>79 (29%)</td>
<td>118 (44%)</td>
<td>73 (27%)</td>
</tr>
<tr>
<td>Life-long learning</td>
<td>83 (31%)</td>
<td>128 (47%)</td>
<td>60 (22%)</td>
</tr>
<tr>
<td>Cognitive expertise</td>
<td>76 (28%)</td>
<td>121 (45%)</td>
<td>74 (27%)</td>
</tr>
<tr>
<td>Performance in Practice</td>
<td>69 (26%)</td>
<td>118 (44%)</td>
<td>82 (30%)</td>
</tr>
</tbody>
</table>
## MOC Survey

How familiar are you with the components of MOC?

<table>
<thead>
<tr>
<th>Component</th>
<th>Very</th>
<th>Reasonably</th>
<th>No idea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional standing</td>
<td>79 (29%)</td>
<td>118 (44%)</td>
<td>73 (27%)</td>
</tr>
<tr>
<td>Life-long learning</td>
<td>83 (31%)</td>
<td>128 (47%)</td>
<td>60 (22%)</td>
</tr>
<tr>
<td>Cognitive expertise</td>
<td>76 (28%)</td>
<td>121 (45%)</td>
<td>74 (27%)</td>
</tr>
<tr>
<td>Performance in Practice</td>
<td>69 (26%)</td>
<td>118 (44%)</td>
<td>82 (30%)</td>
</tr>
<tr>
<td>What would be most useful for Part IV?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in NSQIP</td>
<td>108 (41%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in SCIP</td>
<td>94 (36%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in PQRI</td>
<td>63 (24%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in ACS Case Log</td>
<td>85 (32%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No idea</td>
<td>97 (37%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MOC Update

- What now?
There *is* some good news!
Evaluation of Performance in Practice

- “CMS as a Public Health Agency”
  - $600 billion budget
  - 40 million lives
    - Barry Straube, MD
    - Chief Medical Officer of CMS
The Imperative for Quality & Efficiency:
CMS as a Public Health Agency
Pay-for-Performance

Barry M. Straube, M.D.
Centers for Medicare & Medicaid Services
Alliance for Health Reform/RWJF
Congressional Staff Briefing
May 12, 2006
CMS as a Public Health Agency

- Using CMS influence and financial leverage, in partnership with other healthcare stakeholders, to transform American healthcare system
- Focusing on not just Medicare & Medicaid, but also Commercial, uninsured, etc.
- Quality, Value, Efficiency, Cost-effectiveness
- Person-centeredness
- Assisting patients and providers in receiving evidence-based, technologically-advanced care while reducing avoidable complications & unnecessary costs
Measuring Performance

- Proposed time-table
  - 2006 Voluntary
  - 2007 Pay for reporting
  - 2008 Pay for quality
  - 2009 Pay for efficiency
    - Barry Straube, MD
    - Chief Medical Officer, CMS
SPECIAL SECTION: CONNECTING QUALITY TO COMPENSATION

813
Introduction: The rise of translational outcomes research
Andrew L. Warshaw, MD, David R. Flum, MD, MPH,
Michael G. Sarr, MD, and Carlos A. Pellegrini, MD,
Boston, Mass, Seattle, Wash, and Rochester, Minn

815
Partnering with payers to improve surgical quality: The Michigan plan
Nancy J. O. Birkmeyer, PhD, David Share, MD, MPH,
Darrell A. Campbell Jr, MD, Richard L. Prager, MD,
Mauro Mosucci, MD, and John D. Birkmeyer, MD,
Ann Arbor and Detroit, Mich

820
Invited commentary: The Michigan Plan—Is this a true partnership?
L. D. Britt, MD, MPH, Norfolk, Va

821
Washington State’s approach to variability in surgical processes/Outcomes Surgical Clinical Outcomes Assessment Program (SCOAP)
David R. Flum, MD, MPH, Nancy Fisher, MD, MPH,
Jeffery Thompson, MD, MPH, Miriam Marcus-Smith, RN,
MHA, Michael Florence, MD, and Carlos A. Pellegrini, MD,
Seattle, Washington

829
Surgeon compensation: “Pay for performance,” the American College of Surgeons National Surgical Quality Improvement Program, the Surgical Care Improvement Program, and other considerations
R. Scott Jones, MD, FACS, Cynthia Brown, and
Frank Opelka, MD, FACS, Charlottesville, Va, Chicago, Ill,
Washington, DC, and New Orleans, La

837
The NSQIP: A new frontier in surgery
Shukri F. Khuri, MD, Boston, Mass
Evaluation of Performance in Practice

- Communications and interpersonal skills
- Clinical practice data
  - ACS NSQIP: American College of Surgeons National Surgical Quality Improvement Program
    - Well-proven
    - Not in wide use yet
Evaluation of Performance in Practice

- Communications and interpersonal skills
- Clinical practice data
  - ACS NSQIP
  - SCIP: Surgical Care Improvement Program
    - Not in wide use yet
MOC- Where are we?

- Professional standing (Every 5 years) [approved]
- Lifelong learning and self-assessment (Every 5 years) [approved]
- Cognitive expertise (Every 10 years) [approved]
- Evaluation of Performance in Practice (Every 5 years) [reviewed by ABMS-negotiations continue!]
- Start date: 2007
Last bit of good news...
National Health Spending in Billions

Note: Selected rather than continuous years of data are shown prior to 2002. Years 2005 forward are CMS projections. Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.
Historic Payment Sources

Notes: Chart reflects national health expenditures (NHE) by source of funds. Some years don’t add to 100 percent due to rounding.
Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.
### Table 3.6
Number of Medicare Beneficiaries, 1970-2030

The number of people Medicare serves will nearly double by 2030.

*Numbers may not sum due to rounding.

**Source:** CMS, Office of the Actuary.

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Disabled &amp; ESRD</th>
<th>Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>20.4</td>
<td>28.4*</td>
</tr>
<tr>
<td>1980</td>
<td>25.5</td>
<td>34.3</td>
</tr>
<tr>
<td>1990</td>
<td>31.0</td>
<td>39.6*</td>
</tr>
<tr>
<td>2000</td>
<td>34.1</td>
<td>45.9</td>
</tr>
<tr>
<td>2010</td>
<td>45.9</td>
<td>52.2</td>
</tr>
<tr>
<td>2020</td>
<td>61.0*</td>
<td></td>
</tr>
<tr>
<td>2030</td>
<td>76.8</td>
<td>8.6</td>
</tr>
</tbody>
</table>

* Medicare Enrollment (millions)
Percent of gross domestic product (GDP) spent on health care, 2002

United States: 14.6%
Germany: 10.9%
France: 9.7%
Canada: 9.6%
Australia (2001): 9.1%
OECD Median: 8.5%
New Zealand: 8.5%
Japan (2001): 7.8%
United Kingdom: 7.7%

National Health Spending as a Share of Gross Domestic Product

1960: 5.2%
1970: 7.2%
1980: 9.1%
1990: 12.4%
2000: 13.9%
2002: 15.4%
2003: 15.0%
2004: 16.0%
2005P: 16.2%
2006P: 16.6%
2015P: 20.0%

Note: Data is for calendar years except 2015, which is a projection. Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary.
**A Variation Problem**

Map 2.5. Inpatient Hospital Services per Medicare Enrollee by Hospital Referral Region (1995)

- $2516 to 3723 (61)
- 2321 to < 2516 (60)
- 2117 to < 2321 (61)
- 1893 to < 2117 (62)
- 1483 to < 1893 (62)
- Not Populated
Performance on Medicare Quality Indicators, 2000–2001

Quartile Rank
- First
- Second
- Third
- Fourth

The Healthcare Quality Challenge

- We spend more per capita on healthcare than any other country in the world.
- In spite of those expenditures, US Healthcare quality is often inferior to other nations and often doesn’t meet expected evidence-based guidelines.
- There are significant variations in quality and costs across the nation.
- CMS is responsible for the healthcare of a growing number of persons.
- CMS, in partnership and collaboration with other healthcare leaders, must demonstrate leadership in addressing these issues.
CMS Quality Roadmap

- **VISION:** The right care for every person every time
  - Make care:
    - Safe
    - Effective
    - Efficient
    - Patient-centered
    - Timely
    - Equitable
CMS Quality Roadmap: Strategies

1. Work through partnerships to achieve specific quality goals
2. Publish quality measurements and information as a basis for supporting more effective quality improvement efforts
3. Pay in a way that expresses our commitment to quality, and that helps providers and patients to take steps to improve health and avoid unnecessary costs
CMS Quality Roadmap: Strategies for QI

4. Assist practitioners in making care more effective and less costly, especially by promoting the adoption of HIT

5. Bring effective new treatments to patients more rapidly and help develop better evidence so that doctors and patients can use medical technologies and treatments more effectively, improve quality and avoid unnecessary complications and costs
CMS Quality Initiatives

- Hospitals
- Nursing Homes
- Home Health Agencies
- Dialysis Facilities
- Physician Offices
- More to come
CMS Quality Initiatives

- Broad Quality Alliances
  - Hospital Quality Alliance
  - Ambulatory Care Quality Alliance
  - Pharmacy, ESRD, Cancer Quality Alliances with more emerging

- Quality data
  - Collection
  - Aggregation
  - Reporting

- Linking payment to quality and efficiency
CMS Incentive Payment Initiatives

- Hospital Quality Initiative
- Premier Hospital Quality Incentive Demo
- Physician Voluntary Reporting Program (PVRP)
- Medicare Health Support Program
- Medicare Care Management Performance Demo
- High Cost Beneficiary Program
- Section 646 and Section 649 demos
- Gainsharing demonstration
- Post-acute care payment reform demo
CMS Incentive Payment Initiatives

- Development and implementation of standard performance measures in every setting
- Efficiency measures analysis and development
- P4P Initiatives being developed in all settings
- AQA Pilots on shared data aggregation and reporting
- Expansion of AQA pilots to include:
  - Focus on Efficiency
  - Hospital pilots
  - Transparency
  - Consumer choice, responsibility, empowerment
Common Quality Themes

- Physician-Patient partnership
- Benefits of group practice and systems integration
- Efficiency & value through coordinated care, systems improvement, health information technology, etc.
- Management of chronic illness
- Benefits of prevention
- Use of evidence-based medicine
- Focus on care across the continuum
- Transparency in the health care system
Congressional & Payment Reform

- Many opportunities for improving the quality of healthcare services, outcomes and efficiency
- Increasing reimbursement for healthcare services leads to:
  - No uniform or widespread improvement in quality
  - Increased utilization of some services
  - Net increase in overall healthcare expenditures
- Congress looking to CMS and healthcare providers to demonstrate ability to improve quality, avoid unnecessary complications and costs
  - Overall Medicare payment reform contingent linked
CMS P4P: Paths on the Roadmap

- Hospital Quality Initiative & the Hospital Quality Alliance
- Premier Hospital Demonstration
- Physician Voluntary Reporting Program
- Multiple Demonstrations
Components of Hospital Quality Initiative

- National Voluntary Hospital Reporting Initiative (NVHRI) public-private initiative
  - Federation of American Hospitals
  - AHA
  - AAMC
  - CMS, JCAHO, others
- Hospital Quality Alliance
Hospital Quality Measures

**Acute Myocardial Infarction**
- ASA at arrival
- ASA at discharge
- Beta Blocker at arrival
- Beta Blocker at DC
- ACE inhibitor for LV systolic dysfunction

**Heart Failure**
- LV function assess
- ACE inhibitor for LV systolic dysfunction

**Pneumonia**
- Initial antibiotic timing
- Pneumococcal vaccination
- Oxygenation assessment
Premier Hospital Quality Demonstration

- 260 participating hospitals
- 34 Quality Metrics
  - Acute myocardial infarction (9)
  - Coronary artery bypass graft (8)
  - Heart failure (4)
  - Community acquired pneumonia (7)
  - Hip and knee replacement (6)
Premier Demonstration

- Hospital scores
  - “Rolling up” individual measures into one score for each disease category
  - Each disease category will be categorized by hospital scores by decile
- Public reporting of all data available
- Financial awards
  - Hospitals in top 20% will be given bonuses: 2% for top decile, 1% for second decile
  - Cost of bonuses will be $7 million per year, $21 million over three years
Premier Demonstration

- Improvement over baseline
  - Hospitals that do not improve over demonstration baseline will have adjusted payments
  - Demonstration baseline cut-off will be at level of the 9th and 10th deciles of base year
  - Hospitals below baseline 9th decile will have 1% reduction in DRG reimbursement
  - Hospitals below baseline 10th decile will have 2% reduction in DRG reimbursement
Premier Hospital Demo: Results

- $8.85 million paid in first year
  - AMI – $1.756 million to 49 hospitals
  - CHF – $1.818 million to 57 hospitals
  - Pneumonia – $1.139 million to 52 hospitals
  - CABG – $2.078 million to 27 hospitals
  - Hip & Knee Replacement – $2.061 million to 43 hospitals
- 49 out of 260 participating hospitals received bonuses
- 39 out of 260 have < 100 beds, several with awards
- All five clinical quality areas demonstrably improved
Premier Hospital Results

- Two hospitals in top two deciles for all 5 conditions
  - Hackensack University Hospital, NJ
  - McLeod Regional Medical Center, SC
  - Fairview Lakes Medical Center, MN in 3/5

- Individual category top performers
  - AMI – Fairview Lakes Medical Center, MN
  - CHF – Lourdes Hospital, KY
  - Pneumonia – St. Francis Hospital, Broken Arrow, OK
  - CABG – Greenville Hospital, SC
  - Hip & Knee – Bone & Joint Hospital, Oklahoma City
Wide variation in resource use raises question of whether Medicare is getting good value in all areas.

CMS supports and is implementing MedPAC’s March recommendation to Congress that:

“The Secretary should use Medicare claims data to measure fee-for-service physicians’ resource use and share results with physicians confidentially to educate them about how they compare with aggregated peer performance.”
PVRP: The Message

- **Voluntary**
- An interim step to more sophisticated systems using EHRs, outcomes and efficiency measures
- Allows physicians and CMS to test various collecting and reporting methods together, getting things correct for eventual P4P
- Allows physician offices to gain experience in data reporting prior to initiation of P4P
- Demonstrates to Congress physician and CMS commitment to measure and improve quality
Physician Voluntary Reporting Program (PVRP)

- Program implementation began January 2006
- G-code submission for relevant measures
- Distilled down to a starter set of 16 measures
- Need for progressive additional measures development
- Burden being scrutinized and addressed
- CMS will calculate results
- Feedback to clinicians as early as Summer 2006
- No public reporting, anonymous QI focus only
**PVRP Measures**

- ASA arrival AMI
- Beta blocker
  - Arrival AMI
  - Prior MI
- Antibiotic timing for pneumonia
- Control in DM
  - HbA1c
  - LDL
  - Blood pressure
- LVSD
  - ACEI or ARB
  - Beta blocker
- CAD
  - Anti-platelet therapy
  - LDL control
- Osteoporosis screening in elderly women
PVRP Measures

- Screening
  - Falls in elderly
- ESRD
  - Dialysis adequacy
  - Anemia control
  - AV fistula use
- Antidepressant medication in acute phase depression

- Surgical patient
  - Antibiotic prophylaxis
  - Thromboembolism prophylaxis

- CABG
  - Internal mammary artery
  - Pre-op beta blocker
Physician P4P: A Potential Timeline

- 2006: Voluntary reporting and performance feedback
- 2007: Pay-for-reporting and test-run P4P
- 2008: P4P for quality
- 2009: P4P for efficiency
- Timetable not fixed
  - Congressional actions would modify
Deficit Reduction Act of 2005

- Medicare Part A
  - Hospital Value-based purchasing plan
  - Demonstration projects in gainsharing
  - Post-acute care payment reform demonstration project
  - Hospital quality reporting

- Medicare Part A and Part B
  - Home Health Agency quality reporting

- Prelude to wider P4P nationally?
Contact Information

Barry M. Straube, M.D.
CMS Chief Medical Officer
Director, Office of Clinical Standards & Quality
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD  21244

Email: Barry.Straube@cms.hhs.gov
Phone: (410) 786-6841