ABEM: MOC, LLSA, APP – Enough! Just Tell Me How to Stay Certified

Currently, there is both confusion and anxiety regarding ABEM’s Maintenance of Certification (MOC) program. The speaker, an ABEM director, will explain how to successfully complete the four components of MOC. Attendees will also learn how to earn CME for completing the LLSA readings and exams, and about obtaining CME for the successful completion of the ConCert exam.

- At the conclusion of the course, the attendee will understand the four components of maintenance of certification (MOC) required by the American Board of Emergency Medicine (ABEM).
- At the conclusion of the course, the attendee will understand the process for obtaining CME credit available through ABEM’s MOC program.

WE-259
10/10/12
5:00 PM - 6:00 PM

Colorado Convention Center
Room: 401

(+)No significant financial relationships to disclose
Goals
- Understand why MOC exists
- Understand research and rational that supports MOC (emphasis; requested by diplomates)
- Understand the design of the ABEM MOC program
- Understand meeting the requirements of the ABEM MOC program

Introduction
- Board certification first proposed in 1908 by the President of the American Academy of Ophthalmology and Otolaryngology.
- Public had no easy way to be assured that physicians who claimed expertise as specialists were qualified
- Led to the first specialty board, Ophthalmology (1916)
- Ophthalmology, Otolaryngology, Obstetrics-Gynecology, and Dermatology formed the Advisory Board for Medical Specialties (1933)
- Later named the American Board of Medical Specialties (ABMS) in 1970

Purposes of Board Certification
- To assure the public that physicians are qualified to practice medicine in the specialties they claim.
- Used examinations as a means to ascertain whether or not a physician had the necessary knowledge and skills worthy of board recognition.
- All early boards granted lifetime certification
- Later boards (e.g., Family Medicine / Emergency Medicine) incorporated recertification processes from the outset

History of MOC
- MOC is a logical evolution in board certification
- Board Certification legitimized EM in the House of Medicine
- MOC legitimizes a medical specialist in the eyes of the public

MOC Development
- MOC developed in parallel with quality movement
- The considerable variations in medical practice, cost, access, and outcomes.[1-5]
- The IOM Reports: To Err Is Human and Crossing the Quality Chasm [6, 7]
- An enhanced desire by the public and health care providers to improve patient safety evolved
  - 91% of public believe board certification is important*
  - Board certification ranks #2 among factors determining choice of physician*
  - 95% of public believe their doctor’s participation in MOC is important*
Enter the ABMS
- The oversight organization for 24 medical specialty boards
- Nearly 800,000 physicians are board certified by an ABMS Member Board
- Defines standards for certification and specialty recognition
- All medical specialty boards are accountable to the ABMS, including ABEM
- Not all specialties as active in quality movement as EM

Government Engagement
- CMS – PQRS
- HHS Office of National Coordinator of Information Technology
- FSMB, NBME – MOL (Maintenance of Licensure)
- CMS Episode Grouper Project

The ABMS and MOC
- ABMS introduced MOC in 2000
- I: Professional Standing (licensure)
- II: LLSA (Life Long Learning and Self-Assessment): knowledge acquisition
- III: Cognitive Expertise examination (ConCert): assesses fundamental knowledge
- IV: Assessment of Practice Performance (APP): QI activity
- Over 375,000 physicians currently participate in ABMS MOC program*
  - Nearly 20% increase over previous year

ABEM MOC and ABMS
- Pursuant to ABMS mandate, ABEM developed its MOC program in 2004 (EMCC)
- Committee on Oversight and Monitoring of Maintenance of Certification (COMMOC)
  - Receives and reviews reports from Member Boards about its MOC program
  - Verifies compliance with the standards and policies for MOC adopted by ABMS BOD

ABMS and ABEM MOC
- All Boards must have secure examination at least every 10 years
- Part IV – demonstrate physicians can assess the quality of care they provide compared to peers and national benchmarks and then apply best evidence or consensus recommendations using QI science to improve that care using follow-up assessments
- All MOC programs must include patient experience of care survey
- All must include a required patient safety activity

Part I: Medical Licensure
- Part I: All medical licenses held in compliance with ABEM Policy
• Hold at least one current, active, valid, full, unrestricted, and unqualified license to practice medicine in U.S., territories, or Canada.
• Any license that is restricted, suspended, or revoked fails to meet this requirement

Part II: LLSA
• Must successfully complete 4 LLSAs in years 1-5 (cert expires in or after 2017)
• Complete 8 in 10 years (cert expires before 2017)
• 10-15 articles, 20-30 questions
• Open book test

Part II: CME
• Beginning with certificates that expire in 2014, must have CME
• 25 AMA PRA Category 1 Credit™ credits annually
• 8 must be “self-assessment” CME
• Self-assessment almost always must have a testing component

Part III: ConCert
• High-stakes, secured examination
• Can take during final 5 years of certification
• ABEM has always required a “recertification” examination
• ABEM recertification examination first given in 1989
• AMA offers Category 1 CME credits (60 hours) completing MOC cycle

Part IV: Assessment of Practice Performance (APP)
• Activities required during years 1-5, and 6-10 of certification
• If certificate expires in 2018 or after, must complete Practice Improvement PI activity
• Review personal requirements in ABEM MOC (EMCC) Online
• AMA offers AMA PRA Category 1 Credit™ for PI activities

APP Patient Care Practice Improvement
• Measure
• Compare
• Implement improvement
• Re-measure

How Much Is Enough?
• Samples of at least 10 patients (before and after)
• Smaller sample for higher-acuity, lower frequency activities (e.g., AMI, CVA)
• Review ABEM requirements on website
• Can review individual or group data

What Can Be Measured?
• Physician Quality Reporting System (PQRS) measures
- Core measures
- Department-specific quality programs
- Six sigma projects
- Lean projects
- Joint commission projects (Ongoing professional practice evaluation (OPPE))

Multi-Specialty Portfolio Pilot Project
- 12 participating boards (ABEM included)
- Three-year pilot
- Boards allow institutions to approve QI activities eligible for Part IV credit
- Opening up to other institutions in 2013

Communication Requirement
- Patient experience of care survey (PECS)
- Completed every five (5) years
- Can use Press-Ganey®, MAPPS, CAHPS/HCAHPS
- Form available on ABEM website

The Attestation
- Attestation website uses drop-down menus
- Do not submit data
- Do attest to completing an activity
- Takes 5-8 minutes
- Costs nothing to complete

Verification
- Must provide contact information for verifier
- Verifier must know about or oversee activity
- ED chairs, medical director, or director of quality improvement
- 10% are verified
- Form: two check boxes and a signature

What is MOC Addressing?
- Single episode of testing insufficient to credibly assert the maintenance of high standards throughout a career
- Patients often fail to receive needed care
- Quality performance measures are inconsistently applied (even to the harm of patients)
It Gets Even More Complicated...
- Physicians are imprecise in independently self-assessing knowledge base and skill deficits
- Physicians who are the most confident are often the least proficient in determining and accepting their faults.
  - Davis DA, et al. JAMA. 2006;296:1094-102
- For self-directed learning, physicians often rely on CME
- Most prefer passive learning formats that are ineffective
  - Mazmanian PE, Davis DA. JAMA 2002;288:1057-60.

A Perfect Storm?
- “Thus we have the perfect storm; the predominant form of CME, the didactic-based learning experience, is ineffective in changing behavior; physicians’ knowledge and skills decline, on average, over time; and physician's ability to perform accurate and effective self-assessment is suspect.” – Eric Holmboe, M.D.

How Part II Fits
- LLSA assesses if key article points are understood
- The test reinforces article concepts
- The physician can compare practice to that in peer-review literature

How Part III Fits
- ConCert examination assesses internalized core of medical knowledge
- Broad knowledge base important to make absolute decisions with limited clinical information in a time-compressed environment
- Clinical practice of EM frequently restricts luxury of looking up information during patient care
- Without an adequate knowledge base – don’t know what you don’t know (or what to look up)

How Part IV Fits
- Assures the public that medical knowledge is being translated/integrated into patient care
- ED environment involves nearly constant assessment of quality measure use
- Many EDs are involved in quality-based patient care projects (e.g., door-to-balloon, stroke team activations, shortening door-to-doctor times, etc.)
- The C/P component of Part IV monitors and measures the physician’s interpersonal skills and professionalism
  - These characteristics are important to the general public

The Evidence for MOC
- There is growing evidence that MOC is associated with improved care
ABEM is looking at the issue in a deliberate fashion
Mounting substantial evidence in other specialties

Barriers to Proof
- Barriers to demonstrating individual physician competency are apparent when trying to design the proper study
- Particularly difficult to measure the impact of MOC on individual physician performance
  - Such a study would likely be intrusive and onerous
  - Difficult to acquire adequate sample sizes per physician for a reliable outcome measure
  - Considerable patient variability in ED further complicating

Stepping Back
- Not a “leap of faith” to accept that quality improvement processes lead to improved care
- Strong support in literature that APP-like activities led to performance improvement
- Lean and Six Sigma have yielded positive results

Diagnostic Acumen and Patient Safety
- Medical knowledge an essential element of the clinical reasoning process and contributes to diagnostic acumen
- This cardinal skill of diagnostic acumen—the translation of signs and symptoms into a diagnosis—is of paramount importance to the emergency physician.
- Patient safety is improved when the core knowledge based is substantial
- Inversely, deficiencies in knowledge-based behavior lead to harmful mistakes

Does ABEM MOC Change Practice?
- LLSA CME Activity Survey: Questions by CME Task Force including ACEP, AAEM, and ABEM
- Not designed to assess article selection per se, but to rate CME experience
- Selection bias (but comparisons of CME v. non-CME similar): 47.7% opted for CME
- 8% of 1,354 respondents answered gained no or little new knowledge that would change clinical practice
- 92% responded that the LLSA activity would help them (some to significantly) improve clinical practice

Clinical Relevance
- MOC program must be clinically relevant
- Any person generating MOC and examination content must be clinically active
Relevance of LLSA

- Journal club format: cornerstone teaching technique universally used in residencies
- 2011 LLSA CME survey (same study; same limitations)
- 2% of respondents said that LLSA articles not clinically relevant
- 98% some to significant relevance

ConCert Exam Is Relevant (GRAPH? Graph would be helpful)

- Analysis of 2011 ConCert results (Authors, Manuscript submitted 2012?)
- Emergency physicians with more years of clinical experience tended to have higher scores
- Examination is clinically focused
- Test avoids esoteric minutiae (beware the field test item)
- Emergency physicians tend to remain generalists
- Selection bias

ConCert Relevance Determined in Multiple Ways

- Relevance honed by test-taker feedback
- Comments are provided every time a question is used on an ABEM exam
- Test editors and ABEM staff review every comment
- No question on the ConCert examination counts until field tested and proven to be valid
- A question’s “fate” is the result of test-taker comments, further editorial review, and the ability of the question to measure something distinct and important to the clinical practice of emergency medicine as determined by its psychometric performance
- ABEM is listening!

Relevance of APP

- Emergency physicians choose the APP activities in which they wish to participate
- Thus, it is the physician who selects the degree of clinical relevancy
- APP activities can assess either process and outcome measures—you decide

External Regulation Risk

- A privilege of practicing medicine in the U.S. is the opportunity to be self-regulating
- “Among the most highly valued characteristics of any profession is its autonomy, the privilege of self-regulation granted by society.”
- Can only continue if certification and MOC are credible in the eyes of the government and public
ABEM believes that clinically active emergency physicians are the best group to develop assessment processes for other emergency physicians.

If we are not engaged in a robust self-evaluating and improvement process, then external agencies will intercede

A Straw Man Argument?
- Pay-for-performance measures
- PQRS physician reporting
- Imposition of CMS rules despite rejection by the National Quality Forum (e.g., head CT for non-traumatic HA) are examples of external intercession

An International Example
When the medical profession does not adequately satisfy public expectation...
- The General Medical Council (GMC) in the United Kingdom
- Formation of the GMC resulted from highly publicized criticism of the medical care (the Bristol inquiry)
- The most sensible way to address public expectation is to demonstrate that the public’s interests are being preserved through this self-regulating process
- ABEM believes that having physicians lead the standard-setting process for emergency medicine is more favorable than having this done by a governmental agency

Advise on Meeting the Requirements
- Take the LLSA nearly annually
- Do not fall behind in the 5-year window (NOT 10)
  - Failing to meet LLSA requirement can lead to decertification
- Take the ConCert in year nine of certification cycle
- When taking LLSA, review and complete Part IV attestations

Help on the Way
- ABEM working to broaden Part II opportunities
  - Can take Med Tox, Peds EM, and EMS LLSAs in future
- Broadening Part IV
  - Reciprocity with other boards
  - Allow approved externally developed Part IV activities
  - Working to develop Part IV for locums, urgent care, rural practices

If You Have Difficulty
- Review the website
• Review the FAQs
• Call ABEM support staff

An Important Message about Physician Quality Reporting System (PQRS)
• If you are reporting PQRS (majority do)...
• Encourage participation in 2012 (no later than 2013)
• If not by/in 2013, penalty begins in 2015
• Enhanced reimbursement (0.5%) if ABEM diplomate and...
• Meeting “more frequently” in MOC requirements

Participation in PQRS
• ABEM only one of 9 (of 24) participating Boards
• Begins in 2012
• Webinar and website information forthcoming in fall
• ACEP is a messaging partner with ABEM
• Stay tuned...

Summary
• ABEM MOC program is a vehicle for continuous professional development
• The ABEM MOC assures the public in a credible, objective manner that certified physicians are active in quality improvement and the acquisition of new knowledge and skills
• Part IV is largely self-directed by the physician and probably the easiest to accomplish
• ABEM MOC satisfies the social contract between the public and EM that allows for continued self-regulation