NATIONAL ASSOCIATION MEDICAL STAFF SERVICES
NAMSS
ADVANCING THE DELIVERY OF QUALITY HEALTHCARE

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November 20, 2013

Dr. Lois Margaret Nora
President and Chief Executive Officer
The American Board of Medical Specialties
222 North LaSalle Street, Suite 1500
Chicago, IL 60601

Re: Proposed Standards for the ABMS Program for MOC

Dear Dr. Nora:

The National Association Medical Staff Services (NAMSS) appreciates the opportunity to provide feedback to the American Board of Medical Specialties (ABMS) on its Proposed Standards for the ABMS Maintenance of Certification (MOC). NAMSS commends ABMS on undertaking a rigorous and thorough process to develop overarching standards to "maintain and improve the quality of medical care," as well as its intent to provide flexibility to its Member Boards to better facilitate MOC.

In enhancing the program for MOC, it is critical that the final standards are clear and specific to reduce – not create – uncertainty for physicians, and adequately and fairly assess their competency. As such, NAMSS encourages ABMS to enhance components of its standards by employing the following recommendations.

Recommendation One: Implement More Uniform Measures among Member Boards
NAMSS recognizes that each Member Board is unique and requires a certain degree of flexibility, but the overarching policy is vague and invites ambiguity for physicians and medical staffs. Granting each Member Board such leeway could create significant inconsistencies and would make MOC an overly complex and arbitrary process.

For example, the proposal does not limit time-certificate exemptions. Leaving this to each Member Boards' discretion may create 24 different exemption policies, placing a significant strain on NAMSS' members, Medical Services Professionals (MSPs). MSPs maintain persistent verification and would potentially have to track 24 different timelines and requirements for MOC re-verification. The chance for such inconsistency overly complicates the MOC process. Establishing a uniform timeline for all Member Boards would prevent unnecessary work and confusion for all MSPs and entities.

Recommendation Two: Implement More Objective Competency Measures
The final Standards should clearly explain how competency data is compiled, assessed, and weighted for each module of MOC's four-part competency framework: 1) Professional Standing and Professionalism; 2) Lifelong Learning and Self-Assessment; 3) Assessment of Knowledge, Skills, and Judgment; and 4) Improvement in Medical Practice.

MOC's evaluation process should assess the quality of the data, as well as the degree of difficulty associated with each module, to determine how each module is weighted or scored. Some of the data that the proposed standards would use to measure competency are subjective and should be weighted accordingly. The Accreditation Council for Graduate Medical Education's Six Core Competencies provides a framework for assessing skill. Yet, these assessments are vulnerable to subjectivity, as much of the data is self-reported or hand-picked.

Depending so heavily on intangible data presents validity and reliability issues and may not appropriately assess a diplomate's competency. For example, one of these six competencies, *Interpersonal & Communication Skills*, evaluates a diplomate's "…skills that result in effective information exchange and partnering with patients, their families, and professional associates…." There is no objective mechanism to assess this data.

The MOC's four competency modules are also prone to significant subjectivity. Part II largely bases its competency measures on "self-assessment," Part III stresses the importance of external review, and Part IV (Improvement in Medical Practice) bases competency measures on "…registries, patient logs, patient surveys, peer surveys, practice improvement modules…." The subjective data upon which these competency modules rely provides no standard mechanism to uniformly measure competence among diplomates. Self-reported data, patient-satisfaction surveys, and peer evaluations, have a place in the evaluation process, but these data elements should not serve as major competency measures. The final Standards should require more objective forms of data to score these modules.

Using team-based data also complicates individual competency evaluation. For example, Part IV encourages team-based assessments in which "Diplomates work across the medical specialties, as part of multi-professional health care teams…." Deciphering individual data from group-reported data causes attribution issues. These data elements are not only difficult to measure, but do not accurately reflect individual competence. This inhibits accurate individual assessment and is a disservice to physicians undergoing the MOC process.

The final Standards should also address cases in which diplomates have not been tested because they are life-time certified. Because much of the certification assessment is not evidence-based, there is no objective criterion to determine these diplomates' qualifications and competencies.

Recommendation Three: Accurately Define MOC's Participation Policy
ABMS' MOC process is not mandatory, but it is not truly voluntary. Diplomates who do not participate in the MOC process lose their certification. This gives those who intend to continue to practice their specialties little choice but to participate. If MOC is truly voluntary, the final Standards should include a "Not Participating" category to classify non-participants. The current process only offers, "Yes," "No," or "Not Required." There is no option that accurately categorizes

those who choose not to participate. ABMS should better accommodate physicians' participation decisions and provide facilities a certification end-date for those who do not choose to participate in MOC.

That MOC is technically voluntary creates many inconsistencies throughout the industry – especially for physicians and facilities. Many facilities, departments, and specialties mandate MOC, which compels participation. The resulting inconsistency is unfair to physicians and does nothing to simplify healthcare and only muddles the concept of MOC for the healthcare community, patients, and the public. NAMSS does not assert that everyone must participate, (e.g., life time certificants), but recommends that ABMS add a category that would represent the non-participatory provider, which is not punitive in nature to the healthcare community.

Recommendation Four: Define and Clarify Board-Certification Status

The final Standards should explicitly define "Board Certified" so that diplomates are not publicly maligned if their certification status is inaccurately depicted or interpreted. An explicit definition would also prevent a myriad of resulting ambiguous and misleading categories, such as "Board Eligible." Accordingly, the final Standards should include an "In Progress" or "Maintaining Certification" option to accurately categorize diplomates who are in the process of pursuing MOC.

The final Standards should also provide detailed guidance on cases in which diplomates pursuing MOC do not meet the requirements of a specific stage of the process. Allowing each Member Board to determine its own procedure may unequally hinder a physician's ability to obtain MOC, especially if some Member Boards implement more stringent requirements than others. It would also force MSPs and facilities to track 24 different policies. The final Standards should include a detailed, overarching protocol for categorizing these diplomates' MOC statuses and explicitly outline their rectification options to facilitate their MOC pursuit.

Recommendation Five: Make the Recertification Examination Optional

If MOC adequately measures "…knowledge of core content, judgment, and skills," the 10-year examination, which claims to do the same, is unnecessary for diplomates who successfully complete continuous certification. NAMSS recommends that these diplomates be exempt from this exam. ABMS should instead incorporate the exam material into the four competency modules to strengthen ongoing assessment of current competency. By providing this option, ABMS would further incentivize MOC participation – and better accomodate physicians. Individual Member Boards could increase annual fees to compensate from the lost exam revenue.

Recommendation Six: Collaborate with the Federation of State Medical Boards

ABMS should collaborate with the Federation of State Medical Boards to ensure that MOC satisfies each state medical board's maintenance of licensure criteria. Additionally, diplomates who successfully complete MOC should also receive CME credit for state medical licensure requirements.

Conclusion

NAMSS recognizes the value of these proposed standards, but strongly encourages ABMS to make the process more practical for physicians, implement more overarching uniformity, include more evidence-based competency measures, rely less on subjective data, provide more explicit instruction on the process, and include more categories to accurately classify diplomates' statuses**.**

Implementing the above recommendations will enhance the MOC process and make it more effective, objective, and less burdensome for physicians. It will also reduce complexity, making MOC more user-friendly for MSPs and the healthcare community. NAMSS appreciates ABMS' consideration and looks forward to the final MOC Standards. For any questions regarding our comments, please contact John Richardson at jrichardson@namss.org or at 202-367-1239.

Sincerely,

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NAMSS President