

The Changing Landscape of Competency

Federation of State Medical Boards

2009 Annual Meeting

May 2, 2009

Claudette Dalton, M.D.

History of the Proof of Competency Movement

- IOM publishes Quality Chasm and other reports
- Specialty boards consider how to implement Board re-certification
- Quality and performance improvement measures proliferate
- NBME and FSMB partner to institute the Clinical Skills Exam for initial licensure
- ACGME refines the concept of competencies in practice and define six areas of competence
- ABMS adopts concept of competencies and incorporates them and performance improvement into re-certification, now known as MOC process
- FSMB forms a special MOL committee in 2003 and in 2008, adopt guiding principles and promise to further study the impact of the process

NBME Clinical Skills Exam

- Uses 12 standardized patient scenarios for student to examine and provide diagnosis and plan
- Assesses clinical skills, ability to communicate and English Language skills
- Touted as a “safety exam”—i.e. to prove safety to practice
- Offered in 5 centers, expensive, logistically difficult
- No evidence that this tests competency

ACGME Competencies

- Medical Knowledge
- Patient Care
- Practice Based Learning and Improvement
- Systems Based Practice
- Professionalism
- Interpersonal and Communication Skills

ABMS Maintenance of Certification

- Use ACGME six core competencies
- 24 Boards all use same 4 part format:
 - Professional standing--hold a valid license
 - Cognitive Expertise—usually a written test
 - Practice Performance Assessment—specialty specific PI/QI activity
 - Life-long learning and self-assessment--CME credits
- Timing of re-certification varies from Board to Board—none less than five years
- No provision for physicians without Boards or who have assumed non-clinical roles
- Endorsed new model at March meeting

ABMS MOC Model

- An in-depth review of each board's standards should occur every 5 years
 - Increases frequency of revisions
- A patient satisfaction survey should be added (CAHPS or other equivalent)
- Part 4 should only be reported every 2-5 years
- Delayed the “new” practice profile survey requirement
 - Concerns that this would be onerous for individual physicians to comply

Other ABMS Actions

- Added deferment options for implementation—up to two years
- COMMOC formed a working group to examine relationship of licensure to MOC
 - Issue: Do not want “diplomates with licensure restrictions” to be “automatically excluded from the MOC process”

FSMB Maintenance of Licensure

- Assumes state boards have responsibility to ensure that licensees are competent
- Strategies should be developed to ensure this
- FSMB Special Committee with wide input
- State medical boards are sole entities with authority to require periodic demonstration of competency
- *“State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking relicensure”* FSMB HOD, 2004

FSMB BOD Report -08

- MOL should support lifelong learning and improvement in practice
- MOL should be administratively feasible and developed in collaboration with other stakeholders.
 - The authority for establishing MOL requirements rests with the state medical boards
- MOL should not be overly burdensome for the profession and should not impede mobility
- The MOL infrastructure must be flexible and offer options to encourage compliance
- MOL processes should balance transparency and privacy

Additional National Factors

- CMS, NQF, AHRQ and other national organizations call for more and more adoption of performance improvement measures
- Pay for performance is introduced by CMS; other payers follow
- Hospital credentialing and privileging is closely watched by JCAHO and others
- No definition of competency is available
- Clinical skills tests do not necessarily correlate with competency
- Manpower issues rise to crisis levels; re-entry processes are needed
- AMA defines new PRA Category 1 credit for performance improvement
- ACCME develops New Paradigm for accreditation
- AMA produces MOC/MOL informational report for June, 2009 meeting and Lifelong learning, CEJA companion and other CME related reports

National Alliance for Physician Competency (NAPC)

- NBME (+/- FSMB and AAMC) convened as collaborative attempt to define competency—many national groups participate, including consumer groups
- Three products are forthcoming:
 - Good Medical Practice Document
 - eFolios
 - Trusted agent
- Current status of GGMP is as an aspirational document rather than regulatory model

NAPC Products

- Good Medical Practice Document
 - Describes attributes of the “perfect” doctor
 - Originally described as model for regulatory and legislative action
 - Large consumer generated section
- eFolios
 - Electronic system to collate all proofs of competency: Board MOC, PI measures, CME credits, etc in one place
- Trusted agent
 - FSMB would oversee a system to release documentation in eFolio and other repositories to entities desiring credentials
 - Who controls release of data not completely established

Additional Factors in Virginia

- AARP legislation to ask Board of Medicine to monitor proof of competency with each licensure cycle
- Board of Medicine reconstitutes competency committee
 - Initial and on-going competency recognized as fundamentally different processes
 - Both need to be examined further
- Wide range of Virginia representatives active in National Alliance for Physician Competency

Potential Impact

- No proof that any of these activities correlate well with true competency
- Much of competency is local and cultural
- Physicians will be required to do multiple QI and PI activities for multiple agents
- No provision is made for those without initial specialty Board certifications or in non-clinical roles
- Requirements missing both standardization in some areas and flexibility in others.
- Requirement for Boards of Medicine to investigate proof of competency in each licensure cycle will have large financial and manpower consequences
- Correlation of these activities with hospital credentialing is unclear
- Workforce and re-entry issues will be impacted

The Crystal Ball

- The future is cloudy *but....*
- Best current tests of competency are MOC *plus* some form of observationally based evaluations
- Performance improvement activities need to be based on an individual's practice and should be counted across requirements
- Access to affordable CME (in all of its forms) must be protected
- New forms of MOC for un-boarded, re-entering or non-clinical physicians need to be developed
- Remediation and re-entry programs need to be available at low cost and in many geographic venues

More of the Future...

- More patient satisfaction and peer assessment formats need to be developed
- The current emphasis on teams and other new or regional models of health care delivery must be part of any evaluations
- The financial impacts to both practices and Boards of Medicine need to be considered
- Partnerships across the House of Medicine are needed to develop, assess and disseminate new paradigms
- We must hold ourselves accountable at all levels

Thank you!

*Questions will be addressed
at the end of the panel
presentation.*