MOC
WHY YOU AND WHY NOW?

EMORY UNIVERSITY
SCHOOL OF MEDICINE

November 14, 2012
Emory University
Atlanta, GA
DISCLOSURE

Member, Board of Directors
The American Board of Medical Specialties
Aim for MOC (all boards):
Factors in Flight Selection

- Tucson origin: limited carriers, flights
- Carrier of choice: Does AA fly there?
- Flight choice: meeting schedule, $$$ price
- Schedules + nonstops / connections
- Return options, compounded travel
- Frequent flyer miles
- Equipment: not really
Airline Transport Pilot License (ATPL) (FAA-qualified to fly commercial jetliners): Highest

Have embraced:
Primacy of passenger safety
Standards
Team/crew training, responsibility
Checklists
Mandatory training, simulation
Federal oversight

Have relinquished:
All other possible considerations
Individuality of approach
Autonomy
Dependence on memory, experience
Luck-of-the-draw experience
Self-regulation

Board Certification and Participation in MOC
“They have also made the improbable come true. High-volume, high-speed jet travel is the safest form of transportation in the world.”
• Assume 71,000 deaths per year…
• 195 deaths per day…
• Equivalent to…

One 737 loaded with passengers crashing every day…

If this were the safety record of the airline industry, I would not have flown here to give this talk!
January 15, 2009, Capt. Chesley B. Sullenberger, First Officer Jeffrey B. Skiles, and crew successfully landed an Airbus-320-214 on the Hudson River after a bird (Canadian Geese) strike incapacitated both engines. This event further strengthened the public's image of commercial pilots and aviation.
If board certification could guarantee patient safety and high quality care by physicians ("Good Housekeeping Seal of Approval"), perhaps we would not have such a large array of stakeholders demanding a dominant voice in physician performance measurement, public reporting, and payment reform.
Groups Weighing in on Physician Performance Measurement

- National consumer groups (AARP, Consumer’s Union)
- Business coalitions (Leapfrog, Pacific Business Group)
- Unions (AFL-CIO, SEIU)
- Insurers (BCBS, United Health, AHIP, others)
- Quality organizations (AQA, QASC, etc.)
- Accrediting/certifying bodies (ABMS, NCQA, TJC, etc)
- Private non-profits (IOM, NQF, IHI)
- Government (CMS, AHRQ, CDC, NIH, other)
- Healthcare professionals (AMA, AHA, ANA, etc.)
Topics

- Specialty board certification: very brief history
- Influence of the quality and safety movement
- Emergence of MOC
- Why and how the profession and board certification must change and are changing
- What’s new in MOC today, and why MOC makes sense for you
In the U.S., before 1875

No requirements to become a licensed medical practitioner
MEDICAL EDUCATION
IN THE
UNITED STATES AND CANADA
A REPORT TO
THE CARNEGIE FOUNDATION
FOR THE ADVANCEMENT OF TEACHING
BY
ABRAHAM FLEXNER

WITH AN INTRODUCTION BY
HENRY S. PRITCHETT
PRESIDENT OF THE FOUNDATION

BULLETIN NUMBER FOUR (1910)
(Reproduced in 1920)
(Reproduced in 1978)

497 MADISON AVENUE
NEW YORK CITY 10022

Flexner Report: Impact on Medical Education
1908-1910

- 155 U.S. medical schools, many proprietary
- Standards: extremely low to none
- Lab, clinical conditions abysmal
- Testing of knowledge, skill lacking
GEORGIA

Number of medical schools, 5.


Atlanta College of Physicians & Surgeons (1898, independent)
Atlanta School of Medicine (1905, independent)
Georgia Coll. of Eclectic Medicine & Surgery (1877, independent)

"Its anatomy room, containing a single cadaver, is indescribably foul…The school is practically without clinical facilities. Its outfit in obstetrics is limited to a tattered manikin…Nothing more disgraceful calling itself a medical school can be found anywhere." (visited February, 1909)

Hospital Medical College (1908, independent; secessionists)
Medical College of Georgia (1828)

Lab: "…exceedingly foul dissecting room." Clinic: City Hospital, (100 beds); dispensary, no records kept.
EMORY: Atlanta Medical College began accepting students 1859. In 1898, it merged with the Southern Medical College to form the Atlanta College of Physicians and Surgeons. In 1913, ACPS merged with the Atlanta School of Medicine. In 1917, Emory University School of Medicine was admitted into the AAMC.
1st Major Transformation in American Medicine

Standardization of Medical Education
Before Accredited Training and Certification

- Physicians simply chose area of practice
  - General practice
  - Surgery
  - ENT
  - Ophthalmology
  - Etc.

- Public subjected to unscrupulous characters, charlatans, danger

- Hospitals: dreadful places where hopeless went to die
1908 – Dr. Derrick T. Vail, Sr. presidential address to the American Academy of Ophthalmology and Otolaryngology

“... and if he sound competent, let him then be permitted and licensed to practice ophthalmology.”

SPECIALTY BOARDS

- Established to assure the public that the physician has specific qualifications
  - American Board of Ophthalmology 1917
  - American Board of Otolaryngology 1924
  - American Board of Obstetrics 1930
  - American Board of Dermatology 1932

- Advisory Board for Medical Specialties (forerunner of ABMS) established 1933
  - The 4 Boards
  - Associate Member organizations
The American Boards of:

- Allergy and Immunology
- Anesthesiology
- Colon and Rectal Surgery
- Dermatology
- Emergency Medicine
- Family Medicine
- Internal Medicine
- Medical Genetics
- Neurological Surgery
- Nuclear Medicine
- Obstetrics and Gynecology
- Ophthalmology
- Orthopaedic Surgery
- Otolaryngology
- Pathology
- Pediatrics
- Physical Medicine and Rehabilitation
- Plastic Surgery
- Preventive Medicine
- Psychiatry and Neurology
- Radiology
- Surgery
- Thoracic Surgery
- Urology

38 primary, 118 subspecialty certificates, as of November 2012
Established 1934

Today: 3 Primary Certificates (DR, RO, MP)
1 more just approved: IR/DR

Subspecialties
- Neuroradiology
- Vascular & Interventional Radiology
- Pediatric Radiology
- Nuclear Radiology
- Hospice and Palliative Medicine

Maintenance of Certification: All disciplines
“... to serve patients, the public, and the medical profession by certifying that its diplomates have acquired, demonstrated, and maintained a requisite standard of knowledge, skill, understanding, and performance essential to the safe and competent practice of Diagnostic Radiology, Radiation Oncology and Medical Physics.”
Mission restated as overarching goals:

- Safe, high-quality patient care
- Well-placed confidence of the public in the skills, knowledge, and competence of ABR diplomates
**ABMS Member Boards**

**General Certificates Issued**

<table>
<thead>
<tr>
<th>BOARD</th>
<th>2000-2010</th>
<th>CUMULATIVE</th>
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</thead>
<tbody>
<tr>
<td>Internal Med</td>
<td>76,791</td>
<td>241,225</td>
</tr>
<tr>
<td>Family Med</td>
<td>34,352</td>
<td>103,755</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>30,168</td>
<td>99,283</td>
</tr>
<tr>
<td>Psych / Neuro</td>
<td>19,150</td>
<td>66,554</td>
</tr>
<tr>
<td>Radiology</td>
<td>14,568</td>
<td>57,094</td>
</tr>
<tr>
<td>Surgery</td>
<td>12,066</td>
<td>59,981</td>
</tr>
</tbody>
</table>
Unique Features of the American Medical Specialty Board Movement

- System of professional self-regulation
- Boards/physicians fulfill social contract
- Voluntary (whereas licensure is compulsory)
- Linkage: certification and accredited training
- Unlike UK and Canada: Boards are not membership organizations
- Firewall between educ/training and assessment
- Has withstood test of time; global gold standard
May 2008 Opinion Research Corp. Telephone Poll
When asked:

“Key factors when choosing a doctor…”
95% bedside manner; communication skills
91% board certification
82% friend or family member recommendation
78% doctor’s hospital affiliation
75% doctor’s office location
60% hospital or school where doctor trained
August 2003 Gallup Poll:
When asked:

“If you knew your doctor’s board certification had expired, would you change doctors?”

54% Very Likely
27% Somewhat Likely
9% Not Too Likely
8% Not at All Likely

81%
“the ABMS and its member boards have the obligation to assure the public that their doctors are competent and that this should be done through the certification and recertification process.”

Birth of MOC
ABMS Adopted the 6 ACGME Competencies

- Medical knowledge
- Patient care [and procedural skill]
- Interpersonal and communication skills
- Professionalism
- Practice-based learning and improvement
- Systems-based practice
The 4 Parts of MOC

- Professional Standing
- Lifelong Learning and Self-assessment
- Cognitive Expertise
- Practice Performance Improvement
  (ABR’s Practice Quality Improvement—PQI)
2nd Major Transformation in American Medicine

Quality and Safety Movement

- Nothing of this importance or magnitude since Flexner
- Models: quality manufacturing, systems engineering
- Rationale: healthcare systems are complex; goals difficult to achieve (eg. safety)
Calls for fundamental change in aims, with delivery of healthcare that is:

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

INSTITUTE OF MEDICINE

CROSSING THE QUALITY CHASM
A New Health System for the 21st Century

2001
Healthcare Quality Aims

Quality Aim
- People get the care they need
- People need the care they get
- Provided safely
- Timely
- Patient-centered
- Delivered efficiently
- Delivered equitably

Problem to Address
- Underuse
- Overuse
- Error, harm
- Delays
- Unresponsive
- Waste
- Disparities

IOM, Crossing the Quality Chasm (2001)
MOC Part IV: Practice Quality Improvement

- Where the rubber meets the road

- Part 4 of MOC: we demonstrate what we do, not just what we know; we strive to improve.

- Profession does its part in the quality and safety movement
Quality Healthcare

Minimal shift in overall quality

Goal: an overall quality shift

Identify outliers

Patients

Low Quality

Best Practice
Adults received 55% of care that is recommended

Children received 46% of the care that is recommended


EXHIBIT 3
National Health Expenditures (NHE) Share Of Gross Domestic Product (GDP) And Private And Public Shares Of NHE, Selected Years 1965–2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Private share of NHE</th>
<th>Public share of NHE</th>
<th>NHE share of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1965</td>
<td>20</td>
<td>80</td>
<td>5</td>
</tr>
<tr>
<td>1970</td>
<td>25</td>
<td>75</td>
<td>10</td>
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<td>1980</td>
<td>30</td>
<td>70</td>
<td>15</td>
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<td>1993</td>
<td>45</td>
<td>55</td>
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<td>2003</td>
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<td>2006</td>
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<tr>
<td>2009</td>
<td>65</td>
<td>35</td>
<td>45</td>
</tr>
<tr>
<td>2014</td>
<td>70</td>
<td>30</td>
<td>50</td>
</tr>
</tbody>
</table>

**SOURCE:** Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

**NOTES:** The left axis (public and private spending’s share of NHE) relates to the two line graphs. The right axis (NHE’s share of GDP) relates to the gray-shaded bars. Data for 2006, 2009, and 2014 are projections.

The data and projected data are from the Centers for Medicare and Medicaid Services, Office of the Actuary.

Lee PV, Berenson RA, Tooker J. NEJM 2009
In a predominantly publicly-funded healthcare system...

- Who (what entity) determines the minimum quality practice standard?
- Who determines whether a practitioner has met the standard?
- How is the value (\$\$cost/outcome) of a particular healthcare service determined?
“I strongly urge the ABMS—with its Member Boards—to position itself as the agency for physician accountability in a government-controlled or government-directed healthcare system. That is, assume the task of certifying to the government as well as to the public that its doctors are competent and that they are accountable for their work.”

David L. Nahrwold. Remarks on receiving the Derrick T. Vail Award, September 18, 2007
Fortunately, as 2012 ends:

- ABMS & boards have been proactive
- MOC has been included in ACA 2010
- We are entering 3rd year of MOC:PQRS
- CMS will include board certification and MOC status on Physician Compare website
- CMS has turned to specialty boards for help with measures and value modifiers
- MOC as equivalent of PQRS under discussion
MOC

Present Status

- Boards perceive need to maintain autonomy, uniqueness
- MOC standards a work-in-progress; rules change
- Gradual transition to all time-limited certificate holders
- Perception of MOC as added burden, unfunded mandate
- Value of MOC?
- Consumers’, purchasers’, payers’, credentialing bodies’ need to know

Challenges

- MOC appears complex and heterogenous to external gps
- Credibility of boards with their diplomats
- Pace of full adoption of MOC
- MOC should fit seamlessly into daily workflow
- Demonstrate MOC outcomes, effectiveness
- Reporting all needed info in understandable terms; risk adjustment, attribution/team care; system of care
To simplify MOC participation rules, continue the evolution to a more continuous process, and comply with the ABMS standard on public reporting of diplomate MOC status, ABR is doing the following:

Continuous Certification and Public Reporting
Continuous Certification

- MOC reality: Continuous is best
  - All 6 competencies must become integral to ongoing practice
    - Keeping up on medical knowledge
    - Improving patient care and procedural skill
    - Practicing professionalism
    - Effectively communicating and relating to others
    - Practice-based learning and improvement
    - Systems-based practice
Continuous Certification

- Certificates issued in 2012 and after no longer have “valid through” dates – instead, ongoing validity of the certificate is contingent upon meeting MOC requirements.
  - Annual look-back to determine MOC status.
  - Rolling 3-year look-back window.
  - MOC requirements and fees unchanged.
How does continuous certification work?

<table>
<thead>
<tr>
<th>MOC Year</th>
<th>Look-back date</th>
<th>Element(s) Checked</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>3/15/2013</td>
<td>Licensure, Exam</td>
</tr>
<tr>
<td>2013</td>
<td>3/15/2014</td>
<td>Licensure, Exam</td>
</tr>
<tr>
<td>2014</td>
<td>3/15/2015</td>
<td>Licensure, Exam</td>
</tr>
<tr>
<td>2015</td>
<td>3/15/2016</td>
<td>Licensure, CME, SA, Exam, and PQI</td>
</tr>
<tr>
<td>2016</td>
<td>3/15/2017</td>
<td>Licensure, CME, SA, Exam, and PQI</td>
</tr>
<tr>
<td>2017</td>
<td>3/15/2018</td>
<td>Licensure, CME, SA, Exam, and PQI</td>
</tr>
<tr>
<td>2018</td>
<td>3/15/2019</td>
<td>Licensure, CME, SA, Exam, and PQI</td>
</tr>
<tr>
<td>20XX</td>
<td>3/15/20XX</td>
<td>Licensure, CME, SA, Exam, and PQI</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Element</th>
<th>Compliance Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensure</td>
<td>At least one valid state medical license</td>
</tr>
<tr>
<td>CME</td>
<td>At least 75 Category 1 CME in previous 3 years</td>
</tr>
<tr>
<td>SAMs</td>
<td>At least 1/3 of CME incorporates self-assessment</td>
</tr>
<tr>
<td>Exam</td>
<td>Passed any ABR Certifying or MOC exam in previous 10 years</td>
</tr>
<tr>
<td>PQI</td>
<td>Completed at least 1 PQI project in previous 3 years</td>
</tr>
</tbody>
</table>
Advantages of Continuous Certification

- If \( \geq 2 \) time-limited certificates \( \rightarrow \) synchronized.
- The number of CME and self-assessment credits counted per year is unlimited.
- MOC exam may be taken any time, provided previous MOC exam was passed \( \leq 10 \) yrs ago.
- Built-in “catch-up” period of one year – still certified.
- Aligns reporting more closely with CMS, TJC, credentialing and state licensing board rqmts.
Public Reporting of MOC Status

- Beginning March 2013: ABR will begin to report to ABMS the MOC status (by certificate) of every diplomate. Public reporting, an important driver of healthcare transformation, began for 7 of the boards as early as August 2011.

- Info is to be displayed on ABMS website and ABR website:
  - Meeting the Requirements of MOC
  - Not Meeting the Requirements of MOC
  - Not Required to Participate in MOC (Lifetime Certificates)
Physician Compare has information about Medicare-enrolled Physicians and Healthcare Professionals.

Persons using assistive technology may not be able to fully access information on these pages. For assistance, please contact CMS Web Team.
Lifetime Certificate (LTC) Diplomates and MOC
LTC Diplomate Enrollment in MOC

- Initially, apprehensive about enrolling, participating
- Still asking about immediate benefits (to them)
- Concerns: exams, fees, requirements
- Want no exams, but if they must, exams should be:
  - Free
  - Taken from home
  - Tailored precisely to my practice
  - Automatically passed
- Don’t understand Part IV
- Myths and misconceptions
Myths and Misconceptions

- Loss of lifetime certificate
- Once you’re in MOC, you can’t get out
- Your MOC exam results are shared with institution, credentialers, etc.
- I won’t ever need MOC to practice – likely wrong because of: P4P, TJC, credentialers, public reporting of MOC status, MOL, etc.
- Not a myth: Pressure mounting, as TLC diplomates are near to becoming the majority; whole group practices enrolling
The Upside of MOC Enrollment

- Right thing to do professionally
- Valued by patients and physician colleagues
- Maintains a credential you worked hard to earn
- Public reporting of “meeting MOC requirements”
- Satisfies CME and self-assessment requirements
- P4P: PQRS:MOC incentives from CMS
- Qualifies you to bill (some health plans)
- MOC aligning with credentialing, TJC, MOL, etc., and thereby decreasing burden on diplomates
- Letter of MOC Enrollment available immediately
- Additional certificate if “meeting the requirements” of MOC at first look-back (continuous certification)
LTC Enrollment in MOC

1) PQRS: MOC incentive
2) Entire practices enrolling in MOC as groups
Making MOC painless for individuals and group practices…
MOC Advisory Committee (DR)

Milton J. Guiberteau, MD, Chair, President-Elect
James P. Borgstede, MD, President
Thomas M. Anderson, MD
Eric Brandser, MD
Greg Galdino, MD
Richard Gunderman, MD
Ramsey K. Kilani, MD
Amy B. Kirby, MD
Christine A. Lamoureux, MD
Alex Margulis, MD
Mark E. Mullins, MD
Group Practice MOC
Online Administrative Tool

- Optional program
- Group practice administrator has access to MOC data on PDB
- Easy system for tracking MOC progress of individual diplomates in a group practice
- Requires each diplomate to: 1) approve GPA access, 2) access own PDB ≥1 time/year & verify
- Reporting function
- Now in beta-testing
- Live version for widespread use: early 2013
## CME Entry

### Smith, Jane MD [12345]

<table>
<thead>
<tr>
<th>Credit Year</th>
<th>Gateway CMEs</th>
<th>Self Entered CMEs</th>
<th>Total CMEs</th>
<th>Total Applied</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>2012</td>
<td>36.75</td>
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<td>36.75</td>
<td>Edit</td>
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<tr>
<td>2011</td>
<td>60</td>
<td>0</td>
<td>60</td>
<td>50</td>
<td>Edit</td>
</tr>
</tbody>
</table>

Category 1 CME earned before Jan 01, 2011 cannot be applied to your MOC cycle. Please ensure your total credits attested for those years do not include credits earned prior to those dates.

### Total CME Credits Applied: 86.75

<table>
<thead>
<tr>
<th>Credit Year</th>
<th>Gateway CMEs</th>
<th>Self Entered CMEs</th>
<th>Total CMEs</th>
<th>Total Applied</th>
<th>Action</th>
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<tr>
<td>2012</td>
<td>36.75</td>
<td>0</td>
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<td>2011</td>
<td>60</td>
<td>0</td>
<td>60</td>
<td>50</td>
<td>Edit</td>
</tr>
</tbody>
</table>

Category 1 CME earned before Jan 01, 2011 cannot be applied to your MOC cycle. Please ensure your total credits attested for those years do not include credits earned prior to those dates.
Diplomate Notification

Welcome back Dr. Jane Doe, MD!
You last signed in on 7/19/2012 8:03:12 PM

Optional Programs

Group MOC
Organization: Sonia Organization

Group Practice Admin:
Test GPA

Recent changes made by your Group Practice Administrator
Date: 7/11/2012
Change: CMEs Edited
New Value: Cat1 2012, 25

Click here to opt out of Group MOC

For details about compliance click here

Optional Programs

Group MOC
Organization: Sonia Organization

Group Practice Admin:
Test GPA

Recent changes made by your Group Practice Administrator
Date: 7/11/2012
Change: CMEs Edited
New Value: Cat1 2012, 25

Click here to opt out of Group MOC
Group Definition
- 2 or more radiologists, radiation oncologists, or medical physicists

Requirements
- All members of group must participate, including Lifetime Certificate Holders
- Annual fees must be paid in aggregate
- Must use Group MOC Online Administrative Tool

Discount: 10% of the total fees due

Available January 2014
HEALTH CARE REFORM LEGISLATION
MARCH 2010

The Patient Protection
& Affordable Care Act

111th Congress of the United States
H.R. 3590
Since 2011: CMS recognizes MOC participation as marker of physician quality

ABR is CMS-qualified to attest to CMS on behalf of participating diplomates

For 2012, participant must:
− Enroll in MOC, if not already enrolled
− Maintain valid & unrestricted medical license(s)
− 30 CME & 3 Self Assessment (SAM) credits
− Attest to completion of ≥1 PQI project
− Attest to completion of a patient experience-of-care survey
## Why Participate?

<table>
<thead>
<tr>
<th>Year</th>
<th>PQRS</th>
<th>PQRS:MOC</th>
<th>Total Incentive</th>
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</thead>
<tbody>
<tr>
<td>2011</td>
<td>1.0 %</td>
<td>0.5 %</td>
<td>1.5 %</td>
</tr>
<tr>
<td>2012</td>
<td>0.5 %</td>
<td>0.5 %</td>
<td>1.0 %</td>
</tr>
<tr>
<td>2013</td>
<td>0.5 %</td>
<td>0.5 %</td>
<td>1.0 %</td>
</tr>
<tr>
<td>2014</td>
<td>0.5 %</td>
<td>0.5 %</td>
<td>1.0 %</td>
</tr>
<tr>
<td>2015</td>
<td>-1.5 percent (98.5% of CMS payment due)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>-2.0 percent (98% of CMS payment due)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Welcome back Dr. Gary Jay Becker!
You last signed in on 10/3/2012 4:36:47 AM

HOME ADDRESS
Primary Contact
3368 E. Camino Boscaje Escondido
Tucson, AZ 85718

WORK ADDRESS
American Board of Radiology
5441 E. Williams Circle
Tucson, AZ 85711

Primary Email: gbecker@theabr.org
Primary Phone: 520-790-2900

MOC Enrollment: You are currently enrolled in: MOC in Diagnostic Radiology and MOC in Vascular and Interventional Radiology.

Licenses:
Your AZ license expires on 3/18/2014
Your FL license expires on 1/31/2013
Your IN license expires on 6/30/2013

Payments: Your current balance due is $0.00

MOC Status: Your MOC Cycle in Diagnostic Radiology & MOC in Vascular and Interventional Radiology will complete in 2014.

Part 1: Professional Standing

Part 2: Lifelong Learning & Self Assessment
463.50 Category 1 Credits
14.00 SAMs

Part 3: Cognitive Expertise
Part 3: Cognitive Expertise

Part 4: Practice Quality Improvement

You are currently Compliant in PPI. For details about compliance click here

<table>
<thead>
<tr>
<th>Optional Programs</th>
<th>Click here to participate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 MOC:PQRS</td>
<td></td>
</tr>
<tr>
<td>Focused Practice Recognition in Cardiac CT</td>
<td></td>
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</tbody>
</table>

News

Lifelong Learning! If you are a participant in the CME Gateway or the ASTRO Gateway and have recently experienced a problem with Self-Assessment Modules (SAMs) not being transferred to your Personal Data Base (PDB) via either Gateway, please note that this issue has been resolved.

SAM credits earned through a society or organization that participates in the CME Gateway or the ASTRO Gateway are now displayed on the SAMs page of your CME/SAM attestation box.

IMPORTANT: If you have self-entered any Gateway SAMs, please be sure to remove those SAMs so that your SAM credits will be reported accurately.

IMPORTANT! Be sure to see your 2012 DIAGNOSTIC RADIOLOGY ABR-MOC ANNUAL UPDATE. This update contains important information regarding the ABR MOC program.

NEW! Be sure to see your 2012 DIAGNOSTIC RADIOLOGY ABR-MOC ANNUAL CALENDAR.

PLEASE READ! The ABR has recently added a provision to the Participation Policy to allow you to complete and record more MOC requirements in each calendar year. Click here for more details

Having a problem with the website?
Professionalism vs. $$ Incentives

- Models of physician payment reform seem to ask, “How should we pay doctors so that they will be motivated to provide high-quality care?”

- This question includes 2 assumptions:
  - Reason for poorer-than-desired quality is that physicians—who are intrinsically motivated professionals--aren’t motivated enough
  - $ incentives will increase physicians’ motivation

- Research over 4 decades: tangible rewards have a significant negative effect on intrinsic motivation.

MOC Pilot Innovation
Focused Practice Recognition in MOC

- Professional growth continues after training
- Medical knowledge, technology evolve rapidly
- New proficiency and expertise develop in practice
- Areas of practice concentration in which some maintain a large emphasis, others none at all
- Within practice domain of parent specialty
- Subspecialty training, certification not available
- How to recognize? ABMS & ACGME not nimble
- Pilots: Designed to determine whether proficiency can be demonstrated, and to assess value
MOC Pilot Innovation

Focused Practice Recognition in MOC

- Only 3 Focused Practice Recognition Pilots approved by ABMS:
  - Hospital Medicine (ABIM, ABFM)
  - Brachytherapy (ABR)
  - Cardiac CT (ABR)

- Recognition on ABMS and ABR websites: “Meeting MOC requirements in Diagnostic Radiology, with Focused Practice Recognition in Cardiac CT”
FPR in Cardiac CT

Qualifications

- Certified by ABR in Diagnostic Radiology
- Participating in MOC (can enroll in MOC now and begin FPR-CCT, provided other qualifications met)
- >1 year post-residency
- Experience: >150 gated, enhanced cardiac CTs in past 3 years (>75 with primary responsibility)
- CME: 50 AMA Cat. 1 credits in CCT
- > 1 PQI project in CCT
FPR in Cardiac CT
Qualifications

- Application submitted to ABR (see website)
- Passing score on ACR’s Cardiac CT Advanced Proficiency (CoAP) Examination
- Maintain specific MOC requirements in CCT
Welcome back Dr. Gary Jay Becker!
You last signed in on 10/3/2012 4:36:47 AM

HOME ADDRESS
Primary Contact
3368 E. Camino Boscaje
Escondido
Tucson, AZ 85718

WORK ADDRESS
American Board of Radiology
5441 E. Williams Circle
Tucson, AZ 85711

Primary Email: gbecker@theabr.org
Primary Phone: 520-790-2900

MOC Enrollment: You are currently enrolled in: MOC in Diagnostic Radiology and MOC in Vascular and Interventional Radiology.

Licenses: Your AZ license expires on 3/18/2014
Your FL license expires on 1/31/2013
Your IN license expires on 6/30/2013

Payments: Your current balance due is $0.00

MOC Status: Your MOC Cycle in Diagnostic Radiology & MOC in Vascular and Interventional Radiology will complete in 2014.

Part 1: Professional Standing
3 license(s) on file

Part 2: Lifelong Learning & Self Assessment
463.50 Category 1 Credits
14.00 SAMs

Part 3: Cognitive Expertise
Part 3: Cognitive Expertise

Part 4: Practice Quality Improvement
You are currently Compliant in PQI. For details about compliance click here

Optional Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Click here to participate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 MOC:PQRS</td>
<td></td>
</tr>
<tr>
<td>Focused Practice Recognition in Cardiac CT</td>
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</tbody>
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News

Lifelong Learning! If you are a participant in the CME Gateway or the ASTRO Gateway and have recently experienced a problem with Self-Assessment Modules (SAMs) not being transferred to your Personal Data Base (PDB) via either Gateway, please note that this issue has been resolved.

SAM credits earned through a society or organization that participates in the CME Gateway or the ASTRO Gateway are now displayed on the SAMs page of your CME/SAM attestation box.

IMPORTANT: If you have self-entered any Gateway SAMs, please be sure to remove those SAMs so that your SAM credits will be reported accurately.

IMPORTANT! Be sure to see your 2012 DIAGNOSTIC RADIOLOGY ABR-MOC ANNUAL UPDATE. This update contains important information regarding the ABR MOC program.

NEW! Be sure to see your 2012 DIAGNOSTIC RADIOLOGY ABR-MOC ANNUAL CALENDAR.

PLEASE READ! The ABR has recently added a provision to the Participation Policy to allow you to complete and record more MOC requirements in each calendar year. Click here for more details

Having a problem with the website?
I don’t understand what it is.

Explain to me why I am doing this.

Tell me what you want me to do.

Show me how to do it.
The Quality Improvement Process

**PLAN**
- Identify area needing improvement
- Devise a measure
- Set a goal

**DO**
- Carry out the measurement plan
- Collect data

**ACT**
- Develop and improvement plan
- Implement for cycle #2

**STUDY**
- Analyze the data
- Compare to goal
- Root Cause Analysis

DO

STUDY

PLANE

ACT

PLAN

DO

STUDY

ACT

PLAN

DO

STUDY

ACT

PLAN

DO

STUDY

ACT

PLAN

DO

STUDY

ACT
American Board of Radiology

MOC Part 4: Practice Quality Improvement (PQI)

Group Participant PDSA (Plan-Do-Study-Act) Checklist & Summary Record*

BASELINE PDSA CYCLE (Cycle #1)

(In Cycle #1, a topic is selected and baseline data gathered to compare with post-improvement plan data in Cycle #2.)

- **Step 1: PLAN. Identify and Describe the Project (Group-Designed)**
  
  [GROUP MEETING #1]
  
  - Select a Topic (area of interest): (this should address part of your group’s practice which you would like to improve, or an observed gap in service or patient care.)
  - Define a Measure to be obtained:
  - Establish a desired measurement target/goal (What does the group want it to be to achieve an appropriate standard of performance and/or patient care?):
  - Estimate the predicted baseline measurement result (What does the group think it *will* be?):

- **Step 2: DO. Baseline Measurement Summary**
  
  - Number of Data Points collected:
  - Baseline Measurement Value calculated:

- **Step 3: STUDY. Baseline Data Analysis**

*Templates include steps to comply with ABR Meaningful Participation Standards*
Group PQI Criteria

- Group consists of 2 or more ABR diplomates
- Group Project Team Leader
  - Team organization, meetings and record keeping
  - Must document team participation
- Project may be group designed, society-sponsored, or involve a registry
- Requires at least 3 team meetings:
  - Project organization meeting
  - Data and root cause analysis meeting
  - Improvement plan development
GROUP PQI: INDIVIDUAL CREDIT
MEANINGFUL PARTICIPATION

Individual diplomate MOC PQI credit requires:

- Documented attendance at 3 team meetings
- Personal self-reflection statement describing impact of project on practice or patient care
- Access to project records in event of an ABR audit
- Attestation on ABR Personal Database (PDB) to in-progress participation and/or project completion
Changes in PQI Attestation

PQI Project Outline

Project: ARRS - Screening Patients
Type: Baseline
Project Type: Diagnostic

Step 1 - Plan
Step 2 - Do
Step 3 - Study
Step 4 - Act

Go to where I left off.
PQI Project Outline

Project: ARRS - Screening Patients  
Type: Baseline  
Project Type: Diagnostic

Project Status 100%

- Step 1 - Plan
- Step 2 - Do
- Step 3 - Study
- Step 4 - Act
Transparency and Accountability

Continuous Certification
A Lifetime of Professional Competence

ANNUAL REPORT 2011-2012
View the 2011-2012 Annual Report:

- Electronic Book Format
- PDF File

View The Beam, Spring 2012

ABR Video
Find out more about the ABR and MOC

More News & Updates >>

Certification Information from the American Board of Medical Specialties (ABMS)

The mission of the American Board of Radiology is to serve patients, the public, and the medical profession by certifying that its diplomates have acquired, demonstrated, and maintained a requisite standard of knowledge, skill, and understanding essential to the practice of diagnostic radiology, radiation oncology, and medical physics.

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Unless retiring in 1-2 years, you belong in MOC.
Patients expect doctors to continuously improve. MOC is your framework for CPD.
Much is being done to align MOC with practice life, and to minimize busy work and duplication.
Continuous Certification simplifies MOC and makes requirements easily understood for everyone.
Website is being streamlined and modernized. Look for myABR in March of 2013.
SUMMARY

- Public reporting of MOC status on ABMS and ABR website to begin 03/2013 (ABMS standard)
- MOC is part of the federal accountability framework; ABR diplomates can earn incentive, avoid penalties
  - MOC:PQRS, next:
  - Reporting of Board Certification and MOC status on Physician Compare website; more detailed reporting ahead
  - Value-based payment modifiers (ABR remaining engaged)
  - Possible: MOC = structural equivalent of PQRS reporting
- Majority of U.S. physicians will be employed. Future of medical professional self-regulation is dependent upon the success of MOC