

THE ABPN MAINTENANCE OF CERTIFICATION PROGRAM FOR NEUROLOGISTS; PAST, PRESENT, AND FUTURE

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Introduction

Since its inception in 1934, the American Board of Psychiatry and Neurology (ABPN) has attempted to design processes for the credentialing and evaluation of neurologists in a manner to assure the public that its diplomates are competent to practice their specialties.¹ Increasing public and political concerns about medical errors, patient safety, and quality of care² have shifted the focus of attention of the ABPN and other Member Boards of the American Board of Medical Specialties (ABMS) to the identification and evaluation of specific neurology competencies and to maintenance of certification (MOC).³

There is also evidence in the literature that supports the movement toward MOC as a program of life-long medical learning. Reviews of studies of medical knowledge and health care quality compared to years in practice and physician age have found that 73% (45/62) of the studies reported decreasing physician performance with increasing years in practice for at least some outcomes; 100% (12/12) reported decreasing physician knowledge with increasing experience; 63% (15/24) reported decreasing adherence to standards of practice with increasing years in practice; 74% (14/19) reported decreasing adherence to standards of appropriate therapy with increasing physician age; and 57% (4/7) reported decreasing actual health outcomes with increasing years in practice.⁴ The ability of physicians to evaluate their own performances has also been questioned.⁵ It has been reported that 65% (13/20) of studies have found that physicians' self-assessments were inconsistent with observed measures of their competence. The worst accuracy in self-assessment was frequently among the least skilled or most confident physicians.

The public also seems to support MOC. In a 2003 Gallup Poll commissioned by the American Board of Internal Medicine, 54% of respondents said they would "very likely" change physicians if they knew that their current physician's board certification had expired; 75% would opt for a board-certified physician over a non-board-certified physician recommended by a trusted friend or family member; 73% considered it "very important" for physicians to be re-evaluated on their qualifications every few years; and 68% considered it "very important" for physicians to periodically pass a written test of medical knowledge.⁶

In designing its MOC Program, a significant challenge for the ABPN has been to strike a balance among the sometimes conflicting factors of quality and credibility, convenience and cost, and diplomate satisfaction and participation. The ultimate ABPN objective is to develop an MOC Program that is of high quality and credibility, relatively convenient and affordable, and sufficiently acceptable that diplomates will participate in it.

Philosophical Foundation of the ABPN MOC Program

There are several interconnected philosophical tenets that form the rationale for the existence and current structure of the ABPN MOC Program. Attention to most of these issues has actually been a focus of the ABPN since its inception,¹ and they are now reinforced in the ABPN MOC Program.

Accountability. A major goal of the ABPN has always been to reassure the public about the qualifications of its diplomates.¹ This has now been extended through the ABPN MOC Program to cover diplomates over their entire professional careers.

Independence. Another theme from the beginning of the ABPN has been the perceived pressure to act before some government entity steps in to take control.¹ Increasing public and political concerns about patient safety and the quality of medical care have been significant stimuli for the expeditious development of the ABPN MOC Program.

Competence. Attention to diplomate competence has always been a central component of ABPN evaluation processes.¹ The recent focus on core competencies throughout medical education, however, and the identification of specific core competencies for neurologists, have modified the ABPN initial certification processes and also guided the design of all components of the ABPN MOC Program.³

Continuous Quality Improvement. Increasing awareness of the importance of continuous quality improvement in the business and professional sectors was one of the major factors that called into question the adequacy of the more limited and intermittent approach of the original ABPN Recertification Program.⁷ It has also influenced the development of the Self-assessment and Performance in Practice components of the ABPN MOC Program.

Professionalism. ABPN diplomates have always been required to possess an unrestricted medical license as one means of demonstrating acceptable professionalism.¹ The Professional Standing component of the ABPN MOC Program will continue this emphasis, and professionalism will be addressed in the Performance in Practice component as well.

Credibility. ABPN certification has frequently been cited as one measure of diplomate qualification for academic and other purposes.¹ A major goal of the ABPN MOC Program is for it to be designed in a manner that will be acceptable to public and private organizations concerned with licensure, credentialing, privileging, accreditation, and physician reimbursement.⁸

Scientific Rigor. The ABPN has always attempted to develop and implement its certification and recertification examinations in a manner consistent with state-of-the-art psychometric processes.¹ The ABPN MOC Program has also been designed with that goal in mind.

Collaboration. While the ABPN has always been an independent organization,¹ it is also one of 24 Member Boards of the American Board of Medical Specialties (ABMS) which has established required guidelines for its Member Board certification and MOC initiatives.⁹ The ABPN MOC Program is required to be developed and implemented in a manner that is consistent with those guidelines and also as responsive as possible to constructive feedback from diplomates and other professional organizations.

Components of the ABPN MOC Program

Cognizant of the need to reassure the public about the competence of specialist physicians, in the late 1980's the ABMS joined with the Accreditation Council for Graduate Medical Education (ACGME) to formulate the six areas of competency that physicians should develop and maintain throughout their professional careers: medical knowledge, patient care, interpersonal and communication skills, practice-based learning and improvement, professionalism, and systems-based practice.¹⁰ The ABPN responded to the ABMS mandates and established a ten-year MOC cycle, developed its own specific requirements for each of the four components of its MOC Program, ensured that its MOC Program addressed all six core competencies, and adopted a specific timetable for the phase-in of each MOC component (Table 1).

1. Professional Standing. Lacking the resources and the mandate to implement its own independent process to thoroughly evaluate physician ethics and professionalism, the ABPN has always relied on the requirement that its candidates and diplomates must possess a license to practice medicine in at least one state, commonwealth, territory, or possession of the United States or province of Canada, and all licenses must be unrestricted. This requirement continues in the ABPN MOC Program and went into effect at its inception in 2007 (Table 1).

Many state medical boards now mandate that physicians complete a certain number of hours of continuing medical education (CME) to maintain licensure and also require new licensure applicants to have completed some type of cognitive examination within a specified time period. The Federation of State Medical Boards (FSMB) and some individual state medical boards are currently considering whether or not to require physicians to participate in a Maintenance of Licensure Program that is akin to the ABMS MOC Program.¹¹

2. Self-assessment and Life-long Learning. This component of the ABPN MOC Program actually consists of two parts: self-assessment (SA) and CME. Over the ten-year MOC cycle, diplomates will be required to show evidence of participation in at least two SA activities, and this requirement will be phased in beginning in 2010 (Table 1). To be accepted by the ABPN, SA activities (e.g., examinations) must total at least 100 questions, cover new knowledge or current best practices, and provide feedback to diplomates that can be used to guide subsequent CME, life-long learning, and career development. The minimum of 100 questions can come from multiple SA activities. When the ABPN MOC Program is fully implemented in 2017, the first of the two required SA activities must be completed during years one to three of the ten-year MOC cycle and the second during years six to eight. This should help ensure that SA activities guide diplomates' continuous cognitive development and CME activities.

Beginning in 2007, diplomates will be required to complete an average of 30 specialty or subspecialty Category One CME credits per year over the ten-year MOC cycle (Table 1). To be accepted by the ABPN, CME activities must be accredited by the Accreditation Council for Continuing Medical Education (ACCME) or the Royal College of Physicians and Surgeons of Canada (RCPS(C)), and CME activities must be relevant to the specialty in which a diplomate is certified. Diplomates certified in more than one area will still only need to accrue an average of 30 CME credits per year, as the same CME credits can be used to satisfy the MOC requirements for multiple ABPN subspecialties. When the ABPN MOC Program is fully implemented in 2017, 150 CME credits must be earned during each five-year block of the ten-year MOC cycle. This should help ensure that diplomates attend to their cognitive development in a continuous manner. Considered together, SA and subsequent CME might be viewed as a quality improvement cycle focused primarily on medical knowledge.

3. Performance in Practice. This component of the ABPN MOC Program is designed to encourage diplomates to incorporate the principles of quality improvement into their clinical practices. Each Performance in Practice (PIP) Unit consists of two parts: a PIP Clinical Module and a PIP Feedback Module. Over the ten-year MOC cycle, diplomates will be required to complete three PIP Units, and this requirement will be phased in beginning in 2013 (Table 1). When the ABPN MOC Program is fully implemented in 2017, the first of the three required, two-part PIP Units must be completed during years one to three of the ten-year MOC cycle, the second during years four to six, and the third during years seven to nine. This should help ensure that diplomates demonstrate their ongoing attention to clinical quality improvement. As with SA and CME, PIP Units complete quality improvement cycles, but here the focus is on clinical activities.

To be accepted by the ABPN, PIP Clinical Modules must require that diplomates collect data from at least five of their own clinical cases in a similar category (e.g., diagnosis, type of treatment, location of service) over the previous three-year period; compare that data with published best

practices, practice guidelines, or peer-based standards of care (e.g., hospital quality improvement programs); identify opportunities for improvement in the effectiveness or efficiency of their clinical activities; take steps to implement the suggested improvements; and, within two years, collect the same data on another five clinical cases in the same category to see if improvements in clinical activities have occurred. The specific focus of the category in the PIP Clinical Modules and the comparison standards selected (e.g., practice guidelines) are chosen by the diplomates themselves and not by the ABPN.

To be accepted by the ABPN, PIP Feedback Modules must require that diplomates solicit the opinions of at least five peers or five patients concerning their clinical activities over the previous three-year period; identify opportunities for improvement in the effectiveness or efficiency of their clinical activities; take steps to implement the suggested improvements; and, within two years, solicit the feedback of at least another five peers or five patients to see if improvements in clinical activities have occurred.

4. Cognitive Expertise. Once they have satisfied all of the other ABPN MOC Program requirements that are in effect at the time that their certification is due to expire, diplomates are qualified to take the ABPN MOC Cognitive Examination (Table 1). Diplomates must be able to provide records documenting completion of SA, CME, and PIP requirements, and some of those applying to complete the MOC Cognitive Examination will be audited by the ABPN.

Similar to their predecessor, the ABPN Recertification Examination, the MOC Cognitive Examinations in neurology and child neurology are multiple-choice, computer-based tests. They are administered at Pearson VUE Professional Centers located in over 200 sites around the country. The MOC Cognitive Examinations are practice relevant and focus on the clinical application of knowledge. Specific content outlines for the MOC Cognitive Examinations are available on the ABPN website (www.abpn.com). Diplomates must pass the MOC Cognitive Examination prior to the expiration date on their ABPN certificate, and a passing score extends the renewal date of their certificate to December 31 of the tenth year after the date of the examination. As has historically been the case for all ABPN recertification examinations, it is expected that the pass rates for the ABPN MOC Cognitive Examinations will be high.

Preparation of ABPN MOC Products for Diplomates

As the different required components of the ABPN MOC Program are instituted (Table 1), diplomates will need to have available options for their fulfillment. Unlike some of the other ABMS Member Boards, the ABPN has decided at this point not to undertake the preparation of MOC products other than the MOC Cognitive Examinations themselves and some model forms available on the ABPN website (www.abpn.com) that might assist diplomates with completion of their PIP Units. To be accepted by the ABPN, SA activities, CME credits, and PIP Units must meet the criteria for approval outlined above, but they do not have to be formally endorsed by the ABPN.

This decision by the ABPN not to develop its own MOC products partly represents its long-standing philosophical position that processes and products to help prepare diplomates to meet its certification and MOC requirements should be developed, if possible, by non-ABPN organizations and individuals. It also embodies the belief of the ABPN that the entire MOC process should be a collaborative venture with its affiliated professional organizations, and that this approach stands the best chance of encouraging diplomates to participate in the MOC Program. To that end, the ABPN has already approved several CME (e.g., Continuum, Quintessentials, and American Academy of Neurology (AAN) meetings) and SA (e.g., Continuum post-reading questions and Quintessentials program modules) activities prepared and submitted by the AAN and created links to those products on its website (www.abpn.com).

Discussion

The ABPN MOC Program is a work in progress, and a number of questions about it remain to be answered completely. First, will diplomates participate in the voluntary ABPN MOC Program? If the ABPN MOC Program is relatively convenient, reasonably priced, and broadly recognized as a legitimate measure of physician competence, then we expect a high rate of diplomate participation. The only MOC fee charged by the ABPN will be for its Cognitive Examination, and that fee will be reduced from \$2,125 in 2007 to \$1,900 in 2008.

Second, will organizations that license, credential, privilege, and reimburse physicians accept diplomate participation in the ABPN MOC Program in lieu of their own specific requirements? We believe that the success of this effort may well depend upon how specific MOC components are designed and implemented. For example, some organizations may require physicians to demonstrate their competency in specific areas (e.g., patient safety, professionalism, adherence to certain practice guidelines), through specific requirements (e.g., total numbers of SA, CME, and PIP activities), in a relatively continuous manner (e.g., number of SA, CME, and PIP activities per year of the MOC cycle), or according to specific time frames (e.g., length of the entire MOC cycle). The ABPN plans to ensure that its MOC Program has the flexibility to respond to these or other similar requirements that may evolve over time.

Third, will diplomate participation in the ABPN MOC Program satisfy the public and political pressures for documentation of continued physician competence? We expect that the continuous involvement of diplomates in MOC activities that demonstrate their ongoing competence will be especially important in this regard. This effort would certainly be strengthened by rigorous research that links MOC activities to positive patient outcomes and by auditing requirements that ensure that diplomates participate in meaningful MOC activities.

Fourth, will professional organizations affiliated with the ABPN (e.g., the AAN) develop sufficient MOC products to meet diplomate needs? If this does not occur, the ABPN may be forced to take steps to develop its own MOC products, as it obviously cannot find itself in the unfortunate situation of requiring diplomates to fulfill requirements that they have no means to accomplish.

Fifth, will ABPN diplomates whose certificates are not time-limited be required to participate in the ABPN MOC Program? When the ABPN Recertification Program began, all diplomates certified before 1994 were exempt from having to complete the Recertification Examination. These diplomates were told that, upon completion of all requirements then in effect for ABPN certification, they would hold a "life-time" certificate as long as they maintained an unrestricted license to practice medicine. It was believed to be legally untenable to attempt to subsequently modify that implicit agreement between the ABPN and those diplomates by requiring them to become recertified. Likewise, these same diplomates are also exempt from having to participate in the ABPN MOC Program. Despite this policy, all current ABPN Directors are required to participate in the ABPN MOC Program, and some diplomates with "life-time" certificates are choosing to do so voluntarily.

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Table 1. Phase-in Schedule for ABPN MOC Components

Original Certification Year	MOC Application Year	MOC Examination Year	CME Credits Required	First SA Activity Required	Second SA Activity Required	First PIP Unit Required	Second PIP Unit Required	Third PIP Unit Required
1997	2006	2007	30					
1998	2007	2008	60					
1999	2008	2009	90					
2000	2009	2010	120					
2001	2010	2011	150	X				
2002	2011	2012	180	X				
2003	2012	2013	210	X				
2004	2013	2014	240	X	X	X		
2005	2014	2015	270	X	X	X		
2006	2015	2016	300	X	X	X	X	
2007	2016	2017	300	X	X	X	X	X

Notes: Every ABPN diplomate must possess a medical license, and all licenses must be unrestricted.

Each SA activity must total a minimum of 100 questions.

Only after completing licensure, CME, SA, and PIP requirements are diplomates qualified to complete the ABPN MOC Cognitive Examination.