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American Board of Medical Specialties
1007 Church Street, Suite 404
Evanston, IL 60201
T: (847) 491-9091
F: (847) 328-3596
www.abms.org

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Kevin Weiss, MD

Statement of Kevin Weiss, M.D., MPH; President and CEO
American Board of Medical Specialties (ABMS)

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Hearing on Improving Health Care Quality: A Key to Healthcare Reform

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Chairman Baucus, Senator Grassley and members of the Senate Finance Committee, thank you for the invitation to testify about improving health care quality. My name is Kevin Weiss, and I am a physician, board certified in internal medicine and President/CEO of the American Board of Medical Specialties (ABMS).

ABMS is an independent, non-profit organization which for 75 years has been assisting 24 medical specialty boards in developing and using standards to evaluate and certify physicians. The Boards were founded to assure the public that physicians have the knowledge, skills and attitudes to practice in a given specialty. ABMS, recognized as a "gold standard" in physician certification, believes higher standards for physicians means better care for patients and extensive research confirms this.[i,ii] We are pleased that national surveys suggest that over 90% of the general public use Board Certification in their choice of physician.

ABMS's reach is broad and deep – There are over 700,000 US Medical Doctors and Doctors of Osteopathy that hold a certificate by one or more of ABMS' Boards, – and the standards that we set shape both medical residency training programs and physician practices of all sizes in every conceivable setting. The profession's investment in enhancing quality through the Boards is significant, totaling

approximately $150 million annually, and are paid by physician fees. We speak of fees as the certifying boards are not membership organizations. We are funded by physicians voluntarily seeking to prove that they can reach the high mark of initial board certification and, more recently, maintenance of certification (MOC). We are fortunate that the physician community supports and respects our role – with an estimated 85% of the U.S. physician workforce voluntarily going through the certification process as evidence of their support.

ABMS Boards are "public facing" in that we set standards to assure patients about the competency of physicians, and patients regularly seek out board certification as a marker of quality whether choosing a pediatrician, cardiologist, neurosurgeon, radiologist or any other kind of physician. Our Boards are not member organizations, nor do we accept support from the pharmaceutical or medical device industries in order to maintain our independent, standard setting status. Also, our focus on standard setting for the profession is not associated with any discussion about physician payment. In short, ABMS Boards are private sector oversight organizations very similar in mission, for example, to the National Committee for Quality Assurance (NCQA) or The Joint Commission.

ABMS Boards have embraced a new definition of professionalism – embodied in a Physician Charter[iii] adopted by 130 medical organizations across the globe – that commits physicians to a set of principles that resonates with the notion of value-based purchasing that many public and private sector healthcare leaders have embraced, including many members of this Committee. These principles include a commitment to improving quality of patient care, and also recognize that physicians have a key role to play in controlling costs as stewards of the community's scare medical resources.[iv]

In my testimony today I hope to inform the Committee about three key issues:

1) **No single strategy is sufficient to improve our health care system.**

2) **The best model for physician accountability will need to combine performance measurement with other tools for physician assessment, and**

3) Alignment of public and private sector quality agendas will provide the strongest possible basis for physician accountability and health system improvement.

Let me briefly provide some detail on each issue. First **we believe that no single strategy is sufficient to improve our health care system.** To cross the chasm that exists in quality, we believe that multiple strategies are needed to leverage the distinct and potentially complimentary roles of regulation, the market and professional accountability. Most physicians in practice are imbued with a deep sense of professional responsibility to provide the best possible care to their patients – but they have not historically had the data to know how they are doing or the tools to help them improve identified weaknesses. The certifying boards have demonstrated that with trusted and actionable data, physicians will get engaged in improving care -- thereby tapping into their intrinsic motivation to do well by their patients;

The best model for physician accountability will need to combine performance measurement with other tools for physician assessment. The tools ABMS Boards use to assess physician competency are multi-faceted – and we believe that taken together they provide a comprehensive picture of an individual physician's performance. Research shows that while performance measures are important, they are not sufficient to fully assess physician competency.

The standards that the Boards set and the tools that they use to periodically assess physicians are varied – and together represent a

comprehensive picture of physician competency. Examples of these tools include those that focus on performance measures -- clinical measures, CAHPS patient experience surveys, and a condensed version of the NCQA physician practice connections (PPC) – in addition to other kinds of evidence based tools. These tools have been rapidly evolving over the last decade as the science of assessment has become more sophisticated and as the physician community has learned about the scope and depth of the nation's healthcare quality problem.

Based on these different kinds of performance measures, ABMS Boards generate web-based reports that provide physicians with the information they need to know how they are doing and to diagnose practice strengths and weaknesses. For example, if a physician is not doing a good job of helping her diabetic patients to control glucose levels, she can examine if it is because she needs to learn about new medications, or because her patients do not understand how to manage their condition, or because her office does not have the practice infrastructure in place to regularly identify at risk patients and bring them in for a visit. This kind of data is actionable and the ABMS Boards require that physicians design and implement a quality improvement intervention in response to the individual reports they receive, and then measure the effects of that intervention on their practices.

While practice-based performance assessment is a key component of Board assessment, many aspects of physician clinical competency do not lend themselves to being represented as performance measures -- even as such performance measures become more sophisticated -- because of the complex and/or multi-faceted nature of what they are assessing or because many conditions for which people seek care are

not common; for example while it is possible to develop performance measures to examine the care of diabetes or breast cancer screening which are important and frequent public health problems, other important patient needs such as the diagnosis and treatment of thyroid disease, viral meningitis or rheumatoid arthritis are thankfully much less common -- limiting any role for performance measures in assessment of a physicians skill for such issues. The ABMS Boards have other tools for such assessment that include:

- A secure closed book exam targeted to their medical specialties and scope of practice that assesses whether a physician is staying current in their field. The evidence suggests that this is critical when you consider that 10,000 randomized controlled trials are conducted every year along with the related new medical knowledge that such research generates.
- An evaluation of clinical judgment, through high and low fidelity simulation exercises, which is similar in concept to those simulation exercises that pilots must use to demonstrate their skills.
- Requirements for ongoing continued professional development through required standards for continuing medical education based on self assessment tools with feedback.

While performance measures are beginning to provide a window into practice quality – particularly determining if needed processes have been implemented – they are not able to round out a full picture of physician competency, including diagnostic acumen, clinical judgment, ability to appropriately and efficiently manage care, and grasp of the ever evolving evidence base. The ABMS Boards have been providing that broader assessment, and look forward to integrating our work

more seamlessly into the wider accountability framework.

Our last key issue is that only by public and private sector alignment will we achieve the strongest possible basis for physician accountability. Out of a desire to reduce wasteful, redundant data collection and to accelerate improvement, the ABMS Boards have begun to align their assessment methods with those of private health plans, hospitals, CMS and other emerging forces in the quality movement such as NQF and the health care quality Alliances. The focus to date has been in the performance measurement arena – which has taken the form of health plans and hospitals recognizing and/or rewarding physicians for assessing their performance as part on ongoing certification. This has translated into pay for performance rewards, input into placement within health plan physician recognition programs based on quality, recognition in provider directories, and input into hospital staff credentialing programs. In addition, a number of ABMS Boards are helping to facilitate the reporting of clinical data to CMS as part of the Physician Reporting Quality Initiative. These arrangements serve to incentivize physicians to more regularly (in most cases annually) self assess performance – a habit of practice that ABMS Boards are well positioned to inculcate – and allows physicians to collect data once and use if for multiple purposes.

This alignment of performance measurement efforts is an important first step but not adequate to realize the performance gains that our healthcare system needs and our patients deserve. Other areas of alignment include public and private payer expectation that physicians will regularly maintain their certification – which includes ongoing participation in the full range of assessment activities. For more than a decade, ABMS Boards have been providing time limited certification that must be periodically renewed. Given the evidence that knowledge

and skills deteriorate over time[v] – or in other words that practice does not make perfect – it is vitally important that physicians are regularly keeping up and have feedback from a trusted source as to where they are performing well and where improvement is needed. The ABMS Boards are not seeking that payers – particularly the public sector -- require ongoing certification out of concern that a requirement will undermine the strong voluntary support that board certification currently enjoys from the profession. However incentives and strongly communicated expectations can go a long way in signaling to the physician community the importance of this driver towards improved quality of care.

The ABMS Boards are developing new kinds of partnerships with public payers, private payers, and particular patients and consumer groups who represent them to get a deeper appreciation about the kinds of information they seek and their expectations for care – and we seek to further such collaborations. For example, ABMS has just embarked on a project with the National Quality Forum (NQF) that will bring together leaders from the major healthcare stakeholder groups at a national summit to discuss how board certification may be better integrated into the accountability framework as well as to gain a deeper understanding of their expectation for the ABMS Boards. The ABMS has also been serving on the NQF National Priorities Partnership Committee and we will be bringing a resolution to endorse the national priorities to the ABMS Board meeting later this month. My colleague, Dr. Bill Roper, will next be discussing this effort in more detail.

In summary, the ABMS Boards are rooted in the profession but firmly committed to serving the public – which is a mission we share with the public sector. Ultimately while market levers, including pay for performance programs and public reporting programs, as well as

regulatory requirements may be able to partially shape physician practice , they will not in and of themselves be able to bring about the radical changes needed in the practice of medicine that are necessary to transform our nation's healthcare system. Professional accountability – and the public facing values it embodies – offers a proven mechanism to connect to physicians and engage them in improving patient care. Then perhaps by bringing to bear professional accountability as offered by the ABMS Boards, along with the emerging efforts in public accountability by Congress through CMS, along with marketplace efforts we can more rapidly achieve the high quality, efficient, and patient-centered health care system that we would all like to see, know is possible, and that our patients deserve.

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[i] Holmboe ES, Wang Y, Meehan TP, et al. Association between maintenance of certification examination scores and quality of care for Medicare beneficiaries. *Arch Intern Med*. 2008;168:1396-1403.

[ii] Holmboe ES, Lipner R, Greiner A. Assessing quality of care: knowledge matters. *JAMA*. 2008;299:338-340.

[iii] ABIM Foundation, ACP-ASIM Foundation, European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med*. 2002;136:243-246.

[iv] Cassel CK, Brennan TA. Managing medical resources: a return to the commons? *JAMA*. 2007;297:2518-2520.

[v] Choudhry NK, Fletcher RH, Soumerai SB. Systematic review: the relationship between clinical experience and quality of health care. *Ann Intern Med*. 2005;142:260-273.