American Board of Medical Specialties
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DATE: January 25, 2011

TO: ABMS Member Board Executives
ABMS Committee Chairs
ABMS Associate Members

CC: ABMS Board of Directors
F. Daniel Duffy, MD
Richard E. Hawkins, MD

FROM: Mellie Villahermosa Pouwels on behalf of F. Daniel Duffy, MD
Chair, ABMS Maintenance of Certification (MOC) Committee

RE: ABMS White Paper on MOC CME

During its meeting in December 2010, the ABMS MOC Committee officially received the ABMS/ACCME Joint Working Group on MOC CME white paper. Per the committee's request, additional text was incorporated to provide stakeholders with a better understanding of the white paper's purpose within the context of the future development and refinement of an MOC CME framework. Upon review and approval by Dr. Daniel Duffy, the MOC Committee Chair, the final version was included in the ABMS Board of Directors' January 2011 Retreat materials.

The MOC Committee also endorsed the dissemination of the amended white paper to external parties for further discussion and development. Please note that while the white paper is being broadly distributed within the ABMS Board Enterprise, it is also being shared with leadership of the Alliance for Continuing Medical Education (ACME), the Society of Academic Continuing Medical Education (SACME), and the National Institute for Quality Improvement and Education (NIQIE) for review and comment. With this distribution approach in mind, we also encourage you to forward this white paper to educational leaders within your respective societies, academies, colleges, academic institutions, and other educational partners.

All interested individuals and entities are encouraged to submit comments to inform the MOC Committee as they guide the ongoing evolution of the ABMS MOC program. Comments are to be received in written form sent to the attention of the ABMS MOC Support Program or via email sent to ABMS_MOC_Support_Program@abms.org by Tuesday, March 1, 2011.

Attachment

White Paper: CME for MOC
ABMS/ACCME Joint Working Group on MOC CME
January 2011

Background: The ABMS/ACCME Joint Working Group on MOC CME was proposed by the ABMS MOC Task Force in 2009 and was charged to serve as a "think tank" to explore the concept of MOC CME during 2010. Representatives were appointed by both ABMS and ACCME, based upon their expertise and experience in CME accreditation policies and program planning. The Working Group was co-chaired by Debra Perina, MD (ACCME Chair) and Tom Norris, MD (ABMS Vice-Chair). Additional Working Group members included David Davis, MD (ABMS), Nancy Davis, PhD (ABMS), George Mejicano, MD (ABMS), Ajit Sachdeva, MD (ABMS), Richard Berger, MD, PhD (ACCME), Karla Matteson, PhD (ACCME), Richard Reiling, MD (ACCME), and Sterling Williams, MD (ACCME). Senior leadership and staff from both organizations also served as facilitators and supported the working group. The working group had one conference call and two in-person meetings.

Initially, the group focused on key topics that would inform their subsequent discussions of MOC CME. The initial agenda included presentations and group discussion regarding the evolving standards for MOC and the related implications for CME; the current state of CME accreditation systems; the current status of CME credit systems; and the differences among what the ABMS Member Boards accept in terms of CME (for Part II and Part IV). With this information in mind, the group began its discussions and prepared the following recommendations. As noted in these recommendations, the ABMS MOC Committee is tasked with developing a proposed implementation plan. Throughout 2011, the MOC Committee will refine its proposed implementation plan and present this plan within the context of an evolving MOC program.

Findings: The group first reaffirmed that MOC CME appropriately exists as a distinct subset within the universe of accredited CME. MOC CME possesses a discrete set of characteristics enabling it to optimally support the principles and objectives of MOC.

Traditionally, CME was thought to be relevant to only Part II. However, MOC CME has relevance to all 4 Parts of MOC creating a cyclical linkage between guided self- assessment of knowledge and practice and education and practice improvement activities across the MOC framework. Strengthening this linkage could stimulate and promote diplomate practice improvement and professional growth.

The characteristics of CME that are of specific relevance for MOC were divided into three focus areas and include the following:

- Clinical (and Professional) Content
    - Learner Centered--diplomates are expected to ensure the practice relevance of the educational or practice improvement activity and to demonstrate learning and/or improvement outcomes.
- Educational Format and Quality
    - CME Provider (program) Centered--characteristics of CME programs would include the deployment of appropriate learning needs and practice outcomes assessments, the use of educational formats that have been shown to correlate with desired learning outcomes, and compliance with commercial support/influence requirements subsequently approved for MOC CME. The clinical content of the educational program

must be supported by the best available evidence, and the level of evidence supporting the educational content must be transparent to the learner.

- Requirement for Proportional Coverage of the ABMS/ACGME Competencies
  - Historically, CME has been heavily oriented toward acquisition of medical/clinical knowledge. MOC CME must include education and skill development that addresses the broader set of ABMS/ACGME competencies; learners should ensure that their CPD/CME efforts, in sum, include learning in all six competencies.

The differences between Continuous Professional Development (CPD) and Continuing Medical Education (CME) as related to MOC CME are important. CPD may be defined as what the physician does to remain current, expand awareness, knowledge and skills, and provide quality care, while CME represents the educational and practice improvement tools and resources used in support of CPD. Therefore, MOC CME is more appropriately considered a CPD model.

The roles financial relationships with industry should play in regard to MOC CME were explored. ABMS serves as a public trust and published articles suggest the public's perception concerning commercial funding of CME for physicians is not positive. As such, it is important for ABMS to reflect both the reality and perception of the consequences of relationships between industry and physicians, as well as between industry and CME providers. Both sets of relationships have come under public scrutiny, and both deserve consideration Commercial entities provide close to one billion dollars of annual support for CME, and this support has the potential to influence both the content and the availability of educational programs.

The working group considered the continuum of acceptable commercial support. On one end of the continuum is the current state (i.e., commercial support is allowed in accordance, at a minimum, with the ACCME's Standards for Commercial Support, which require that planning, delivery, and evaluation must be independent of commercial influence). On the other end of the continuum was the position that no commercial support of any kind would be acceptable. Initial discussion addressed the issues of public trust versus public perception and the influence of commercial support on the national CME curricula. The positive role of commercial support was also considered. There may be alignment between commercial support and the public interest to the extent that commercial support may 1) facilitate affordable access to CME activities for physicians (especially physicians in rural and/or underserved areas); 2) accelerate the translation of new science and technologies into clinical practice and drive practice change (the importance of this aspect for equipment dependent specialties such as surgery and radiology was emphasized); 3) promote multi-center or multi-provider group activities; and 4) encourage educational innovation. Commercial support may become less of an issue if educational content is relevant to practice, evidence-based, practice-based, and includes core competencies. Ultimately the recommendations must consider what is best for patients, regardless of the mechanism of support. It is recognized that allowable levels of commercial support may vary among Member Boards.

Recommendations:

1. ABMS and the MOC Committee should assist the Member Boards in facilitating the development of approaches to CME for MOC Part II and Part IV that emphasize "informed learning" or "formative CME/CPD" for diplomates that incorporates the following characteristics:
   a. Addresses self- or externally-identified practice gap(s)

   b. Is relevant to the physician's scope of practice
   c. Utilizes evidenced-based content (best available which is shared with diplomates)
   d. Includes established professional standards of care/behavior (when available)
   e. Demonstrates that planning, delivery, and evaluation is independent of commercial influence
   f. Reflects preference for sequential programming (presented in multiple formats) to reinforce learning
   g. Includes formative and/or summative assessments
   h. Documents learning and performance or outcome improvement
   i. Utilizes effective instructional approaches such as interactive, case-based, team-based learning
   j. Includes concepts of quality improvement and patient safety

2. The ABMS and the MOC Committee should assist the Member Boards in developing approaches to Part II and Part IV MOC CME that emphasize coverage of all core competencies. These approaches should:
   a. Address the unique educational needs of each Member Board's scope of practice
   b. Be based on formative and/or summative assessment (including Part I peer/patient surveys and Part III examination results to further integrate all parts of MOC)
   c. Encourage the integration of multiple competencies within single programs (i.e., medical knowledge, system-based practice, and communication), and inclusion of all competencies within the entirety of a diplomate's CPD program
   d. Ensure that Part II activities inform Part IV participation, and that Part IV activities inform Part II educational needs

3. ABMS and the MOC Committee must consider the diplomate-centered and program-centered characteristics of MOC CME in subsequent discussions regarding development and integration of MOC CME into the MOC framework and standards.

   A general framework for MOC CME must be developed that assures the public trust by progressively eliminating or reducing, to the extent possible, influence exerted by commercial entities.

   The MOC Committee should include feedback from the ABMS Ethics and Professionalism Committee, other related standing committees, and public input, to allow full consideration of perceptions of specific bodies and the public to assure optimal degrees of separation between educational and commercial interests.

4. The MOC Committee should continue discussions with the ACCME and others regarding the development of a "standard currency" for MOC CME that would ensure interchangeability of programming between Member Boards, and other stakeholders, and would also identify the special nature of CME programming that meets the identified characteristics of MOC CME.

This document was received by the MOC Committee on December 06, 2010.