The Future of CME
and Why It’s Important
for US Healthcare

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School of Medicine and Public Health
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Disclosure Slide

- Dr. Mejicano has no personal financial relationships with commercial interests
- Dr. Mejicano is a CME consultant to the American Board of Medical Specialties
Forces for Change in CME/CPD

**Bridge to Quality and Collaboration**

**Forces for Change in CME/CPD**

**Increased Regulation, Scrutiny, Criticism, and Transparency**

**New Rules/Roles for CME?**

- FDA allows certified CME as part of REMS
- ACCME increases transparency through the release of increased information about providers
- US Senate Special Committee on Aging holds CME
- ABMS adopts new standards for Maintenance of Certification
- JOM issues report on "Conflict of Interest in Medical Research, Education, and Practice"

**2001 to 2009**

- Conjoint Committee on CME Formed to Reposition CME
- Recommendations to address the gap in knowledge & performance
- IOM Report; "Crossing the Quality Chasm: A New Health System for the 21st Century"
- "Quality problems are everywhere, affecting many patients. Between the health care we have and the care we could have lies not just a gap, but a chasm..."

**2002 to 2010**

- PI — CME
  - New CME credit format rewarding quality improvement in practice
- ABMS underscores Performance Improvement for Maintenance of Certification Part IV

**Winds of Change**

- ABMS mandates Performance Improvement for Maintenance of Certification Part IV

**2003 to 2011**

- PI — CME
  - New CME credit format rewarding quality improvement in practice

**Crossing the Chasm**

- "CME as a Bridge to Quality: The ACCME Updated Accreditation Criteria"

**2004 to 2012**

- Pay for Performance
- From reporting to improving

**2005 to 2013**

- Conjoint Committee on CME Formed to Reposition CME
- Recommendations to address the gap in knowledge & performance
- IOM Report; "Crossing the Quality Chasm: A New Health System for the 21st Century"
- "Quality problems are everywhere, affecting many patients. Between the health care we have and the care we could have lies not just a gap, but a chasm..."

**2007 to 2015**

- ABMS mandates Performance Improvement for Maintenance of Certification Part IV

**2008 to 2016**

- PI — CME
  - New CME credit format rewarding quality improvement in practice

**2009 to 2017**

- Pay for Performance
- From reporting to improving

**2010 to 2019**

- Conjoint Committee on CME Formed to Reposition CME
- Recommendations to address the gap in knowledge & performance
- IOM Report; "Crossing the Quality Chasm: A New Health System for the 21st Century"
- "Quality problems are everywhere, affecting many patients. Between the health care we have and the care we could have lies not just a gap, but a chasm..."
A Perfect Storm

- Increased cost of healthcare
- Concerns about patient safety
- Evidence of poor clinical care

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**Actual and Projected Health Spending for Selected Years, 1993-2019**

<table>
<thead>
<tr>
<th>Year</th>
<th>$ Trillions</th>
<th>% of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>$0.91</td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>$1.97</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>$2.11</td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>$2.24</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>$2.34</td>
<td></td>
</tr>
<tr>
<td>2009a</td>
<td>$2.47</td>
<td></td>
</tr>
<tr>
<td>2010a</td>
<td>$2.57</td>
<td></td>
</tr>
<tr>
<td>2014a</td>
<td>$3.23</td>
<td></td>
</tr>
<tr>
<td>2019a</td>
<td>$4.48</td>
<td></td>
</tr>
</tbody>
</table>

Sources:
Healthcare Spending Compared to Risk

A value-based health care system moves people to the left — and keeps them there.

NCQA Essential Guide to Healthcare Quality

To Err is Human: Building a Safer Health System

Institute of Medicine, 2000
American Adults Receive About Half of Recommended Care


[McGlynn et al., NEJM (2003)]
Quality of Care for Heart and Lung Problems Varies Widely

- Coronary artery disease
- Hypertension
- Heart failure
- Stroke
- Chronic lung disease
- Asthma
- High cholesterol
- Pneumonia
- Atrial fibrillation

% of quality standards passed

[McGlynn et al., NEJM (2003)]

And You Aren’t Safe Anywhere…

Boston
Cleveland
Greenville
Indianapolis
Lansing
Little Rock
Miami
Newark
Orange Co
Phoenix
Seattle
Syracuse

% of recommended care received

[McGlynn et al., NEJM (2003)]
Following the ATS/IDSA Community Acquired Pneumonia Guidelines

Data: Population → Individual

- Population data
- Hospital performance
- System performance
- Clinic performance
- Individual performance
### Number of Hospital Acquired Infections (HAIs) by Site of Infection - 2007

<table>
<thead>
<tr>
<th>Major site of Infection</th>
<th>Estimated Number of Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare-Associated Infection (all HAI)</td>
<td>1,737,125</td>
</tr>
<tr>
<td>Surgical Site Infection (SSI)</td>
<td>290,485</td>
</tr>
<tr>
<td>Central Line Associated Bloodstream Infections (CLABSI)**</td>
<td>92,011</td>
</tr>
<tr>
<td>Ventilator-associated Pneumonia (VAP)**</td>
<td>52,543</td>
</tr>
<tr>
<td>Catheter associated Urinary tract Infection (CAUTI)***</td>
<td>449,334</td>
</tr>
<tr>
<td>Clostridium difficile-associated disease (CDI)17</td>
<td>178,000</td>
</tr>
</tbody>
</table>


### Aggregate Attributable Patient Hospital Costs by Site of Infection

<table>
<thead>
<tr>
<th>Major site of Infection</th>
<th># of infections</th>
<th>Range of $ estimates based on 2007 CPI for all urban consumers</th>
<th>Range of $ estimates based on 2007 CPI for Inpatient hospital services</th>
<th>Range of estimate using CPI for Inpatient hospital services (billions)</th>
<th>Range of estimate using CPI for Inpatient hospital services (billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI</td>
<td>290,485</td>
<td>$11,987 - $29,443</td>
<td>$11,874 - $34,670</td>
<td>$3.22 - $8.35</td>
<td>$3.45 - $10.07</td>
</tr>
<tr>
<td>CLABSI</td>
<td>92,011</td>
<td>$6,461 - $25,849</td>
<td>$7,288 - $29,156</td>
<td>$0.59 - $2.38</td>
<td>$0.67 - $2.66</td>
</tr>
<tr>
<td>VAP</td>
<td>52,543</td>
<td>$14,806 - $27,520</td>
<td>$19,633 - $28,568</td>
<td>$0.78 - $1.45</td>
<td>$1.03 - $1.50</td>
</tr>
<tr>
<td>CAUTI</td>
<td>449,334</td>
<td>$749 - $832</td>
<td>$862 - $1,007</td>
<td>$0.34 - $0.37</td>
<td>$0.39 - $0.45</td>
</tr>
<tr>
<td>CDI</td>
<td>178,000</td>
<td>$5,682 - $8,090</td>
<td>$6,408 - $9,124</td>
<td>$1.01 - $1.44</td>
<td>$1.14 - $1.62</td>
</tr>
</tbody>
</table>

**Death Rate for Heart Attack Patients**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>U.S. National 30-Day Death Rate for Heart Attack Patients (%)</th>
<th>Lower Percentages Are Better</th>
<th>Number of Medicare Patients Admitted for Heart Attack</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST MARY'S HOSPITAL</td>
<td>13.0</td>
<td>Below 16.2%</td>
<td>Based on 391 patients</td>
</tr>
<tr>
<td>MERITER HSPITAL</td>
<td>12.3</td>
<td>Below 16.2%</td>
<td>Based on 358 patients</td>
</tr>
<tr>
<td>UNIVERSITY OF WI HOSPITALS &amp; CLINICS AUTHORITY</td>
<td>14.4</td>
<td>No Different from U.S. Rate</td>
<td>Based on 318 patients</td>
</tr>
</tbody>
</table>

Legend

- ![](https://www.hospitalcompare.hhs.gov/Graphs/Hospital-OOCGraph.aspx?hid=520089,520083,520098&stype=GENERAL&mCode=MORT&MTorAM=MORT)

These percentages were calculated from Medicare data on patients discharged between July 01, 2008 and June 30, 2009. They don’t include people in Medicare Advantage Plans (like an HMO or PPO) or people who don’t have Medicare.

Variation in Care: Within a Clinic

Provider Performance at a sample of seven UW Health Primary Care Clinics July 2008-June 2009

Red represents average clinic rate, blue represents individual provider performance. The size of the bubble correlates to the size of the diabetes population for that provider.

Source: UW Health Internal Data
Comparing Healthcare Quality

Physician Compare: January 2011

Medicare Program; Town Hall Meeting on the Physician Compare Web Site,
October 27, 2010

A Notice by the Centers for Medicare & Medicaid Services on 09/24/2010

SUMMARY

Section 1019 of the Patient Protection and Affordable Care Act of 2010, "Public Reporting of Performance Information" requires CMS to establish a Physician Compare Web site by January 1, 2011. This notice announces a Town Hall meeting to discuss the Physician Compare Web site. The purpose of this Town Hall meeting is to solicit input from stakeholders on the Physician Compare Web site. The opinions and alternatives provided during this meeting will assist us in future expansion of the Physician Compare Web site. The meeting is open to the public, but attendance is limited to space available.
Six Aims for Improvement

- **Safe**: avoiding injuries to patients from the care that is intended to help them.
- **Timely**: reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Effective**: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.

[Source: IOM, Crossing the Quality Chasm (2001)]
Six Aims for Improvement

- **Efficient**: avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- **Patient-centered**: providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.

Strategic Assets to Improve Quality

- Electronic Health/Medical Records?
- Clinical Decision Support Systems?
- Pay-for-Performance?
- Public Reporting!
- Quality Improvement Processes!
- Continuing Professional Development!
The Effect of Public Reporting

NCQA Essential Guide to Healthcare Quality

The Ventilator Bundle

....is a package of evidence-based interventions that, when implemented together for all patients on mechanical ventilation, has resulted in dramatic reductions in the incidence of ventilator-associated pneumonia.

[http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Changes/ImplementtheVentilatorBundle.htm]
Ventilator Bundle Elements

1. Elevation of the head of the bed to between 30 and 45 degrees
2. Daily awakening: “sedation vacation”
3. Daily assessment of readiness for weaning
4. DVT prophylaxis (unless contraindicated)
5. Stress bleeding prophylaxis

Do Bundles Work?

Our Lady of Lourdes, Binghamton, NY
310 days since last VAP!

Lourdes Hospital
Number of Days Between Ventilator Associated Pneumonia (VAP)

© 2007 Institute for Healthcare Improvement
Can CME Help Improve Clinical Practice?

Is CME Effective?

“...the literature overall supported the concept that CME was effective, ...including knowledge (22 of 28 studies), attitudes (22 of 26), skills (12 of 15), practice behavior (61 of 105), and clinical practice outcomes (14 of 33). Common themes included that live media was more effective than print, multimedia was more effective than single media interventions, and multiple exposures were more effective than a single exposure.”

Is CME Effective?

“Educational meetings alone or combined with other interventions, can improve professional practice and health-care outcomes for the patients. The effect is most likely to be small and similar to other types of CME, such as audit and feedback, and educational outreach visits. Strategies to increase attendance at educational meetings, using mixed interactive and didactic formats, and focusing on outcomes that are likely to be perceived as serious may increase the effectiveness of educational meetings.”


What is a Professional Practice Gap?

“What is”

Actual Patient Care

GAP
Knowledge Skills Behavior

“What should be”

Optimal Care As Informed by

Evidence-based Medicine Guidelines Key Opinion Leaders Clinical Research
Moore’s Evaluation Framework

1) Participation
2) Satisfaction
3a) Learning (declarative knowledge = knows)
3b) Learning (procedural knowledge = knows how)
4) Competence (shows how)
5) Performance (does)
6) Patient Health
7) Community Health

What is the issue or problem? | Intervention? | Expected results?
---|---|---
Need for knowledge, skill or attitude | Didactic CME | Improvement in knowledge, skill or attitude
Relevance to the patient being seen | Analysis of most recent literature | Appropriate utilization of new knowledge
Lack of experience | Practice experience with new skill | Technical competence, dexterity, comfort
Systems barriers and obstacles | Help the learner change the system or overcome the barrier | Barrier is overcome or resolved
ABMS and FSMB

- American Board of Medical Specialties
  - Assists 24 approved medical specialty boards in the development and use of standards in the ongoing evaluation and certification of physicians
  - Higher standards means better care for patients
  - Maintenance of Certification (MOC)

- Federation of State Medical Boards
  - Represents and supports the 70 state medical and osteopathic boards of the USA and its territories
  - Public protection mandate
  - Maintenance of Licensure (MOL)

Maintenance of Certification:
[Updated by ABMS in 3/09]

- Professional standing
  - Includes communication assessment every 5 years

- Lifelong learning & self-assessment
  - Average 25 CME credits per year

- Cognitive expertise
  - Proctored examination every 7-10 years

- Practice performance assessment
  - Depending on the board, every 2-5 years
MOC Part IV: Potential Models

- Practice Audits
- Peer Review
- Organizational Recognition of QI
- Clinical/Surgical Registries

Part IV

Courtesy of Mellie Pouwels at ABMS

MOC for Psychiatrists

Phase-In Schedule for ABPN MOC Program Component Requirements

<table>
<thead>
<tr>
<th>Original Recert. Year</th>
<th>MOC Application Year</th>
<th>MOC Exam Year</th>
<th>CME Credits required</th>
<th>CME from SA</th>
<th>First SA Activity required</th>
<th>Second SA Activity required</th>
<th>First PIP Unit required</th>
<th>Second PIP Unit required</th>
<th>Third PIP Unit required</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>2011</td>
<td>2012</td>
<td>180</td>
<td>0</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2003</td>
<td>2012</td>
<td>2013</td>
<td>210</td>
<td>0</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>2013</td>
<td>2014</td>
<td>240</td>
<td>20</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>2005</td>
<td>2014</td>
<td>2015</td>
<td>270</td>
<td>40</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>2015</td>
<td>2016</td>
<td>300</td>
<td>60</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>2016</td>
<td>2017</td>
<td>300</td>
<td>80</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2008</td>
<td>2017</td>
<td>2018</td>
<td>300</td>
<td>80</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2009</td>
<td>2018</td>
<td>2019</td>
<td>300</td>
<td>80</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>2010</td>
<td>2019</td>
<td>2020</td>
<td>300</td>
<td>80</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2011</td>
<td>2020</td>
<td>2021</td>
<td>300</td>
<td>80</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Notes:
- Every ABPN diplomat must possess an active medical license in the U.S. or Canada, and all licenses must be unrestricted.
- At least an average of 0 of the CME credits per year (averaged over 2-5 years) should involve self-assessment.
- Only after completing licensure, CPE, SA and PIP requirements are diplomats qualified to complete the ABPN MOC Cognitive Examination.

### Self-Evaluation Activity Report for Dr. George C. Mejicano

You have completed or are working on the following activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Type</th>
<th>Points</th>
<th>Status</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010 Update in Hospital-Based Internal Medicine</td>
<td>Medical Knowledge</td>
<td>10</td>
<td>Complete</td>
<td>11/28/2013</td>
</tr>
<tr>
<td>2009 Update in Office-Based Internal Medicine</td>
<td>Medical Knowledge</td>
<td>10</td>
<td>Complete</td>
<td>11/14/2009</td>
</tr>
<tr>
<td>2008 Update in Critical Care Medicine</td>
<td>Medical Knowledge</td>
<td>10</td>
<td>Complete</td>
<td>09/10/2008</td>
</tr>
<tr>
<td>2008 Update in Hospital-Based Internal Medicine</td>
<td>Medical Knowledge</td>
<td>10</td>
<td>Complete</td>
<td>06/24/2009</td>
</tr>
<tr>
<td>Communication with Referring Physicians</td>
<td>Practice Performance</td>
<td>20</td>
<td>Complete</td>
<td>09/31/2009</td>
</tr>
<tr>
<td>2009 Update in Infectious Disease</td>
<td>Medical Knowledge</td>
<td>10</td>
<td>Complete</td>
<td>05/27/2009</td>
</tr>
<tr>
<td>2008 Update in Infectious Disease</td>
<td>Medical Knowledge</td>
<td>10</td>
<td>Complete</td>
<td>01/04/2009</td>
</tr>
<tr>
<td>2007 Update in Infectious Disease</td>
<td>Medical Knowledge</td>
<td>10</td>
<td>Complete</td>
<td>11/12/2009</td>
</tr>
<tr>
<td>Clinical Skills</td>
<td>Medical Knowledge</td>
<td>20</td>
<td>Complete</td>
<td>11/02/2009</td>
</tr>
<tr>
<td>General Infectious Disease</td>
<td>Medical Knowledge</td>
<td>20</td>
<td>Complete</td>
<td>07/01/2003</td>
</tr>
<tr>
<td>General Infectious Disease</td>
<td>Medical Knowledge</td>
<td>20</td>
<td>Complete</td>
<td>09/23/2003</td>
</tr>
<tr>
<td>General Infectious Disease</td>
<td>Medical Knowledge</td>
<td>20</td>
<td>Complete</td>
<td>09/23/2003</td>
</tr>
<tr>
<td>General Infectious Disease</td>
<td>Medical Knowledge</td>
<td>20</td>
<td>Complete</td>
<td>06/01/2009</td>
</tr>
<tr>
<td>General Infectious Disease</td>
<td>Medical Knowledge</td>
<td>20</td>
<td>Complete</td>
<td>06/03/2002</td>
</tr>
<tr>
<td>General Infectious Disease</td>
<td>Medical Knowledge</td>
<td>20</td>
<td>Complete</td>
<td>04/03/2003</td>
</tr>
</tbody>
</table>

- Diplomates are required to complete a total of 100 points of self evaluation.
- You must have at least 20 points in practice performance and 20 points in medical knowledge. The remaining points may be in either practice performance or medical knowledge. All points must be completed within 10 years prior to the date your certification is renewed.

### Maintenance of Certification Status Report

**Maintenance of Certification (MOC) Status Report for George C. Mejicano As of 09/26/2011**

**Maintenance of Certification (MOC) Status Report**

- Current MOC status is below. Click view your Self-Evaluation Activity Report for more information.

<table>
<thead>
<tr>
<th>Certificate</th>
<th>Current Status in MOC Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>In order to maintain this Certification by 12/30/2013, you must fulfill the following requirements:</td>
</tr>
<tr>
<td>Medical Specialty examination</td>
<td>- Pass an examination</td>
</tr>
<tr>
<td>Complete 10 more self-evaluation points</td>
<td></td>
</tr>
<tr>
<td>Maintain an unrestricted license</td>
<td></td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>You must be enrolled in the MOC program by the time this report is issued. Your enrollment in the MOC program began on 12/02/2005.</td>
</tr>
<tr>
<td>Medical Specialty examination</td>
<td>- Be enrolled in the MOC program</td>
</tr>
<tr>
<td>Complete 10 more self-evaluation points</td>
<td></td>
</tr>
<tr>
<td>Maintain an unrestricted license</td>
<td></td>
</tr>
</tbody>
</table>

Note: Points for self-evaluation activities may be applied toward the requirements of multiple certifications. If you have completed the activities, you must enroll in the 13-year period preceding the date the new certification is issued. The self-evaluation and examination components must be completed. Any order you wish. You are required to complete the self-evaluation activities prior to registering for or taking the examination.
Structure of a Performance Improvement Module

Data Collection
- Chart review
- Patient survey
- Practice survey

Plan for Improvement
- Automatic practice analysis
- Practice improvement plan

Test of Change
- Test plan’s impact (PDSA)

Example: PI CME – MOC Activity

Performance Improvement CME
Get Serious About Practice Change

Want to get serious about changing your practice? CS2day Performance Improvement (PI) activities allow you to analyze how you personally, as well as your practice as a whole, are caring for current and past smokers. Through reflection, education, and analysis you and your team can implement new processes to change how you deliver care.

Enroll today in a CS2day/PI project and:
(a) Dive deeper into your practice through the use of tailored performance measures,
(b) Identify areas of need based on actual data analysis,
(c) Access tools and resources necessary to target your key areas of need, and
(d) Make lasting changes that will ultimately help you better treat and manage your tobacco using patients.

In addition to invaluable experience participating in a PI activity, you will also have access to patient registries, earn up to 20 AMA PRA Category 1 Credit(s)™ and you may be able to use the data you collected in your activities towards additional CME credit and Maintenance of Certification (MOC) points.

[http://www.ceasesmoking2day.com/index.php?option=com_content&view=section&layout=blog&id=5&Itemid=41]
If you have a contract with any of the health plans below, you may report completion of an ABIM PIM™ Practice Improvement Module to a participating plan for recognition and/or reward. Please be certain you are in the health plan’s network prior to transmitting your information.

Aetna
Blue Cross and/or Blue Shield Plans
CIGNA HealthCare
Health Alliance Plan
Humana
United Health Care
Upcoming Programs
Recommend Programs

Increasing External Pressure

- CMS PQRS reporting – requires more frequent reporting & patient experience data
- Maintenance of Licensure – “substantial compliance” but data needed every two years for most jurisdictions
- Credentialing and privileging – Ongoing Professional Practice Evaluation (OPPE) from Joint Commission every 2 years

Next Iteration of MOC Standards (20XX)

- More continuous process – QI at least every two years
- Inclusion of other measures (cost/efficiency/appropriateness)
- Requirement for demonstrated learning and/or improvement

Courtesy of Mellie Pouwels at ABMS
Next Iteration of MOC Standards (20XX)

- Patient/Peer surveys as core requirements
- More transparency regarding participation by physicians
- More effective and rigorous CME ("MOC CME" or "CME for MOC")


MOC CME

- Definition is evolving that perhaps MOC CME is a subset of certified CME
- ABMS-ACCME Joint Working Group was convened in 2010 and white paper written
- ABMS MOC Committee is taking the report into consideration as they consider next steps in the evolution of MOC
MOC CME Program Specific Elements

- Clinical evidence base must be transparent to the learners
- Educational format is consistent with emerging evidence base about effective CME

Courtesy of Mellie Pouwels at ABMS

MOC CME Diplomate Specific Elements

- Learner needs to include all six competencies
- Based upon individualized needs assessment
- Topics and issues are relevant to individual’s actual practice

Courtesy of Mellie Pouwels at ABMS
ACGME/ABMS Competencies

- Patient Care and Procedural Skills
- Medical Knowledge
- Practice Based Learning & Improvement
- Interpersonal and Communications Skills
- Professionalism
- Systems-based Practice

The Role of the FSMB

- Public trust and protection mandate
- Assurance that physicians are maintaining their competency
- Meeting public expectations and perceptions
- Paradigm shift: reactive → proactive

Courtesy of Jon Thomas at FSMB
FSMB House of Delegates
2004 Policy Statement

“State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking relicensure.”

What is MOL?

- Process by which a licensed physician provides, as a condition of license renewal, evidence of participation in continuous professional development that:
  - Is practice relevant
  - Is informed by objective data sources
  - Includes activities aimed at improving performance in practice
## Maintenance of Licensure

1. **Reflective Self Assessment**
   *(What improvements can I make?)*

   Physicians must participate in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent successful completion of appropriate educational or improvement activities.

2. **Assessment of Knowledge and Skills**
   *(What do I need to know and be able to do?)*

   Physicians must demonstrate the knowledge, skills and abilities necessary to provide safe, effective patient care within the framework of the six general competencies as they apply to their individual practice.

3. **Performance in Practice**
   *(How am I doing?)*

   Physicians must demonstrate accountability for performance in their practice using a variety of methods that incorporate reference data to assess their performance in practice and guide improvement.

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<tr>
<th>Goal</th>
<th>Strategy (HOW)</th>
<th>Options and Examples</th>
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| Reflective Self-assessment  | External measures of knowledge and skills or performance benchmarks | • Self-review tests  
• Professional development activities  
• Literature review  
• CME in practice area |
| Assessment of knowledge and skills | • Structure, valid, practice relevant  
• Produce data to identify learning opportunities | • Practice relevant MCQ exams  
• Standardized patients  
• Computer-based case simulations  
• Patient and peer surveys  
• Procedural hospital privileging  
• Mentored observation |
| Performance in practice     | Incorporate data to assess performance in practice and guide improvement | • 360 degree evaluations  
• Patient reviews  
• Analysis of practice data  
• MOC/OCC Part IV activities  
• Clinical Assessment Programs  
• CMS measures  
• PI CME |

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*Courtesy of Jon Thomas at FSMB*
MOL Challenges

- Will impact every licensed physician in the United States
- Must address a more heterogeneous population of physicians than MOC
- Relies upon financial resources and support that are currently in short supply
- Subject to state laws and regulations that may require legislative action

Courtesy of Jon Thomas at FSMB
MOL Challenges

- Must deal with both clinically active and non-clinically active physicians
- Periodicity
  - Leaning towards every 5-6 years
- Strategies for non-board certified physicians
- Reciprocity
- Remediation programs

Courtesy of Jon Thomas at FSMB

Some Next Steps

- MOL Implementation Workgroup in place
- Pilot projects
  - Develop support materials for state boards
  - Further explore and explain MOL tools
- Research needed regarding MOL program and the impact of MOL on patient care and physician practice

Courtesy of Jon Thomas at FSMB
Wisconsin and MOL

Effective June 1, 2010, the Wisconsin Medical Examining Board now has the authority to enact rules related to MOL.

448.40 (1) The board may promulgate rules to carry out the purposes of this subchapter, including rules requiring the completion of continuing education, professional development, and maintenance of certification or performance improvement or continuing medical education programs for renewal of a license to practice medicine and surgery.
Conclusions

- CPD/CME is evolving rapidly with new formats, more rigor, and more scrutiny
- PI CME/MOC/MOL are linked and are in various stages of being rolled out
- Think of CPD/CME as a strategic asset that is designed to change physician behavior and improve health outcomes

Thank you!!