The Importance of Competition in Board Certification

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www.NBPAS.org

- **NBPAS "Philosophy:"**

  1) NBPAS believes continuous certification is needed to ensure physicians keep up with changes in medicine.

  2) NBAPS believes the work physicians do to keep up and prove they are keeping up should be "MEANINGFUL."

  3) "Busywork" that does not significantly contribute to bullet point #1 above should be completely eliminated.

  4) Administrative requirements (forms, data-entry etc.) should be reduced to a bare minimum

  5) Continuous certification should NOT BE A MONEY MAKER for the Not for Profit boards that administer it.

REGULATORY MONOPOLY: The anti-competitive aspects of MOC

- **Perhaps most disturbing are the anti-competitive aspects of MOC requirements.**

- **While ABMS member board certification originated as mark of distinction, over the decades ABMS member board certification has virtually become a requirement to practice medicine in the United States. Medicare does not require ABMS member board certification (or MOC), but most private payers require physicians contracting with them have ABMS member board certification. Most hospitals now require ABMS member board certification for staff privileges.**

- **Neither insurance companies nor hospitals accept alternative certifications. So, by requiring ABMS MOC to maintain certification, the ABMS member boards have made MOC a requirement to practice medicine.**

What are we doing to complete MOC?

- Part 1: Pass initial ABMS boards in our specialty and maintain an active license
- Part 2 Life Long learning/Self Assessment (functionally CME)
  - 100 points every 5 years: 40 of those MUST come from part 4 requirements. This dilutes our CME

- Part 3: Secure test
- Part 4: Quality Improvement project
- Difficult to navigate

What is Wrong with MOC Exams

- **Arguments against testing:**
  - **The exam questions are often not relevant physician's practice. Questions often relate to parts of their specialty they do not practice.**
  - **We have to study for recertification exams. But we only study what we don't know…we don't know what we don't use**
  - **The questions are often outdated. Most of the studying is done to learn the best answer for the test, which is very often not the current best practice.**
  - **Testing often uses "Guidelines" as gold standard but there is a long history of Guidelines changing and often reversing**
  - **Closed book tests are no longer relevant. We care for patients with input from colleagues and the internet.**
  - **Rural physicians leave their practice for test and review**

REGULATORY MONOPOLY: Restraint of Trade

- **Patients and physicians are harmed by this "certification monopoly" in many ways. Physicians take a significant amount of time away from their practice each year to fulfill ABMS MOC. Those that don't participate in MOC, or have trouble passing the tests (which are believed by most to be poor measures of physician competence) are blocked from the practice of medicine. Physicians are retiring early to avoid MOC. Patients of physicians who do not participate in MOC, therefore, lose the ability to be treated by those physicians.**

- **ABMS has restrained trade by inducing health insurance companies and health plans to exclude physicians who do not purchase and comply with the ABMS MOC program.**

REGULATORY MONOPOLY: MOC Discriminates Against Women and Minorities

- **ABMS has also restrained trade by applying its MOC program unfairly. Physicians certified prior to 1990 are "Grandfathered." Approximately 40% of physicians are grandfathered at this time. Grandfathered physicians are given life-long certification and are exempt from MOC.**
- **Grandfathering means ABMS requires MOC by younger physicians while exempting older physicians, thereby increasing barriers to entry and reducing competition. In addition to age discrimination, such policies are discriminatory towards women and minorities given the changing demographics in medicine.**
- **As the practice of medicine has shifted to include more women and minorities, these are the groups that are being forced to participate in MOC. Older physicians that are Grandfathered are mostly Caucasian males.**

MOC Does Not Improve Patient Care

- **ABMS claims evidence based research proves MOC improves patient outcomes but a close look at these studies reveals a) The studies cited were conducted by highly paid ABMS employees and b) Despite this clear COI, most of the studies found MOC provides no improvement in patient care.**

- **Go to MOC Journal Club (on the Advocacy Center page of NBPAS.org):**

- **Two independent physicians who are a) expert clinical trialists and b) not associated with NBPAS reviewed 10 journal articles cited by ABMS member boards as providing "evidence" the MOC improves patient outcomes.**

- **Handouts provide complete text of this MOC journal club**

David Cohen (Vice Chairman of Medicine for Research, Beth Israel Deaconess Medical Center, Boston, MA) :
"In general, I would say that the literature is mixed as to whether MOC improves patient care or outcomes and that the effects that were noted in the positive studies were fairly modest."

Ajay Kirtane (Associate Professor of Medicine, Columbia University Medical Center):
"In reviewing the 10 manuscripts provided, I was struck by the limitations of the evidence base specifically regarding the current implementation of MOC. "

Problem: Financial Conflicts of Interest

- **The ABMS member boards obtain considerable revenue from MOC. The American Board of Internal Medicine (ABIM) is by far the largest ABMS member board with 200,000 diplomates, and has annual revenue (derived from its 2014 tax Form 990) of $57M, with $27M deriving from MOC activities. Senior administrators of ABIM receive $400-850K in compensation.**

Physician perception of MOC:

MOC has low value in helping physicians care for patients

ORIGINAL ARTICLE

MAYO CLINIC

CrossMark

Physician Attitudes About Maintenance of Certification: A Cross-Specialty National Survey

David A. Cook, MD, MHPE; Morris J. Blachman, PhD; Colin P. West, MD, PhD; and Christopher M. Wittich, MD, PharmD

TABLE 1. Main Survey Results[a]

Item	Mean ± SD, median[b]	Agr[c] n/N (%)
Primary survey items		
MOC activities are relevant to the patients I see[d]	2.9±1.8, 2	200/842 (23.8)
MOC is worth the time and effort required of me[d]	2.4±1.7, 2	122/824 (14.8)
I have adequate support in completing MOC activities	3.1±1.8, 3	223/834 (26.7)
MOC activities are well-integrated with my daily clinical practice	2.4±1.5, 2	101/832 (12.1)
MOC provides all I need to remain a competent physician	2.0±1.3, 2	56/827 (6.8)
MOC is a burden to me	5.6±1.7, 6	673/835 (80.6)
MOC is all about generating money for the boards	5.2±1.7, 6	574/851 (67.5)

[c] "Agree" indicates slightly agree, agree, or strongly agree.

6.4% if remove "slightly agree"

View from the trenches of Medicine

- **MOC is:**
  - **Taking time from patients**
  - **Taking time from meaningful CME**
  - **Imposing onerous busywork**
  - **expensive in a setting of a select few profitting**
  - **has no proven or even perceived patient benefit**
  - **Discriminatory toward women, minorities, younger physicians**
  - **Anticompetitive**

SOLUTIONS: Alternative Certification Boards

- **One alternative to ABMS member board and AOA required MOC is another, 501(c)3 not for profit organization, the National Board of Physicians and Surgeons (see NBPAS.org).**
- **NBPAS was initiated by concerned, academic and private practicing physicians, many of whom are thought leaders in their various medical specialties.**
- **NBPAS is a volunteer organization. The physician board members and President of NBPAS are unpaid.**
- **Certification by NBPAS requires initial ABMS (or AOA) member board certification, but ongoing certification is primarily based on the physician completing 50 hours of ACCME accredited CME every two years and good citizenship (ie unrestricted medical license and no involuntary denial of hospital privileges)**
- **NBPAS certification is inexpensive ($75/year) and does not require the irrelevant, expensive, and onerous requirement of MOC.**
- **NBPAS has been providing board re-certification for over 3 years and is growing rapidly, having certified over 7000 diplomates to date. However, NBPAS is currently not accepted by any payers and is only accepted for admitting privileges by approximately 77 hospitals, although more hospitals are actively considering accepting NBPAS. This precludes the ability of NBPAS to effectively compete with the ABMS.**

- **NBPAS rationale:**
  - **Physician dissatisfaction with MOC**
    - **There is no evidence MOC improves patients outcomes**
    - **Tests can not be tailored to individual physician practices**
    - **Work of MOC lacks meaning**
    - **MOC = busy work**
    - **Complicated ABMS board websites**
    - **Appearance of a financial motivation underlying MOC requirements**

The National Board of Physicians and Surgeons (NBPAS.org)

- **NBPAS provides an alternative for the maintenance phase of certification. Competition for a non profit.**
- **NBPAS board members spent a lot of time discussing the best way for physicians to keep up with changes in medicine. The NBPAS board concluded that CME is the most meaningful method available for "keeping up."**
- **NBPAS replaces computer knowledge modules and exams with accredited, continuing medical education (CME).**
- **Acceptable CME must be accredited by the ACCME…independent of commercial interests.**

Detailed criteria for NBPAS certification:

- **Candidates must have been previously certified by an American Board of Medical Specialties member board or the AOA. Currently, NBPAS certifies physicians in non-surgical ABMS specialties.**

- **Candidates must have a valid, unrestricted license to practice medicine in at least one US state. Candidates who only hold a license outside of the U.S. must provide evidence of an unrestricted license from a valid non-U.S. licensing body.**

- **Candidates must have completed a minimum of 50 hours of continuing medical education (CME) within the past 24 months, provided by a recognized provider of the Accreditation Council for Continuing Medical Education (ACCME). CME must be related to one or more of the specialties in which the candidate is applying. Re-entry for physicians with lapsed certification requires 100 hours of CME with the past 24 months. Fellows-in-training are exempt.**

- **For some specialties (ie interventional cardiology, electrophysiology, surgery), candidates must have active privileges to practice that specialty in at least one US hospital or outpatient facility licensed by a nationally recognized credentialing organization with deeming authority from CMS (ie Joint Commission, HFAP, DNV).**

- **A candidate who has had their medical staff appointment/membership or clinical privileges in the specialty for which they are seeking certification involuntarily revoked and not reinstated, must have subsequently maintained medical staff appointment/membership or clinical privileges for at least 24 months in another US hospital licensed by a nationally recognized credentialing organization with deeming authority from CMS (ie Joint Commission, HFAP, DNV). (Note: This requirement is an example of NBPAS being MORE rigorous than ABMS. ABMS certification is not impacted by loss of hospital privileges.)**

THE NATIONAL BOARD OF NBPAS PHYSICIANS & SURGEONS

NBPAS Fees and Application

- NBPAS is a not for profit 501(c)(3) organization
- Board members are high profile, thought leaders representing most ABMS/AOA specialties
- Fees are very low, only cover costs
- Physician management and board members are unpaid
- Governance: transparent, not-for-profit, two year board terms, COI protections, no physician pay

www.nbpas.org

NBPAS Board Members

- **The majority of NBPAS board members are well respected, high profile members of the academic medical community**

The NBPAS Advisory Board Members are physicians who value patient care, research, and life long learning. Board members (all unpaid) believe continuous physician education is required for excellence in patient care.

NBPAS Board Members:

Paul Teirstein, M.D., President NBPAS, Chief of Cardiology, Scripps Clinic

John Anderson, M.D., Past President, Medicine and Science, American Diabetes Association, Frist Clinic, Nashville, TN

David John Driscoll, M.D., Professor of Pediatrics, Mayo Clinic College of Medicine

Daniel Einhorn, M.D., Immediate-Past President, American College of Endocrinology; Past President, American Association of Clinical Endocrinologists

Bernard Gersh, M.D., Professor of Medicine, Mayo Clinic College of Medicine

C. Michael Gibson, M.D., Professor of Medicine, Harvard Medical School

Michael R. Jaff, D.O., Massachusetts General Hospital, Professor of Medicine, Harvard Medical School

Paul G. Mathew, M.D., FAHS, Director of Continuing Medical Education, Brigham & Women's Hospital/Harvard Medical School, Department of Neurology

Dan Morhaim, M.D. Maryland state representative and emergency room physician.

Jordan Metcalf, M.D., Professor and Research Director, Pulm. & Crit. Care, Oklahoma University Health Sciences Center

J. Marc Pipas, M.D., Professor of Medicine, Dartmouth Medical School

Jeffrey Popma, M.D., Professor of Medicine, Harvard Medical School

Harry E. Sarles Jr., M.D., FACG, Immediate Past President for the American College of Gastroenterology

Hal Scherz, M.D., Chief of Urology- Scottish Rite Children's Hospital, Assoc Clinical Professor of Urology Emory University

Karen S. Sibert, M.D., Associate Clinical Professor: UCLA Health; President-Elect: California Society of Anesthesiologists

Gregg W. Stone, M.D., Professor of Medicine, Columbia University College of Physicians and Surgeons

Eric Topol, M.D., Chief Academic Officer, Scripps Health; Director, Scripps Translational Science Institute

Bonnie Weiner, M.D., Professor of Medicine, University of Massachusetts Medical School

Mathew Williams, M.D., Chief, Division of Adult Cardiac Surgery, New York University Medical Center

NBPAS website

- **NBPAS.org**
  - **Website is simple to navigate**
  - **Contains links publications, lay press articles, videos of debates on MOC**
  - **Contains links to explanatory sample letters to send to hospital administrators and colleagues**
  - **Contains links to downloadable PowerPoint presentations**
  - **Contains advocacy materials**

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PHYSICIAN INFORMATION

ALREADY HAVE AN ACCOUNT? LOG IN HERE.

Create Username *

Password *

Confirm Password *

E-mail Address *

Confirm E-mail Address *

CONTACT INFORMATION

First Name

Last Name

Address

City

State or Territory – choose one –

Zip

Business Phone

Mobile Phone

Below please enter your name exactly as it should appear on printed certificate, i.e. Joe B. Smith, M.D.

Simple application takes <15 minutes to complete

NATIONAL BOARD OF PHYSICIANS AND SURGEONS

- **In just over 3 years of operation with only word of mouth and social media:**

  - **7,000 physicians have been certified by the NBPAS**

  - **A growing number of hospitals (77) have changed their bylaws to allow NBPAS as an alternative certification for maintaining hospital privileges**

NATIONAL BOARD OF PHYSICIANS AND SURGEONS

Four common misconceptions

- **Board certification was created to provide a measure of competence over and above the minimal requirements of state licensing. NBPAS requirements simply mimic most state licensing requirements**
  - **NBPAS *requires* initial ABMS member board certification which is *not* required by state boards**
  - **NBPAS only disputes current ABMS *MOC* pathways**
  - **NBPAS provides an alternative, more meaningful pathway for life-long learning**

NATIONAL BOARD OF PHYSICIANS AND SURGEONS

Four common misconceptions

- **Supporting an alternative certifying organization like NBPAS will open the door to numerous competing boards, standards will erode and certification will lose meaning**
  - **NBPAS *requires* initial ABMS certification, therefore NBPAS actually *supports* ABMS and *requires* a rigorous secure test**
  - **NBPAS disputes ABMS approach to MOC and provides an alternative only to maintenance of certification.**

NATIONAL BOARD OF PHYSICIANS AND SURGEONS

Four common misconceptions

- **NBPAS requirements are not rigorous enough. A rigorous certification process is needed to protect the public from bad doctors.**
  - **This debate is about how to best pursue life-long learning, not initial certification. The is no evidence (or even general belief) that current ABMS MOC programs protect the public from bad doctors. See MOC Journal Club discussion for independent assessments of the studies on MOC.**
  - **Most, if not all of the recent scandals in medicine involved board certified physicians.**

BECKER'S HOSPITAL REVIEW

2 Detroit physicians, chiropractor caught running $5.7M drug ring

Written by Erin Marshall (Twitter | Google+) | March 11, 2016

Along with seven pharmacists and patient recruiters, two metro Detroit-based physicians and a chiropractor have been charged with running a $5.7 million drug ring, according to *The Detroit Free Press*.

Federal prosecutors charged the 10 defendants for a drug trafficking scheme that took place from 2013 to 2015.

Chiropractor Boris Zigmond, DC, was the leader of the ring. He was assisted by Jennifer Franklin, MD, and Carlos Godoy, MD.

Mr. Zigmond, who was also charged with money laundering, collected prescriptions for painkillers. Instead of actually seeing patients, he created offices in metro Detroit, where Dr. Franklin and Dr. Godoy prescriptions.

The above two physicians are ABMS member board certified!

THE NATIONAL BOARD OF NBPAS PHYSICIANS & SURGEONS

Laws Prohibiting Requirement of MOC: Current "Strong" Passed Laws

Approved by Governor:	State:	Bill #:	Status:
7/1/17	Georgia State Legislature	HB165	Passed
4/11/16	Oklahoma Legislature	SB1148	Passed
3/15/18	South Carolina Legislature	HB4116	Passed
1/1/18	Texas State Legislature	SB1148	Passed
4/9/18	Tennessee State Legislature	HB1927	Passed

G. Nothing in the Allopathic Medical and Surgical Licensure and Supervision Act shall be construed as to require a physician to secure Maintenance of Certification (MOC) by a particular certifying organization as a condition of licensure, reimbursement, employment or admitting privileges at a hospital in this state.

Summary:

- **MOC is expensive, onerous, time consuming, brings enormous revenue to ABMS member boards and the AOA yet has no proven or even perceived patient benefit.**
- **ABMS/AOA mandated MOC is an example of an anti-competitive, regulatory monopoly, that discriminates against younger physicians, women and minorities, while exempting older physicians, who are mostly Caucasian.**
- **Alternatives to ABMS/AOA mandated MOC exist.**
- **We respectfully request your support of strong anti-MOC legislation that encourages competition in board certification .**