Special Committee on Physician Executives/Administrative Leaders and Continuing Certification
Draft Report and Recommendations
December 2015

Executive Summary

In May 2015 Dr. Lois Margaret Nora, President and Chief Executive Officer of the American Board of Medical Specialties (ABMS), commissioned the Special Committee on Physician Executives/Administrative Leaders and Continuing Certification (the Committee) to advise ABMS and its 24 Member Boards on ways to make the ABMS Program of Continuing Certification (MOC) more meaningful and relevant to physicians and other ABMS Board Certified healthcare professionals in executive or administrative leadership positions. The Committee emerged from the need on the part of the ABMS Member Boards community to understand how implementation of MOC has and will affect Board Certified medical specialists and to use this information to make the program more relevant, meaningful and of value to those individuals and the patients they serve.

Issues

The Committee identified several important issues questions foundational to improving MOC's value to Board Certified medical specialists in leadership positions. These include:

- Whether Member Boards' expectations for MOC participation should be different for medical specialists in executive or administrative leadership roles than for specialists who provide direct patient care;
- Whether the competencies needed by medical specialists to perform executive or administrative leadership responsibilities are different from those needed to care for patients;
- Whether certification should be considered a clinical or professional credential;
- Whether the interpretation of "clinically active" should be broadened beyond "direct patient care" to encompass physicians and other medical specialists who

have a primary responsibility to the larger context and system of healthcare, and who are principally engaged in activities that impact the healthcare delivery system's capacity to provide optimal patient care;

- What types of activities would make MOC relevant to Board Certified medical specialists employed in executive or administrative leadership roles?

Key Findings

1. Duty to patients: A Board Certified physician executive or administrative leader who provides any amount of direct patient care, however limited or focused, has the same responsibility to maintain the level of clinical knowledge, skill and competence as one whose practice is full time patient care.
2. Certification as a professional credential: Board Certification should be considered a professional credential as well as a clinical credential. Committee members believe there is an opportunity to evolve MOC so that it supports all healthcare professionals certified by ABMS Member Boards as they transition through various professional pathways over the course of their careers, from patient care to research, to teaching, to organizational leadership.
3. Redefining Clinically Active: The term "clinically active" traditionally has been interpreted as "providing direct patient care," and most ABMS Member Boards' MOC Part IV requirements reflect this interpretation. Given the considerable diversity in how Board Certified medical specialists today are influencing the delivery of healthcare, the Committee believes there is a need to broaden the interpretation to include professional activities that directly or indirectly impact the provision of care to an individual or community of patients, including those that contribute to improvement in systems of care and delivery of medical education.
4. Competencies required for effective organizational leadership: Board Certified physicians and other healthcare professionals in executive and administrative leadership positions must be proficient in the six core competencies established by the ABMS and the Accreditation Council for Graduate Medical Education

(ACGME)[1], as well as have a depth of leadership knowledge and management skills in areas such as, but not limited to, quality improvement, change management and financial management.

5. Obtaining competencies for effective leadership: There is an opportunity to position the ABMS Program of Continuing Certification as a valued resource that supports Board Certified physician executives and administrative leaders in a manner that is relevant and meaningful to their day-to-day work. This will necessitate Member Boards recognizing and accepting for MOC credit, participation in programs and services offered by third parties that enhance proficiency in the competencies required to perform executive/administrative as well as patient-care related duties.
6. Evaluation of knowledge and skills required for effective leadership: To make MOC more relevant to physician executives and administrative leaders, ABMS Member Boards should balance the content of the MOC Assessment of Knowledge and Skills so that the examination reflects the core knowledge of a given specialty as well as knowledge and skills required for effective leadership and management.
7. Consistency in MOC program requirements: Given that the knowledge and skills required to perform executive or administrative leadership functions are generalizable across specialties, the ABMS Member Boards community should strive to implement consistent requirements for Board Certified physicians and other healthcare professionals holding such positions.
8. Reentry: Board Certified physician executives or administrative leaders who wish to return to direct patient care should have access to Board-approved reentry programs to facilitate their resuming of patient care responsibilities.

Background

Medical practice has changed significantly over the past 30 years, becoming both increasingly specialized and diversified in terms of the professional pathways available to clinicians interested in influencing patient care through a variety of channels such as health policy, medical education, or health systems leadership or management.

[1] The ABMS/ACGME competencies are patient care, medical knowledge, professionalism, interpersonal communication skills, practice-based learning and improvement, and systems-based practice.

Simultaneously, in response to public calls for regulatory bodies[2] to ensure the continuing competence of the health professions, the 24 Member Boards of the American Board of Medical Specialties (ABMS) have evolved medical specialty certification from a point-in-time verification of a physician's training and knowledge in a particular medical specialty to Maintenance of Certification (MOC). Currently defined, MOC is a continuing certification process comprised of four elements: professionalism and professional standing; self assessment and learning; external assessment of knowledge, skills and judgment; and improvement in medical practice.

The transition from lifetime certification to continuous certification has impacted both the medical specialty boards and the healthcare professionals they certify. The ABMS Member Boards recognize and are committed to understanding the full impact of this transition in order to make continuing certification more relevant, meaningful, and valuable to individuals who participate in the program while upholding the high standards for assessment expected by the public.

To assist Member Boards in this reflective process, Dr. Lois Margaret Nora, ABMS President and Chief Executive Officer, commissioned a series of special committees to examine issues facing three cohorts of Board Certified medical specialists as they engage with certification and continuing certification processes: those in the military, in research positions, and those in executive or administrative leadership roles.

This report represents the work of the Special Committee on Physician Executives/Administrative Leaders and Continuing Certification (the Committee).[3] Comprised of ABMS Member Board representatives as well as individuals representing key external stakeholders, the Committee examined a variety of issues foundational to improving MOC's value proposition to Board Certified physician executives and administrative leaders, including whether certification should be considered a clinical or professional credential, whether Board Certified medical specialists holding such positions should be considered "clinically active," to what extent Member Boards should

---

[2] Crossing the Quality Chasm: A New Health System for the 21st Century. Institute of Medicine 2001.

[3] The Special Committee on Military Physicians and Continuing Certification was the first committee to be convened; its report is available on ABMS' website. The second – the Special Committee on Physician Scientists and Continuing Certification – has issued its draft report for comment.

expect physician executives or administrative leaders to engage in MOC, and whether Member Boards' expectations for lifelong learning and professional development for medical specialists in such positions should be different than for those who provide direct patient care.

Throughout its deliberations, the Committee was mindful of the fact that while all ABMS Member Boards certify MD and DO physicians, two Boards – the American Board of Medical Genetics and Genomics and the American Board of Radiology – also certify non-physician professionals. The Committee presents its report and recommendations for consideration by the entire community of ABMS Member Boards and the professionals they certify.

Definitions

For purposes of its work, the Committee identified and adopted the following terms and definitions:

Physician Executive/Administrative Leader: A physician or non-physician medical specialist certified by an ABMS Member Board, whose scope of work primarily involves:

1) Both direct patient care and substantial administrative functions. For example, a chief medical officer who sees patients, or a residency program director who provides patient care and also performs administrative duties.

2) The direct oversight or management of systems of care or populations of patients, but not the provision of direct patient care. For example, a chief medical officer of an insurance organization or chief executive officer in a clinical delivery system who does not see patients;

3) Activities that influence the delivery of patient care, but do not involve oversight of individual patient care or systems of care. Examples include physicians and other healthcare professionals in health policy positions, regulatory organizations, medical professional organizations, or in healthcare organizations such as pharmaceutical or device companies;

4) Responsibility for overseeing, developing, leading and/or delivering the pedagogy of medical education.

Table 1 provides examples of the types of executive or administrative leadership positions the Committee envisioned when developing its recommendations. The Committee specifically excluded from its definition, physicians and other healthcare professionals who have left medicine to pursue careers in areas unrelated to healthcare, such as an investment banking or financial planning.

Table 1

Position	Scope of duties
Chief Executive Officers, Chief Medical Officers Chief Medical Information Officers, Chief Quality Officers, Patient Safety Officers or similar positions that directly influences the delivery of care to a patient or population of patients	Direct oversight of and involvement in ensuring and improving the quality of patient care provided by a system of care (e.g., a hospital, an insurer, etc.)
Clinical Educator	Significantly or primarily involved in the system processes for clinical education of other healthcare providers.
Medical Regulator	Oversees or manages aspects of regulatory or accreditation organizations that set standards which influence physician practice. Examples of such organizations include The Joint Commission, State Medical Boards, the Accreditation Council for Graduate Medical Education, or Specialty Certifying Boards.
Medical Organization Leader	Oversees or manages aspects of an organization that establishes policy influencing medical professionalism, such as a medical society, a medical specialty board, the American Medical Association, the Federation of State Medical Boards, the Association of American Medical Colleges, or the American Hospital Association.

Clinically active: The term "clinically active" traditionally has been used to describe the degree to which a physician or healthcare practitioner's scope of practice directly involves the care of a patient. The Committee believes there is a need to broaden the

definition to include a scope of professional practice that has the potential to directly or indirectly impact the provision of care to an individual or community of patients. Examples include a chief medical officer who oversees the clinical quality of a community hospital, a medical school faculty member who educates third-year medical students, or a policy maker or regulator who sets or enforces standards that impact public health.

Characteristics of a Physician Executive/Administrative Leader

Healthcare organizations traditionally have separated clinical care management from business operations – physicians and other healthcare professionals were responsible for the former, and business leaders for the latter. This distinction is changing, as healthcare professionals increasingly are playing a critical role in delivery system redesign, influencing the care of both individual and communities of patients. The emergence of positions such as vice-president medical affairs, patient safety officer, chief quality officer, chief medical information officer, chief innovation officer, and chief technology officer are illustrative of the surging interest on the part of healthcare institutions to engage healthcare professionals in delivery system redesign. In fact, many health systems now employ physicians for their chief executive officer positions.

The roles and responsibilities of physician executives/administrative leaders can be quite diverse, impacted by factors such as the individual's place of employment, (e.g., academic institution, insurance company, hospital/provider organization); the position he or she holds (e.g., dean, chief executive officer, or senior leader of a healthcare organization); the scope of work in which the individual engages (e.g., population health management, medical regulation); the point of time in the individual's professional career; and the degree to which the individual's scope of work impacts patient care (e.g., educates future providers of care, sets policy that impacts systems of care or populations of patients).

Physician executives/administrative leaders rely upon the knowledge and skills embodied in the ABMS/ACGME six core competencies upon which MOC is based. However, they may manifest these competencies differently than healthcare professionals who provide direct patient care. For example, to be effective in their roles,

physician executives and administrative leaders could need knowledge and skills in the areas of team-based care, quality improvement science, organizational development, health resources management, and healthcare finance – all of which arguably are facets of professionalism, interpersonal communication, practice-based learning and improvement, and systems-based practice.

Finally, many healthcare organizations view Board Certification as a marker of quality and competence and accordingly, require physician executives and administrative leaders to be Board Certified. For example, it is common for institutions that require their medical staffs to be Board Certified to also require their Chief Medical Officers to have the clinical knowledge, skills and professional standing associated with certification and MOC to ensure that their medical staffs view their executives and administrators as credible leaders.

Stakeholder Needs and Expectations

The Committee considered its charge from the perspective of four key stakeholders: 1) Physician Executives/Administrative Leaders; 2) ABMS Member Boards; 3) Consumers of the credential (e.g. hospitals and insurers), and 4) the Public. Issues identified as important to the targeted stakeholders included:

1. Physician Executives/Administrative Leaders:
    - Board Certified physician executives and administrative leaders who are interested in improving their knowledge and skills through participation in MOC face challenges in doing so because MOC programs – as currently designed – have limited application to their scopes of practice. In particular, MOC content requirements are generally oriented to medical specialists who provide direct patient care.
    - Physician executives and administrative leaders may often rely on knowledge and skills that are different than those needed to provide direct patient care.
    - Many physician executives and administrative leaders who are required by their employers to maintain Board Certification often have difficulty

identifying Improvement in Medical Practice (MOC Part IV) activities they view as relevant to their day-to-day work.

- Physician executives and administrative leaders may experience difficulty obtaining MOC credit from their certifying boards for specific types of CME and QI activities relevant to their scope of work.
- Physician executives and administrative leaders who no longer provide direct patient care still identify themselves as physicians, and for many, medical specialty certification serves as the imprimatur of that identity or requirement for the job, for example the executive director of a specialty society or Member Board of the ABMS.

2. ABMS Member Boards:
   - The majority of ABMS Member Boards define the phrase "clinically inactive" based on whether or not a medical specialist provides direct patient care and the length of time away from such duties. Some Member Boards offer or recognize limited MOC offerings for medical specialists who do not provide direct patient care.
   - Smaller and mid-sized Member Boards have limited resources, which impacts the extent to which they may be able to adapt their MOC programs and policies to make them more relevant to physician executives/ administrative leaders.
   - ABMS Member Boards benefit by maintaining strong relationships with Board Certified physicians and other healthcare professionals in executive or administrative leadership positions.
   - There is value in creating consistency across the Member Boards as it relates to program requirements that are relevant to physician executives and administrative leaders.
3. Users of the Credential (e.g., hospitals, insurers, credentialers, State Medical Boards):
   - While users of the credential expect Board Certified medical specialists to be evaluated in the core knowledge relevant to a given specialty, there

is increasing expectation for accountability in leadership and management areas such as quality, patient safety, and appropriate use of resources.

- Because clinical and business enterprises are integrated, users of the credential often require physician executives and administrative leaders to have both the clinical knowledge and experience related to their discipline as well as the leadership or management expertise necessary to contribute to improving care delivery, and ultimately, patient care outcomes.

4. Patients/Public:
    - The Public expects the certification process to ensure Board Certified physicians and other healthcare professionals in executive or administrative leadership roles have the competencies needed to effectively carry out their roles.

Committee Findings

In considering opportunities to make MOC more relevant and meaningful to ABMS Member Board certified medical specialists who practice in executive or administrative leadership roles, the Committee concluded that certification is both a clinical and a professional credential. The reasons for this were two-fold. First, many clinically successful medical specialists are asked to take on more leadership or management responsibilities. As that transition occurs, their new roles make it increasingly difficult for them to engage in direct patient care and thus, meet MOC Improvement in Medical Practice (Part IV) requirements. Second, many medical specialists in executive and administrative leadership roles influence the delivery of healthcare as they are engaging in clinical decision-making that affects patient care outcomes.

In discussing the concept of "clinically active," the Committee observed that the phrase traditionally has been interpreted as "caring for patients" and in fact, Member Boards with policies that define "clinically inactive" use time away from patient care as the benchmark for determining an individual's clinical status. Additionally, because the healthcare system is moving from disease management to health management, many physician executives and administrative leaders perform duties that influence both

systems of healthcare as well as the quality of care patients receive. Because of these facts, the Committee believes there is an opportunity to broaden the interpretation of clinical activity to include a "scope of activities that directly or indirectly impact the care of one or more patients."

The Committee acknowledged the tension between a recommendation that would increase the value of certification to the physician executive/administrative leader, and the transparency needed to ensure that the public is informed about the degree to which a Board Certified medical specialist is engaged in the care of patients. Recognizing this issue, the Committee agreed that changes in healthcare delivery and patient/population care mandate a broader acknowledgement of medical specialists' impact and influence on individuals and communities.

In considering physician executives and administrative leaders who have not been engaged in the direct care of patients and wish to resume such duties, the Committee determined that active engagement with MOC could enhance the ease of reentry into clinical practice. The Committee acknowledged that those medical specialists who wish to return to direct patient care duties following a period during which they were not actively providing patient care will need access to Board-approved reentry programs to facilitate their return to patient care. This is consistent with the MOC Standards for Professionalism and Professional Standing, which call for each ABMS Member Board to establish and maintain a process that provides former Board Certified healthcare professionals an opportunity to regain Board Certification.

The Committee reviewed the 2015 Standards for the ABMS Program for MOC and discussed the relevance of each MOC component for the physician executive/administrator. The Committee agreed that public accountability is best served when Member Boards require medical specialists who provide any amount of direct patient care, however limited or focused, to maintain the same level of knowledge, skill and competence as medical specialists whose practices are full time patient care. The Committee also agreed to the following:

1. The MOC component pertaining to Professionalism and Professional Standing is essential to the physician executive/administrative leader.

2. The MOC component pertaining to Lifelong Learning and Self-Assessment is also applicable to the physician executive/administrative leader, and Member Boards should be encouraged to accept for MOC credit, continuing medical education activities that focus on competencies associated with effective leadership and management skills.
3. The MOC component pertaining to Assessment of Knowledge, Judgment and Skills could be made more relevant to physician executive/administrative leader if Member Boards were to weight the content of the examination based on the individual's practice profile. The examination could balance knowledge core to the specialty with content that reflects the knowledge and skills needed to be an effective leader/manager. Member Boards that provide modular exams could use this MOC component as an opportunity to offer a module with content that is specifically relevant to physician executives or administrative leaders.
4. The MOC component pertaining to Improvement in Medical Practice could be made more inclusive of medical specialists in executive or administrative leadership roles if it were designated "Improvement in Professional Practice." The diversity of projects appropriate for physician executives or administrative leaders could include traditional quality improvement projects as well as institutional and educational projects designed to improve the care of individual patients, populations of patients, or the healthcare delivery system generally.

The Committee observed that the knowledge and skills needed by physician executives/administrative leaders are embedded in the ABMS/ACGME core competencies of systems-based practice, interpersonal communications, practice-based learning and improvement, and professionalism. However, because of the day-to-day scope of responsibilities of physician executives/administrative leaders, they require professional development resources that may be different from those needed by specialists providing direct patient care. Some of those needed resources include areas such as patient safety, team-building, quality improvement, and organizational and financial management.

The Committee reviewed information related to programs offered by ABMS and select Member Boards that could be leveraged to better support the Board Certified physician executive/administrative leader. Programs submitted for review included the:

- American Board of Family Medicine's Self-Directed Practice Improvement Modules for Board Certified physician specialists who are clinically inactive
- American Board of Preventive Medicine's Aerospace Medicine Practice Assessment Protocol
- American Board of Internal Medicine's Clinical Supervision Practice Improvement Module
- ABMS MOC Directory, powered by the Association of American Medical Colleges' MedEdPORTAL
- ABMS Multi-Specialty Portfolio Program

The Committee observed that the ABMS MOC Directory in particular was positioned to provide physician executives and administrative leaders access to resources aimed at fostering the development of the knowledge and skills required to be effective healthcare leaders and managers. Numerous organizations, including specialty societies, academic institutions and physician organizations, have submitted accredited CME offerings relevant to physician executives for posting on the ABMS MOC Directory website. Specifically, in the arena of MOC Lifelong Learning and Self-Assessment (Part II), ABMS Member Boards should consider accepting for credit the leadership development programming and offerings available either directly from these organizations or via the ABMS MOC Directory. In addition, ABMS Member Boards should consider accepting for MOC IMP (Part IV) credit, organizational-related quality improvement activities submitted by physician executives/administrative leaders.

Recommendations

The Special Committee on Physician Executives/Administrative Leaders and Continuing Certification offers the following recommendations for consideration by the ABMS and its Member Boards:

Defining Clinical Activity

1. Broaden the interpretation of the phrase "clinical activity" to include professional activities that directly or indirectly impact the provision of care to an individual or community of patients, including those that contribute to improvement in systems of care and delivery of medical education.

2. Adopt a statement articulating the position that Board Certified medical specialists who provide direct patient care, however limited or focused, have the same responsibility to maintain their clinical knowledge, skill and judgment as a specialist whose practice is full time patient care.
    a. ABMS Member Boards should have the purview to set criteria for the minimum amount of patient care activity needed to maintain competence in their specific discipline.
    b. ABMS Member Boards who designate medical specialists as clinically inactive on their public-facing websites should consider using the phrase "not currently active in direct patient care."

3. Broaden the MOC Standards for Improvement in Medical Practice (IMP) to MOC Standards for Improvement in Professional Practice, so that physician executives/administrative leaders who contribute to improving the care of patients or patient populations through mechanisms other than direct patient care may engage meaningfully in their certifying board's MOC program.

Application of MOC Standards

5. Support the career path of physician executive/administrative leaders and embrace a pathway to MOC for this population.
6. Establish MOC requirements for physician executive/administrative leaders that are flexible, relevant, and consistent across specialties.

Relevance

7. Accept accredited continuing medical education activities that foster the knowledge and skills needed by Board Certified physician executive/administrative leaders to be effective in their particular scope of healthcare-related responsibilities.

8. Weight the content of the MOC Assessment of Knowledge, Judgment and Skills so that it balances knowledge core to the specialty with content that reflects the knowledge and skills needed to be an effective leader/manager.
    a. ABMS Member Boards should consider whether access to a common bank of multiple-choice questions pertaining to leadership knowledge and skills could be a cost-effective way to enhance their Part III examinations.
    b. Member Boards that offer modular examinations should consider developing a module with content reflecting the competencies required to be an effective healthcare executive or manager.

9. Establish flexible criteria for use in determining the acceptability of organizational-related quality improvement activities submitted by physician executives/administrative leaders for MOC IMP (Part IV) credit. For example, quality improvement activities that are intended to improve the healthcare delivery system or the quality of care delivered to a patient or a community of patients should be acceptable for MOC IMP credit.

Resources

10. Assist physician executives/administrative leaders in accessing continuous professional development resources that are relevant to their scope of activities and acceptable for MOC credit.
    a. ABMS Member Boards should clearly communicate to physician executives/administrative leaders what is acceptable for purposes of meeting MOC Self-Assessment and Lifelong Learning (Part II) and IMP (Part IV) program requirements.
    b. ABMS Member Boards should encourage specialty societies and other physician leadership organizations to develop for MOC credit, educational and mentoring tools and resources aimed at building executive or administrative knowledge and management skills.
    c. ABMS and its Member Boards should collaborate with organizations that are positioned to help increase access to practice-relevant continuous professional development resources for physician executives/administrative leaders.

American Board of Medical Specialties
Special Committee on Physician Executives/Administrative Leaders and Continuing Certification

Peter B. Angood, MD
President and Chief Executive Officer
American Association for Physician Leadership

David Bjorkman, MD, MSPH
Dean and Executive Director of Medical Affairs
Charles E. Schmidt College of Medicine
Florida Atlantic University

Miriam G. Blitzer, PhD
Executive Director
American Board of Medical Genetics and Genomics

Christopher C. Colenda, MD, MPH (Co-chair)
President and Chief Executive Officer
West Virginia University United Health System

John R. Combes, MD
Senior Vice President
American Hospital Association
President and Chief Operating Officer Center for Healthcare Governance

W. Bryan Gamble, MD, FACS
President and Chief Executive Officer
Florida Hospital Medical Group

Trent Haywood, MD, JD
Chief Medical Officer
BlueCross BlueShield Association

Diane Magrane, MD
Executive Director
International Center for Executive Leadership in the Academies
Drexel University

James T. McDeavitt, MD
Professor and Chairman, Department of Physical Medical and Rehabilitation
Baylor College of Medicine

Lois Margaret Nora, MD, JD, MBA (Co-chair)
President and Chief Executive Officer
American Board of Medical Specialties

Susan E. Northrup, MD, MPH
Regional Flight Surgeon, Southern Region
Federal Aviation Administration

Barbara S. Schneidman, MD, MPH
Clinical Professor, Department of Psychiatry
University of Washington

Robert W. Strauss, MD, FACEP
ABEM Board of Directors

Stephen I. Wasserman, MD
President
American Board of Allergy and Immunology

ABMS Staff Support
Carol Clothier, Vice President, State Health Policy & Public Affairs
Hannah Williams, Manager, Policy Operations