NATIONAL
QUALITY FORUM

Enhancing Physician Performance:

A SUMMIT REPORT

NATIONAL QUALITY FORUM

NQF is responsible for the content, quality and scientific integrity of the Enhancing Physician Performance (EPP) summit and related report.

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ENHANCING PHYSICIAN PERFORMANCE SUMMIT: A REPORT

EXECUTIVE SUMMARY

Despite soaring healthcare costs, the current U.S. health system consistently underperforms compared to those of leading industrialized countries and is wholly inadequate to address the pervasive gaps in safety, quality, efficiency, and disparities.[1] Over the past decade, there has been widespread recognition and growing consensus that fundamental change in the public health and personal healthcare delivery systems are needed.

The 2010 Affordable Care Act (ACA) includes an vision for a future healthcare marketplace that leads to "better care, affordable care, and healthy people and communities." The Department of Health and Human Services, with input from the National Quality Forum (NQF)-convened National Priorities Partnership, submitted a high level strategy to achieve this vision to Congress in 2011. Known as the National Quality Strategy, it is being implemented now and involves improving patient safety, ensuring patient and family engagement, promoting better communication and care coordination, promoting effective treatment and prevention practices for the leading causes of mortality, working with communities to promote best practices for healthy living, and making quality care more affordable for all. The breadth and depth of change envisioned is extraordinary, and the timelines are tight.

The changes under way have profound implications for the more than 900,000 practicing physicians in the United States. Of particular note, there will be growing pressure to measure and publicly report on both the quality and cost of care, with performance results tightly linked to payment incentives. For many providers, achieving expected levels of performance will necessitate transitioning into new practice arrangements, such as healthcare homes and accountable care organizations, that enable team-based care assisted by health information technology to promote healthy lifestyles and manage longitudinal patient-focused episodes. Emphasis on consumer-centered care that engages patients

in making decisions and managing their health and healthcare will reshape doctor-patient relationships with an emphasis on collaboration and partnership. These anticipated changes will necessitate new knowledge and skills on the part of practicing physicians as well as changes in behavior.

Both marketplace interventions—public reporting, value-based purchasing, and regulatory programs—and professional programs play important roles in establishing performance standards and expectations and enabling this enormous transition. The health reform legislation places significant emphasis on public reporting of performance results and alignment of payment with value for virtually all types of providers, from individual practitioners and medical groups to hospitals and long-term care organizations. Having a marketplace that encourages and rewards change is critical to success, but probably not sufficient. In the United States, the medical professional has been a powerful force in shaping the values, attitudes, knowledge, and skills of physicians for more than 100 years, and mobilizing the leadership, experience, and resources of professional institutions, such as specialty societies and certification boards, will ultimately be critical to success.

The success and timelines of this transition will hinge in part on the degree to which we develop a cohesive and comprehensive approach to improving quality that takes full advantage of the incentives, knowledge, and resources inherent in both market incentives and professional programs. The Enhancing Physician Performance Summit, convened by NQF and the American Board of Medical Specialties (ABMS) in the summer of 2009, was held to initiate a multi-stakeholder dialogue around the role of Board Certification and Maintenance of Certification (MOC) in the broader quality enterprise. The summit served as a platform for key groups to discuss the roles and potential contributions of all types of accountability programs, including those sponsored by consumers, payers, and regulators and the specialty-specific programs of certification boards.

SIX KEY FINDINGS OF THE SUMMIT INCLUDE:

1 Both market incentives and specialty certification programs are important and complementary elements of a robust national effort aimed at improving healthcare quality.

While the ultimate objective of each of these strategies is to lead to better health and healthcare for populations and patients, the potential contributions to quality assessment and improvement and the tools and techniques employed are quite different. Marketplace programs focus on a distinct set of measures of clinical processes and patient perceptions and outcomes that often reflect the contributions of both clinicians and the systems in which they practice. Certification programs are multi-faceted and comprehensively assess knowledge, management, and diagnostic skills necessary to practice in a specialty area.

2 The incentives and supports provided by marketplace incentives and specialty certification programs can be more synergistic.

The impact of market incentives is tied to the fact that performance results are publicly reported and linked to financial rewards and penalties. Certification programs set standards for recognition in a particular specialty area, and many U.S. healthcare institutions, such as hospitals and health plans, consider board certification as a key element of their credentialing processes. Certification programs also provide feedback on performance to help physicians continuously improve. Together, marketplace incentives and specialty certification programs can provide an environment conducive to change and the knowledge and tools clinicians need to take advantage of this new environment.

3 Marketplace and specialty certification programs are not substitutes for one another, nor should they operate in a vacuum.

Each of these efforts consumes scarce physician time and resources, and all have a responsibility to coordinate their efforts and share information in the interest of minimizing burden and maximizing their collective impact. Aligning around the National Quality Strategy, using NQF-endorsed measures where appropriate, and relying on a common data infrastructure will go far in harmonizing expectations and easing burden on physicians. More discussion is needed to clarify the extent to which some or all boards will make more detailed performance information publicly available in the future, and which forms of information are meaningful to consumers. Finally, payers and regulators need to consider how to value the boards' role in assessing specialty knowledge and skills given certification's demonstrated link to quality.

4 The certification boards are uniquely positioned to play a vital leadership role in achieving patient-centered care because their assessments are focused directly on the individual physician.

Patient and family engagement is multifaceted and involves: facilitating informed decision-making, providing patient self-management support that is linguistically and culturally sensitive and cognizant of health literacy, recognizing the patient as an integral member of the care team, and asking patients about their experiences of care. Certification boards have many opportunities to promote the delivery of

appropriate patient-centered care, and some are already doing so by requiring physicians to demonstrate knowledge of patient-centered care concepts, to demonstrate use of shared decision-making tools and techniques in their practices, and to measure and report on their patient experience of care and outcomes.

5 Both marketplace incentives and specialty certification programs must focus greater attention on stewardship of resources.

Overuse of healthcare—the provision of services that expose patients to more potential harm than good—has resulted in poor quality and unaffordable healthcare for many Americans. The quality community must broaden its focus to encompass appropriate services provided as efficiently as possible.

6 The marketplace environment can facilitate the transition to new organizational arrangements capable of providing physicians with the necessary supports to deliver safe and effective care to all residents of a community, but professional programs must lead the way.

Specialty certification boards set professional standards for nationally recognized specialists and subspecialists. Both specialty certification boards and professional/specialty societies assist physicians in acquiring the necessary knowledge and skills relevant to systems-based care delivery, including making "meaningful use" of health information technology, practicing in interdisciplinary teams, measuring and improving performance, coordinating care across providers and settings, and providing patient-centered care.

Although this inaugural convening activity was successful in generating many sound recommendations that warrant further exploration and action, the findings in this report should be the impetus for ongoing efforts requiring the engagement of the broader healthcare community, beyond the original participants at the summit, as next steps are laid both to align appropriately and recognize the unique roles of market- and professionally based efforts to enhance physician performance.

1 Davis K, Schoen C, Stremikis K, The Commonwealth Fund. Mirror, mirror on the wall: how the performance of the U.S. health care system compares internationally, 2010 update. http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf. Published June 2010. Last accessed August 2010.

INTRODUCTION

It has been 10 years since the Institute of Medicine released its report *Crossing the Quality Chasm*, calling for fundamental change in the health system to address serious safety and quality challenges. Over the past decade, the breadth and depth of quality and safety activities has grown rapidly, and there have been improvements in important areas; but the overall rate of progress has been slow—with the National Healthcare Quality Report showing only very limited improvements in quality and safety across a limited set of performance measures.[1] Many efforts are under way to address these challenges, from value-based purchasing and public reporting, to certification and accreditation, to various educational and technical assistance programs. The organizations spearheading these efforts are both public and private, and many engage in multiple roles and activities.

In addition to growing demands for accountability, other important trends are shaping healthcare, for example, calls to make healthcare more patient-centered in recognition that patients who are engaged as active partners in their care achieve better health outcomes and often tend to use fewer resource-intensive services. Growing awareness of the sizable amount of waste in the health system during a time of extraordinary economic hardship and uncertainty is making it an imperative that health professionals accept greater responsibility for the stewardship of scarce resources. Additionally, there is growing recognition that providing care that is safe, effective, and affordable requires a well-organized system.

The passage of landmark health reform legislation both amplifies the demand for change and accelerates its pace with strong provisions for expanded public reporting and payment alignment. There also are provisions to promote patient engagement in decision-making and payment initiatives that target some of the most wasteful aspects of healthcare, including avoidable hospital readmissions and emergency department visits. The legislation also encourages the development of organizational models (e.g., expanded medical homes and accountable care organizations) capable of providing more coordinated and clinically integrated care.

There is growing awareness that achieving the promise of health reform—access to high-quality, affordable healthcare for all—will require dramatic changes in healthcare delivery and doctor-patient relationships. Marketplace incentives and professional programs represent two powerful levers for change, mobilizing the influence, incentives, and resources of each of them will be essential to our success. Further, the legislation recognizes the importance of building strong public and private partnerships between HHS and private-sector groups, such as ABMS and NQF.

It is in this context that ABMS and NQF decided to sponsor a workshop and summit to explore the roles of these various accountability efforts, with the hope of identifying ways to strengthen and make them more synergistic. The objectives of this paper are to:

- *describe* the current status of marketplace and professional certification programs;
- *identify* how these programs' activities might be better aligned to minimize burden and maximize impact; and
- *explore* ways these efforts can help physicians respond to societal demands for care that is patient centered, efficient and affordable, and provided through clinically integrated delivery systems.

MOC Criteria

PART I

Professional Standing

Medical specialists must hold a valid, unrestricted medical license in at least one state or jurisdiction in the United States, its territories or Canada.

PART II

Lifelong Learning and Self-Assessment

Physicians participate in educational and self-assessment programs that meet specialty-specific standards that are set by their member board.

PART III

Cognitive Expertise

They demonstrate, through formalized examination, that they have the fundamental, practice-related and practice environment-related knowledge to provide quality care in their specialty.

PART IV

Practice Performance Assessment

They are evaluated in their clinical practice according to specialty-specific standards for patient care. They are asked to demonstrate that they can assess the quality of care they provide compared to peers and national benchmarks and then apply the best evidence or consensus recommendations to improve that care using follow-up assessments.

Source: American Board of Medical Specialties, "MOC Competencies and Criteria", available at www.abms.org/Maintenance_of_Certification/MOC_competencies.aspx.

SPECIALTY BOARD CERTIFICATION AND MARKET INTERVENTIONS:

Key Components of a Robust Quality Enterprise

Specialty certification and marketplace interventions share a common aim—to measure, assess and improve health care performance. But the two programs have evolved from very different cultures and employ different techniques and incentive structures, metrics, and tools.

Specialty Certification

Specialty board certification is a voluntary, self-regulatory process overseen by specialty boards and dating back nearly 100 years. ABMS currently is composed of 24 member boards, and more than 750,000 U.S. physicians currently hold one or more certificates from these boards. Originally established to "demonstrate quality and differentiate among specialties,"[2] certification boards now play an important role in ensuring lifelong learning and ongoing quality improvement in practice.

The certification programs of ABMS member boards assess six core competencies:[3]

- patient care that is compassionate, appropriate, and effective for treating health problems and promoting health;
- medical knowledge about established and evolving biomedical, clinical, and cognate sciences and the application of this knowledge to patient care;
- practice-based learning and improvement that involves patients investigating and evaluating their own care, appraisal and assimilation of scientific evidence, and improvements in patient care;
- interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and other health professionals;
- professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population; and
- systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of healthcare and the ability to call on system resources effectively to provide care that is of optimal value.

To achieve initial certification, a physician must be licensed, complete an accredited residency program, and pass an examination that assesses broad-based knowledge and judgment in a specialty area. Before a resident is permitted to sit for this exam, he or she must achieve a threshold level of performance in the training environment as assessed by the program director.

In 1998, ABMS initiated a program known as Maintenance of Certification (ABMS MOC), which member boards are in various stages of implementing. Member board MOC programs vary greatly, yet all require a physician to show evidence of satisfying four criteria as part of a multi-faceted assessment: 1) professional standing, 2) lifelong learning and self-assessment, 3) cognitive expertise, and 4) practice performance assessment. Cognitive expertise involves assessing attributes of physician performance that do not lend themselves to clinical performance measures, for example up-to-date medical knowledge in a given specialty, the ability to diagnose,[4] and clinical judgment in managing complex and multiple conditions.

Board Certification Components

Although board certification is voluntary, more than 80 percent of all U.S. physicians hold one or more ABMS member board certificates.[5] With a few exceptions, only those physicians trained in the United States can achieve certification.[6] Individual physicians use board certification as a way of communicating to the public their ability to serve as nationally recognized specialists or subspecialists in a given area. More than a third of health plans and a significant portion of hospitals (rates vary among medical specialties from 44 percent to 70 percent) require physicians to be board certified for network and hospital privileging, respectively.[7,8,9,10] The industry preference for board-certified physicians has grown stronger in recent years.

A number of studies consistently find better outcomes among board-certified physicians than among non-certified physicians.[11,12,13,14,15]

The impact of MOC is less clear because of the variability in scope and pace of implementation across specialty boards, but emerging research points to a correlation with better quality of care.[16,17,18,19,20]

Marketplace Programs

Marketplace programs are much newer than specialty certification programs; most public reporting and value-based purchasing programs have evolved over the past two decades. Sponsored by public and private purchasers, health plans, and regulatory agencies, these programs support transparency and payment alignment as ways to encourage and reward performance improvement.

There are public reporting and value-based purchasing programs that apply to virtually all levels of the health system (e.g., health plans, hospitals, long-term care organizations, physicians). Programs sponsored by private health plans have for many years focused on individual physicians, and the Centers for Medicare & Medicaid Services (CMS) established a voluntary reporting program for physicians in 2006. ACA requires the Secretary of HHS to establish a physician reporting website by 2011 (which they have done) and to implement a pay-for-performance program by 2015.

Federal programs and many private sector efforts use standardized performance measures endorsed by NQF. NQF has endorsed more than 600 measures, and about one-fifth were developed by the Physician Consortium for Performance Improvement (PCPI), a consortium of specialty societies convened by the American Medical Association. Some measures are cross-cutting and apply to many specialties and practices, for example, care coordination, healthcare-acquired infections, and pain management. Other measures are specific to particular conditions and procedures. There are measures of medical care processes, patient outcomes, and patient perceptions, and efforts are ongoing to re-specify measures for use on an electronic platform.

Public reporting and pay-for-performance programs have flourished in recent years. There are now more than 100 reporting programs, many of which include physician-level data.[21,22] Some are national reporting programs—such as those sponsored by HHS, National Committee for Quality Assurance, and *Consumer Reports*—and others are state and community-based programs. It is now commonplace for public and private payment programs to link payment to performance results on a set of quality measures, and some include measures of patient experience and efficiency (i.e., both quality and cost).

Public reporting programs are intended to spur physicians and other providers to improve and to inform the decisions of multiple stakeholders, including:

- patients who are selecting a clinician, health system, or health plan;
- public and private purchasers designing benefits coverage and payment programs that reward high-quality care;

- federal and state regulators responsible for identifying and acting on unsafe care; and
- clinicians referring patients to specialists or hospitals.

The emerging evidence suggests that public reporting does lead to improvement at the hospital level, acting as an important catalyst for competition.[23] The research is less clear that physicians respond to public reporting (programs are relatively new) and that patients are using such data to select providers.[24]

Both marketplace incentives and professional programs are important and complementary elements of a robust national effort aimed at improving healthcare quality.

The establishment of health information exchanges at the community level, and eventually a national health information network, has very important implications for accountability programs. Electronic health records will provide ready access to clinically rich information, and personal health records to information on patient preferences, health behaviors, understanding of and compliance with treatment plans and outcomes. An electronic infrastructure that provides connectivity across all providers in a community and captures longitudinal patient data will enable measurement across the entire patient-focused episode.

Public reporting programs also are expected to evolve rapidly over the coming decade as more is learned about the types of information that are most salient and useful to different stakeholders. A good deal of measure development and endorsement work currently is under way that will result in more outcome measures (e.g., health functioning, activities of daily living, ability to return to work or school, long-term cancer survival rates); measures of adherence to healthy behaviors and prevention; measures of overuse and cost; measures of patient engagement in decision making; and composite measures that provide an overall indication of the "goodness" of care based on a set of measures.

Contributions of Marketplace Incentives and Specialty Certification Programs

For the most part, these accountability programs are complementary. They share a common commitment to quality measurement and improvement, but the potential contributions and tools and techniques employed are quite different.

Audience. Current public reporting programs aim to provide consumers, purchasers, and regulators with performance information that can be used to create an environment of care that encourages and rewards improvement and the attainment of excellence in care. An additional key audience for public reporting programs is the providers themselves, with research indicating that practitioners and hospitals strive to improve in comparison to the publicly reported performance of their peers. Although achievement of certification is an important quality measure that informs the decisions of patients selecting a doctor, as well as health plan and hospital credentialing programs, the primary audience for the detailed performance information collected by boards is the individual practicing physician. The extent to which some or all boards will eventually make more detailed performance information available to the public is unclear. Also unclear is how much detailed performance information the public is interested in receiving or using in its decision-making processes.

Breadth and Depth of Assessment. Marketplace programs provide patients, purchasers, and other stakeholders with performance results on a limited set of performance measures, generally selected to address high-leverage areas (i.e., areas where improvement will produce sizable gains in health and healthcare). These perform best in process and outcomes amenable to valid

quantifiable assessment, requiring significant frequency of the event being measured; therefore, they are less useful for complex and less common conditions or situations. Many of the performance measures are cross-cutting and apply to different specialty areas and types of patients, for example, healthcare-acquired infections, pain management, patient satisfaction, or high-frequency conditions and procedures for which there is adequate sample size for reliable measurement.

Specialty certification programs are multifaceted and more akin to a 360-degree ("multi-source") individual performance review. Certification programs consist of an in-depth assessment of a physician's knowledge and performance in a specific specialty area. MOC programs have the potential to assess some aspects of performance that generally are not reflected in marketplace programs. For example, the cognitive examination affords an opportunity to determine whether a physician is capable of both making a differential diagnosis and effectively managing clinical issues for complex conditions. Further, the practice performance assessment modules that focus on conditions and procedures may include measures that evaluate very specific and technical aspects of the medical process that may be less useful for public reporting and value-based purchasing. Finally, an often-neglected area where the boards are well positioned to play a significant role is the assessment of performance for low-frequency conditions (e.g., meningitis, influenza, TB, thyroid disease) that are difficult to assess using performance measures due to low volume but are costly regarding disease burden and resources spent.

Quality Improvement Strategy. Marketplace programs provide performance information that is used to create an environment (e.g., payment and public reporting programs) that encourages and rewards improvement and achievement of high levels of quality. MOC programs engage clinicians in ongoing knowledge and skill acquisition in a specialty area via quality improvement efforts, access to measurement tools, and feedback on performance. The Boards assess whether physicians are keeping up with and applying current knowledge and skills in practice.

The incentives and supports marketplace and professional programs provide have the potential to be synergistic. The impact of marketplace programs is tied to the fact that performance results are publicly reported and linked to financial rewards and penalties by health plans, employers, and government entities at all levels. Certification programs, which plans and hospitals use as a quality marker, emphasize professional responsibility to provide high-quality care and strive to make the necessary knowledge and tools available to physicians to improve, while providing physician-specific information to the public about which physicians have met expert standards. By working together, both can provide an environment conducive to change and the knowledge and tools clinicians need to practice effectively in 21st-century practices and care delivery systems.

OPPORTUNITIES FOR GREATER ALIGNMENT:

A Common Agenda and Coordinated Actions

Although marketplace and professional certification programs are distinct, they should operate in alignment. The collective impact of the two programs likely will be far greater if attention is paid to aligning efforts around common priorities and establishing mechanisms to coordinate in key areas to accelerate improvements in quality. In addition, both types of programs also consume scarce physician time and resources, and both have a responsibility to coordinate their efforts and to share information in the interest of minimizing burden.

Efforts to strengthen coordination and collaboration should focus on four key areas:

- alignment around the National Quality Strategy established by the Secretary of HHS;
- use of NQF-endorsed measures, when appropriate;
- use of a common data infrastructure to generate and report on performance information; and
- development and implementation of quality improvement programs and tools.

National Quality Strategy

Foundational to the core functions of the quality enterprise is agreement on a set of national strategies and priorities to mobilize and channel resources around areas that offer the highest leverage for improvement. ACA charged the Secretary of HHS to establish a National Quality Strategy (NQS), released in March 2011, which benefited from the input of the NQF-convened National Priorities Partners (NPP).[25]

Over the past year, at the request of HHS, NPP has made considerable progress in specifying goals, measures, and public-private-sector pathways to facilitate implementation of the NQS, which are captured in a recent report to the Secretary.[26] As an active member of NPP, ABMS has contributed to setting initial priorities and helping to inform HHS about national strategies and goals. ABMS also was one of the first NPP Partners to adopt the priorities. Over the coming year, additional steps could be taken to ensure that each of the ABMS member boards has aligned its activities and programs to the extent possible with the NQS priorities and goals. When the priorities need recognition of new or emerging specialty or programmatic areas, certification and accreditation entities can advance them by developing programs for these new areas, as they did recently with hospice and palliative care.

NQF-Endorsed Measures

When measures are to be used in the marketplace—especially for public reporting, payment, and regulatory programs—it is important that they be NQF-endorsed measures. These applications require measures that meet clear criterion-based standards in terms of validity and reliability and provide results that allow for broad comparability. To the extent that certification boards contribute to public reporting or other marketplace applications, they should seek to use NQF-endorsed measures. However, as noted above, boards already do and should take advantage of opportunities to measure and improve additional aspects of performance, as doing so will afford the public additional assurance of physician competency. Certification boards that develop measures should consider submitting measures to NQF for endorsement if the measures address national priorities and would provide information useful for marketplace applications.

Data and Reporting Infrastructure

Both marketplace and maintenance of certification programs rely on a common data infrastructure to generate performance information about a physician's practice. To the extent that the performance measures required for marketplace applications also are a part of MOC, there may be opportunities to develop a common pipeline for submitting data to satisfy both purposes. Some boards do provide performance results on behalf of their diplomates to CMS.

Certification boards will need to determine the extent to which they wish to engage in public reporting of performance information. All boards do provide information on certification status available to the public at large, but there are opportunities to provide additional information. For example, boards could make available summary results from the measures used in practice assessments. Moving forward, it will be important to assess what is meaningful to the public and for boards to clarify further the extent to which they intend to include public reporting, beyond an overall indicator of certification status.

Quality Improvement Programs and Tools

Although marketplace programs create an environment that encourages and rewards improvements in safety and quality, they generally do not provide the knowledge and tools many physicians need to improve or the in-depth assessments that can help them focus their improvement efforts. Over the coming years, marketplace programs likely will expand in scope, and the stakes will get higher as performance results are linked to both healthcare payment programs and health IT "meaningful use" incentives.

Steps should be taken immediately to better align the efforts of certification boards and specialty societies to assist providers in acquiring the necessary knowledge and skills to succeed in this new environment. In the absence of well-coordinated marketplace and professional certification and education programs, we will have failed to take full advantage of an important educational opportunity.

The healthcare quality community has been steadily and deliberately building toward a common vision to focus its work by setting national priorities and goals, developing high-leverage performance measures, reporting more meaningful information to the public, and creating a quality improvement infrastructure to facilitate improvements in the delivery of care. Concurrently, the certifying boards have facilitated physicians' ongoing acquisition of specialty knowledge and skill as medicine has rapidly evolved and leveraged state-of-the-art assessment tools. The summit has identified alignment as the way that ABMS and its 24 member boards can best work with other national organizations focused on leading U.S. healthcare improvement. By aligning their efforts they can accelerate improvements in quality and reductions in wasteful redundancy while continuing to recognize each other's unique and distinct contributions.

RESPONDING TO MAJOR TRENDS

The coming decades will be transformative for the healthcare system, and several major trends are likely to shape the outcome, such as the demand for care that is more patient centered, the critical need to address healthcare costs, and movement to more systems-based care delivery. These trends have important implications for all national efforts to improve quality.

Patient-Centered Care

A growing body of evidence demonstrates that patients who are engaged as active partners in their care achieve better health outcomes and often tend to use fewer resource-intensive services.[27] Patient engagement is multifaceted and involves: 1) facilitating informed decision-making, 2) providing patient self-management support that is linguistically and culturally sensitive and cognizant of health literacy, 3) recognizing the patient as an integral member of the care team; and 4) asking patients about their experiences with care. Although there are several models of the physician-patient relationship—with the level of patient activation varying along a continuum[28] — current trends toward more patient-centric care embrace collaborative approaches to shared decision-making that explicitly incorporate patient preferences and values.

Embracing person- and family-centered care is a national priority as identified by the National Quality Strategy. This will require standardized measures of patient experience, patient-focused outcomes (e.g., functional status), decision quality, and meaningful and actionable feedback to clinicians. Patients and their families will need to be equipped with tools (e.g., personal health records) and meaningful information to facilitate their active participation in their care decisions and self-management of their chronic conditions. Also, delivery systems must evolve to being capable of managing and being held accountable for providing seamless care across a patient's full trajectory of illness over time.

To support higher levels of patient and family engagement, it will be important for NQF to expand its portfolio of measures pertaining to patient experience of care and patient outcomes, such as functional status and quality of life. The boards could require that information pertaining to a patient's experience of care (e.g., CAHPS survey) and functional assessment be routinely collected and reported—and ensure this feedback is acted on to improve care delivery and patient outcomes.

ACA also includes important provisions related to shared decision making, specifically, the establishment of a certification program for decision tools. Accountability programs will want to include measures of the impact of these programs on patient knowledge and reported levels of engagement. As a part of MOC core competencies, boards have opportunities to require physicians to demonstrate an understanding of and sensitivity to patient preferences, as well as issues around cultural competency and health literacy, and to document the use of shared decision-making techniques and tools, with the goal of eventually being able to link decision quality to patient outcomes and concordance with patient preferences.

Recognizing that collecting patient-centered data, as described above, can impose significant burden both regarding provider time and administrative costs, accountability and professional certification programs will need to work closely with other stakeholders to identify business models that support aggregating and disseminating this information, including a feedback loop for purposes of internal quality improvement.

Stewardship of Resources

More than 10 years ago, *overuse* was defined as a procedure or test for which "the potential for harm exceeds the possible benefits of care."[29] The IOM estimates that 30 percent of healthcare can be attributed to waste[30] and researchers at Dartmouth have shown that there is significant variation in healthcare spending among regions of the United States— explained not by severity of illness but rather by capacity, such as the number of hospitals, physicians, and physician specialists in a given region. For example, areas with more specialists have more consultations and consequently make more referrals for procedures and tests that increase expenditures. Much of this care is often unwarranted, not aligned with patient preferences, and potentially harmful.[31,32] Fee-for-service payment models contribute to the current volume- driven health system, thus providing perverse incentives contrary to value-based purchasing. The current economic climate has escalated the importance of this trend given that expenditures in healthcare continue to outpace resources, which have become even more restricted.

The NQS has identified "affordable care" as one of its six national priorities. Responding to this critical and time-sensitive trend will necessitate the building of a robust evidence base and practice guidelines that address issues around appropriateness of care. Accordingly, measures will need to be developed to assess both appropriateness and overuse. Further, movement toward full transparency would include public reporting on cost of care and quality at the provider and population levels—on which payment models would be based to promote value.

Other areas addressed at the summit included changes in the malpractice system to temper "defensive medicine" and shift the focus from informed consent to informed choice by providing evidence-based care aligned with patient's preferences.[33] Importantly, public education and awareness (e.g., campaign or social marketing) around the message "more is not necessarily better" will be essential to convey, such as increasing public knowledge of the potentially harmful effects of ionizing radiation due to cumulative exposures from imaging procedures.

In response to this trend, the boards can reinforce the responsibility of medical professionals to serve as stewards of scarce resources. Measures of appropriate use, cost of care, and practice variation can be incorporated into MOC requirements. Another promising mechanism is a peer review process designed to identify and address outliers, for example, looking at physician utilization patterns benchmarked to comparable patient populations (e.g., real versus expected) as is currently being done by the American Board of Urology.

Systems-Based Care Delivery

Our current healthcare system is fragmented. As a result, care is uncoordinated, leading to system inefficiency through duplication of diagnostic tests and procedures, overall system waste, and often poor patient outcomes. Although integrated delivery systems (e.g., Mayo Clinic, Kaiser Permanente, and Geisinger Healthcare) have demonstrated success and serve as promising examples of high-quality, efficient care, most of the medical care in the United States is still delivered by small practices.[34]

Contributing to the problem of the lack of clinical integration is an underinvestment in key organizational supports essential to achieving system-based care delivery including: 1) effective use of information technology; 2) redesign of care processes; 3) knowledge and skills management; 4) development of effective multi-disciplinary teams; 5) coordination of care across patient conditions, services, and settings over time; and 6) performance and outcome measurement for continuous quality improvement and accountability.[35]

Central to the function of the national efforts to improve quality is the promulgation of national priorities that drive toward system development such as the NQS designated priority area of effective communication and care coordination. Using payment and public reporting as levers, these organizations can encourage the development of integrated systems of care, initially through piloting and evaluating emerging models that show promise, such as accountable care organizations, medical homes, and virtual integrated networks.[36] Additionally, there must be significant investment in health IT as an enabling tool for promoting coordinated care and real-time sharing of information across settings.

The boards are well positioned through their certification programs to be high-leverage leaders in cultural change among physicians and to evolve the concept of professionalism so it aligns with the core tenets of an accountable, patient-centered, efficient, systems-based healthcare delivery system envisioned at the summit. Boards can advance core competency requirements to reflect the vanguard of care and push assessment to include a physician's ability to lead and practice within a team and the capacity to function within a system. Assessments could include whether practice environments met the following criteria: 1) possessed core attributes of high-performing organizations as defined by the IOM, 2) applied continuous quality improvement tools and applications; and 3) effectively used health IT.

Additionally, opportunities exist for collaboration among the boards and with other stakeholder groups to promote system-based care delivery. Potential partnerships include:

- collaborating with accrediting organizations on systems evaluation of medical homes and mutually recognizing the results in MOC and Patient-Centered Medical Home recognition programs;
- collaborating with the American Association of Medical Colleges, the Accreditation College of Graduate Medical Education, and specialty societies to incorporate "systems knowledge and skills" upstream into educational programs at all levels; and
- recognizing the contributions of both marketplace and professional programs in quality frameworks and strategies.

PATH FORWARD

Strong, coordinated leadership is needed to guide the medical community through a period of enormous change. Both marketplace and professional programs have important contributions to make, and working together, the impact of these programs will be greater than the sum of the parts.

NOTES

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