This COMMENTARY section of *The Journal of Clinical Psychiatry* presents the highlights of the roundtable teleconference "Maintenance of Certification in Psychiatry," which was held January 8, 2009. This report was prepared by the CME Institute of Physicians Postgraduate Press, Inc.

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# Maintenance of Certification in Psychiatry

## Michael H. Ebert, MD, Chair; Larry Faulkner, MD; Dorothy E. Stubbe, MD; and Daniel K. Winstead, MD

### HISTORY OF THE CORE COMPETENCIES

**Dr. Ebert:** In 1999, the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS), spurred by the beginning of the quality movement in organized medicine in the United States, identified 6 general principles to aid in the organization and assessment of medical education. These general principles were intended to be outcome-oriented, non-negotiable competencies or abilities that are central to medical practice for all specialties.

Two seminal publications from the Institute of Medicine, *To Err Is Human: Building a Safer Health System*[1] and *Crossing the Quality Chasm: A New Health System for the 21st Century*,[2] appeared in tandem and facilitated the development of the 6 core competencies, which involve patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, professionalism, and systems-based practice (Table 1).[3]

**Dr. Faulkner:** To develop core competencies specific to each medical specialty, the ACGME and the ABMS created quadrads composed of a specialty board representative, an ACGME Residency Review Committee representative, a program director, and a resident.

**Dr. Ebert:** Right. The pattern of representatives was consistent across all specialties. How were core competencies defined for psychiatry and neurology?

**Dr. Faulkner:** In the early 1990s, the American Board of Psychiatry and Neurology (ABPN) embarked on a strategic planning process. One goal was to identify the core competencies in psychiatry and neurology, which became the background for a 2001 meeting in Toronto, Canada. Leaders in psychiatry and neurology developed the competencies at that summit. Subsequently, the ABPN published the book *Core Competencies for Psychiatric Practice: What Clinicians Need to Know: A Report of the American Board of Psychiatry and Neurology, Inc*,[4] which outlined the competencies based on information from this meeting.

### HISTORY OF MAINTENANCE OF CERTIFICATION

**Dr. Faulkner:** The psychiatry maintenance of certification (MOC) program was developed following the leadership of the ABMS, which had established 4 components of MOC for board-certified physicians. These 4 components are professional standing, self-assessment and lifelong learning, cognitive expertise, and performance-in-practice.[3] The ABMS charged their 24 member boards, of which ABPN is one, with developing

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**FOR CLINICAL USE**

- Maintenance of certification (MOC) programs are required by the American Board of Medical Specialties and are implemented by specialty boards to ensure high-quality physician education and patient care.
- The MOC program for psychiatry and neurology focuses on a 10-year cycle of learning that asks board-certified physicians, or diplomates, to perform regular self-assessments and receive peer assessments to pinpoint areas to improve before recertification.
- Graduate and residency programs are working to integrate the 6 core competencies and 4 MOC components into their training in order to establish a foundation for lifelong learning.
- The MOC requirements continue to be refined, and diplomates should seek detailed updates.

individual MOC programs based upon those 4 broad components. The ABPN designed its MOC program to address the 4 broad components of the ABMS MOC program as well as each of its 6 core competencies.

One of the issues that the ABPN recognized early in the MOC development process was that individuals who were looking at certification programs from different perspectives had different concerns about the rigor, quality, and credibility of the programs. Some groups, including the public, politicians, and insurance payers, leaned toward a more rigorous, higher quality, more strenuous type of program, whereas the diplomates themselves were already overwhelmed and felt inconvenienced by the cost and time involved with these programs.

**Dr. Ebert:** Many diplomates were in the middle of their careers and were focused on their practice, and they did not feel that they could take considerable time off to recertify themselves.

**Dr. Faulkner:** Right. They did not want to spend any more time than they absolutely had to in order to fulfill the requirements. Ultimately, MOC is a voluntary process, so if it is too rigorous, many physicians might not participate. The ABPN has tried to balance meeting the ABMS requirements, which seem to be increasingly rigorous, while trying to establish a program that is reasonable and feasible for its members.

**Dr. Ebert:** This process was a concerted effort to bring about fundamental change in lifelong learning in the profession of medicine, which starts in residency. This type of learning is dramatically different from traditional continuing medical education, which typically used a passive model and, as time went on, received a disproportionate amount of funding from the pharmaceutical industry.

**Dr. Winstead:** This MOC movement strives to put credibility and relevance back into the system and to remind us all that lifelong learning should require physicians to undertake relatively comprehensive self-assessment at certain points in their careers. When they identify weaknesses, they can then strengthen those areas by taking continuing medical education (CME) courses. The cycle should then repeat itself at a later date, at which time the diplomates again go through the self-assessment and decide whether they have accomplished those tasks or not.

**Dr. Ebert:** Right. The cycle of learning was the idea behind the fourth component of MOC for all the specialties, practice performance assessment, which is the newest and the most unusual requirement. Dr. Faulkner, would you say that this component is the most difficult component for the different specialties in the ABMS to draft and conceptualize?

**Dr. Faulkner:** Yes. I agree with Dr. Winstead's idea of a cycle of learning and improvement. It is as if 2 almost simultaneous and concentric cycles are at work; these 2 quality improvement cycles relate to cognitive expertise and clinical expertise. Part 2 of MOC, which involves self-assessment and CME, is a quality improvement cycle for predominantly cognitive expertise. The self-assessment examination helps to direct your CME to your areas of weakness, and then the second self-assessment examination helps to determine whether goals were met. Ultimately this becomes part 3 of the MOC, the cognitive expertise examination.

With the original 3 components of MOC in place, awareness grew that this process was not completely adequate and that an additional focus on clinical practice assessment was needed to find out whether diplomates actually incorporated quality improvement into the way that they practiced. Thus, the performance in practice portion of MOC was added.

**Dr. Winstead:** While this MOC process may not be unusual for specialties with traditionally hospital-based physicians who have a rigorous peer-assessment process, this process is unusual for psychiatry.

**Dr. Faulkner:** Probably the most confusion about MOC is among diplomates who are not affiliated with organized systems, such as hospitals, that already have inherent quality improvement assessments as part of their programs. For example, the Joint Commission on the Accreditation of Healthcare Organizations requires all hospitals to have quality improvement programs. Thus, physicians working in a hospital system already may be familiar with people sampling their records, critiquing their patient care practices, and giving them feedback about how they compare with their peers or with practice guidelines. However, individuals who are in private practice, small group practice, or who see only outpatients


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**Table 1. General Core Competencies for Board-Certified Physicians[a]**

| Categories | Description |
|---|---|
| Patient Care | Provide care and treatment that is compassionate, appropriate, and effective for health problems and to promote health |
| Medical Knowledge | Demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and their application in patient care |
| Interpersonal and Communication Skills | Demonstrate skills that result in effective information exchange and teaming with patients, their families, and professional associates (eg, fostering a therapeutic relationship that is ethically sound, uses effective listening skills with nonverbal and verbal communication, working as both a team member and at times as a leader) |
| Practice-Based Learning and Improvement | Able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their practice of medicine |
| Professionalism | Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diverse patient populations |
| Systems-Based Practice | Demonstrate awareness of and responsibility to larger context and systems of health care. Be able to call on system resources to provide optimal care (eg, coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professions, or sites) |

[a]Adapted from the American Board of Medical Specialties.[3]

may not have any experience with that type of situation, or at least not recently.

**Dr. Winstead:** Right. Those in a hospital setting or a practice group may already be participating in the kinds of activities that allow them to fine-tune their skills and meet the performance-in-practice criteria.

**Dr. Faulkner:** Yes. In fact, we at the ABPN have considered this as we move toward implementing part 4 and are willing to accept that an individual may already be doing things that meet this requirement. So, for these individuals, obtaining credit for this requirement may be just a matter of providing documentation from the quality improvement office of their hospitals or practice plans that indicate that they are already involved in performance improvement activities. I believe that the current ABMS guidelines indicate a willingness to accept these types of documents.

**Dr. Winstead:** Physicians may also be involved in a community research network (CRN) program that also advocates meeting performance standards. Again, some fine-tuning may be needed to synchronize with the demands of the ABPN and the ABMS, but CRN may be another vehicle for meeting the MOC program requirements.

Some programs under development include learning modules that practitioners can use in their practices to fulfill MOC requirements. I suspect that many other modules like this will continue to be developed as an option for solo practitioners and individuals in ambulatory care settings.

## THE MOC COMPONENTS FOR PSYCHIATRY

**Dr. Ebert:** Dr. Faulkner, would you summarize the 4 parts of the MOC for psychiatry as they now stand?

**Dr. Faulkner:** The outline of the ABPN MOC Program is consistent with the ABMS requirements (Table 2).[5] Some requirements are new, and diplomates will be asked to meet these requirements as they are phased in, but the timelines for diplomates to meet requirement differ depending on their original certification year or year of last recertification (Table 3).[5]

### Part 1: Professional Standing

**Dr. Faulkner:** The physician is required to have an unrestricted medical license in at least 1 state or territory of the United States or a Canadian province.[5] This measure of acceptable professional standing has always been a requirement to receive and maintain board certification.

### Part 2: Self-Assessment and Lifelong Learning

**Dr. Faulkner:** Board-certified physicians must complete 2 self-assessment activities over a 10-year MOC cycle. These assessments must be in the form of examinations that are at least 100 questions.[5] Those 100 questions can come from more than 1 self-assessment program. So, two 50-question examinations would be acceptable for each of the 2 self-assessment requirements. The exams must focus on new knowledge or current best practices in psychiatry or neurology and include a feedback component that may be used to direct subsequent CME or career development.

The ABPN has clarified this requirement to make it a more continuous cycle of learning. The first self-assessment activity must take place within the first 3 years of this 10-year cycle, and the second self-assessment activity must take place within years 6 to 8. In other words, a diplomate could not wait until year 9 of the 10-year cycle to complete the 2 self-assessment examinations.

**Dr. Ebert:** What types of exams can diplomates choose for those self-assessment exercises?

**Dr. Faulkner:** They can choose any self-assessment exam developed by the American Psychiatric Association (APA), the American College of Psychiatrists (ACP), or another organization, that is based upon new knowledge or best practices and provides feedback, such as the Psychiatrist In-Practice Examination (PIPE).[6] The APA and some subspecialty groups are developing other assessments.


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**Table 2. Components of the ABPN Maintenance of Certification (MOC) Program[a]**

1. Professional Standing
   - Diplomates must hold a license to practice medicine in at least 1 state, commonwealth, territory, or possession of the United States or province of Canada. All medical licenses must be unrestricted.
2. Self-Assessment and Lifelong Learning
   - First: Diplomates must participate in at least 2 major, broad-based self-assessment examinations during the 10-year MOC cycle
     - One self-assessment activity to be completed in years 1–3 and 1 to be completed in years 6–8 of the cycle
     - Examinations must cover current knowledge and/or current best practices in 1 or more competency areas, total at least 100 questions each, and provide feedback to diplomate for basis of focused continuing medical education
   - Second: Diplomates must complete an average of 30 category 1 CME credits during each year of the 10-year MOC cycle
     - 150 hours to be completed in years 1–5 and 150 hours to be completed in years 6–10 of the cycle
3. Cognitive Expertise
   - Diplomates must pass a cognitive examination prior to the expiration date on their certificates
     - All current MOC requirements must be met before sitting for an examination
4. Performance in Practice (PIP)
   - Diplomates are required to complete 3 PIP units over the 10-year MOC cycle, each of which contains 2 modules (chart reviews and second-party external review)
     - First PIP unit to be completed in years 1–3
     - Second PIP unit to be completed in years 4–6
     - Third PIP unit to be completed in years 7–9

[a]Adapted from American Board of Psychiatry and Neurology, Inc. (ABPN).[5]

**Table 3. Phase-In Schedule for the ABPN Maintenance of Certification (MOC) Component Requirements (rev 2/22/2009)[a]**

| Original Certification Year or Recertification | MOC Application Year | MOC Examination Year | CME Credits Required | First SA Activity Required | Second SA Activity Required | First PIP Unit Required | Second PIP Unit Required | Third PIP Unit Required |
|---|---|---|---|---|---|---|---|---|
| 2000 | 2009 | 2010 | 120 | | | | | |
| 2001 | 2010 | 2011 | 150 | X | | | | |
| 2002 | 2011 | 2012 | 180 | X | | | | |
| 2003 | 2012 | 2013 | 210 | X | | | | |
| 2004 | 2013 | 2014 | 240 | X | X | X | | |
| 2005 | 2014 | 2015 | 270 | X | X | X | | |
| 2006 | 2015 | 2016 | 300 | X | X | X | X | |
| 2007 | 2016 | 2017 | 300 | X | X | X | X | X |
| 2008 | 2017 | 2018 | 300 | X | X | X | X | X |
| 2009 | 2018 | 2019 | 300 | X | X | X | X | X |
| 2010 | 2019 | 2020 | 300 | X | X | X | X | X |

[a]Reprinted with permission from American Board of Psychiatry and Neurology, Inc. (ABPN).[5]
Abbreviations: CME = continuing medical education, PIP = performance in practice, SA = self-assessment.

For lifelong learning, the ABPN requires 300 Category 1 CME credits that have to be relevant to the diplomate's specialty over the 10-year period. In the spirit of continuous learning, 150 of the 300 credits must be completed in years 1 to 5 and another 150 credits in years 6 to 10. Thus, through the combination of self-assessment and CME, a cycle of quality improvement in medical knowledge occurs over time.

### Part 3: Cognitive Expertise

**Dr. Faulkner:** Part 3 of MOC requirements is the cognitive examination.[5] This is similar to the old recertification exam; it is a secure, proctored, multiple-choice, computerized exam administered at a Pearson VUE center.[7] Diplomates have to complete all other requirements of MOC before they will be allowed to take this examination, and the ABPN audits a certain percentage of diplomates to make sure they have completed all the other requirements of MOC.

If diplomates meet all of the requirements and pass the cognitive exam, then their certification is extended for a 10-year period commencing with the year of the exam. We expect a very high pass rate on these exams; currently the pass rates have been above 95%. However, the diplomates who take these exams typically are just 10 years into their careers, so we would expect them to do well on these exams. One study[8] found that quality of care tends to deteriorate as physicians' length of time in practice increases.

### Part 4: Performance in Practice

**Dr. Faulkner:** The fourth component is the most difficult and vexing part of MOC. The ABPN requires 3 performance-in-practice units over the 10-year MOC period, and each unit has 2 types of modules, a clinical module and a feedback module. The first unit must be completed in years 1 to 3 of the 10-year cycle, the second unit in years 4 to 6, and the third unit in years 7 to 9.[5] Again, the focus is on continuous practice improvement, so a


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diplomate cannot try to accomplish all 3 units in the last year or 2 of the 10-year cycle.

The clinical module requires diplomates to collect data from at least 5 of their own cases in a similar category from the previous 3-year period. These categories can be organized around diagnosis, treatment type, treatment setting, or any other way that a diplomate might be able to draw the cases together. Once the cases have been identified, the diplomate compares data from those cases with published best practices, practice guidelines, or peer-based standards of care, such as those in a hospital quality improvement program, in order to identify opportunities for improvement in the effectiveness of his or her practice. The diplomate is then expected to take steps to improve his or her performance based on those comparisons. Within 2 years after the initial comparison, the diplomate must sample another 5 cases in the same category to determine if any improvements have been made.

The second module of the performance-in-practice component requires diplomates to solicit opinions from at least 5 peers from the field of psychiatry and at least 5 patients who can comment on the diplomate's clinical performance over the previous 3 years. Their professional peers can be social workers, nurses, physicians, or other health care professionals. This feedback provides another opportunity for improvement and for the diplomate to take steps to improve efficiency and effectiveness in practice, and then to resolicit opinions within another 2-year period to gauge improvements.

## THE ROLE OF THE ABMS IN ABPN MOC

**Dr. Ebert:** What is the function of the ABMS in specialty boards' MOC oversight? Dr. Faulkner, could you explain the working relationship between the ABPN and the ABMS with regard to MOC?

**Dr. Faulkner:** The ABPN position, and the position of a number of other member boards of the ABMS, is that it is the responsibility of the ABMS to promulgate broad standards or guidelines for the 4 components of MOC. It is the responsibility of the member boards to develop the unique measures of performance and programs that will meet those broad guidelines. Conversely, some boards contend that the ABMS has the authority to mandate specific programs and products for all diplomates in all specialties and the timetables in which the diplomates will meet the requirements.

The Committee on Oversight and Monitoring of Maintenance and Certification of the ABMS is in the process of promulgating new standards, guidelines, and timetables for MOC. These new standards are significantly more rigorous than the current ABPN program, which has already been approved by the ABMS but will not fulfill the recommendations coming forward from the committee in its current form.

The ABPN is concerned about the timetable for implementation for newer components of MOC, which is more aggressive than what ABMS had previously approved for the ABPN. For example, the requirement for part 4 of MOC was originally not scheduled to begin until 2013, but ABMS is asking us to begin in 2010. It is unclear how this will play out.

Few options are available to psychiatrists and neurologists to meet performance-in-practice requirements at this point. The ABPN is working with the APA, the American Academy of Neurology, and other organizations to encourage the development of products that diplomates can use to fulfill performance-in-practice requirements. The aggressive timetables set forth by the ABMS are not as problematic for other boards because they are further along in this process and already have spent a large amount of time, effort, and resources developing modules for their diplomates to use.

However, at the ABPN, we have historically taken the position that, other than the certification exam, we do not develop products for our diplomates to buy from us to fulfill our own requirements. We instead have depended upon our affiliated professional organizations to develop self-assessment examinations (such as the PIPE exam developed by the ACP), CME activities, and performance-in-practice modules. Other member boards do not subscribe to this philosophy, so they are further along and ready to implement these practices sooner.

## PARTICIPATION IN MOC PROGRAMS

**Dr. Faulkner:** Personally, I believe it is important to remember that MOC is a voluntary process. Professional associations like the APA, ACP, the American Academy of Child and Adolescent Psychiatry (AACAP), and others can help the ABPN encourage our diplomates to participate in this MOC process, which, quite frankly, many of them do not want to do.[6]

**Dr. Stubbe:** If physicians are not subject to MOC requirements because they hold lifelong certifications, what reasons might compel them to participate?

**Dr. Faulkner:** The majority of ABPN diplomates do hold lifetime certificates. Fortunately, increasing numbers of people with lifetime certificates are stepping forward to participate in MOC, whether it be for academic interests, stature, professional satisfaction, or outside pressure.

The Federation of State Medical Boards (FSMB) recently passed a resolution and a policy suggesting that maintenance of licensure be pursued by state medical boards and that programs similar to MOC should be required for physicians to maintain their licenses to practice medicine. If states decide to adopt those policies, then lifetime certificates may rapidly disappear; diplomates will likely be required to participate in a program similar to MOC in order to maintain their licenses.


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I suspect that the ABMS has been working with the FSMB to ensure that if these policies are adopted, MOC will be accepted as adequate evidence to maintain licensure. This highlights the importance of discussing MOC, because lifetime certificates may become a thing of the past. If so, diplomates may decide to get involved in the MOC process rather than do something that an individual state might require.

**Dr. Winstead:** The American Board of Family Medicine (ABFM) has always had time-limited certificates, but the time frame was 7 years. The ABFM made it possible for diplomates to do extra work during that 7-year cycle in order to earn a 10-year certificate. This seemed to get people more quickly and intensely involved in the process.

## INCORPORATING CORE COMPETENCIES AND MOC COMPONENTS INTO MEDICAL TRAINING

**Dr. Ebert:** Dr. Stubbe, how will MOC affect teaching and residency programs?

**Dr. Stubbe:** Academic departments face special challenges of both meeting the MOC requirements for their faculty and making sure that, as we conduct medical training, we are setting up the standards by which the graduates will be ready to begin their MOC. A fundamental shift in the approach to the practice of medicine that is highlighted by MOC is the idea of ongoing self-assessment and peer assessment. Although we have had those types of assessments in place in a variety of ways, they have not been quite as specific as what is expected in MOC programs.

In residency training programs, self-assessment is now being built into what we have called the 360-degree evaluation. Individuals in training or in school may be accustomed to feedback and assessment from teachers, so the idea of taking charge of learning themselves and being appropriately self-reflective is a new focus in residency training that may help our graduates prepare for the self-assessments and peer evaluations in the performance-in-practice component.

Practice performance assessment, with its chart review element, requires being able to use medical records and organize charts in such a way as to demonstrate the logic of the practitioner.

**Dr. Ebert:** Health care systems that make use of a sophisticated electronic medical record, such as the Veterans Affairs system, have shown that the medical record itself can critique practice, because the program is set up to indicate what is the appropriate clinical or best practice step as the information is being input.

**Dr. Stubbe:** In academic settings, many individuals predominately have research careers and may not see many patients, which might make meeting the ABMS requirement of patient evaluations difficult. Addressing MOC requirements for physicians who are not primarily in clinical practice will be important.

**Dr. Faulkner:** The ABMS wants its member boards to survey their diplomates, whether they have lifetime certification or time-limited certification, to determine each individual's level of clinical activity and to designate those individuals who are not clinically active. In other words, categories of board certification would specify whether a diplomate is clinically active or clinically inactive.

Completing the fourth part of MOC requires data from a diplomate's own patients or from patients of residents whom one has supervised. An individual who is an administrator or a researcher would not have the data to complete this part of MOC. To maintain certification, these individuals would complete the other components of MOC but be designated as clinically inactive and, therefore, exempt from the fourth component. These individuals could convert relatively easily to clinically active status by informing the board of their changed status and by completing the performance-in-practice module.

**Dr. Stubbe:** Regarding the core competencies (see Table 1), medical knowledge and clinical skills for patient care are 2 competencies that have been a major focus of training in residency programs, but clinical practice and the knowledge base can quickly change. For this reason, teaching individuals to keep up with the literature and practice lifelong learning and quality improvement has become increasingly important. Competencies that focus on synthesizing information and translating it into evidence-based practices are the types of competencies that we need to emphasize. What medical students learn about interpersonal skills and professionalism may not change much over time, but patient care and treatments are constantly evolving. Teaching individuals to keep abreast of evidence-based practices will be crucial to residency training.

Training programs set the stage for a lifelong pattern of self-improvement by modeling these habits, teaching the skills necessary to keep up with changing practice, ensuring that residents practice the art of self assessment of skill strengths and areas for improvement, and by giving objective, frequent feedback to residents on observed clinical skill strengths and areas for improvement. On a pragmatic level, training programs may implement specific types of activities into the curriculum that will help prepare graduates to optimize their lifelong learning and improvement skills. Table 4 gives some suggestions for training programs to incorporate lifelong learning activities into the curriculum.

**Dr. Faulkner:** To a certain extent, much of MOC is a repackaging of things that we have always practiced. As students and residents, we found that our faculty and supervisors referred to the latest journal article about a particular condition. The competencies and MOC components are an effort to model that behavior and organize these practices in a more formal way.


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**Table 4. Residency Curriculum to Teach Lifelong Learning, Knowledge, Skills, and Attitudes**

| Required Skill | Method | Assessment |
|---|---|---|
| Self-Assessment | 1. Model transparency in clinical discussions<br>2. Create a safe learning environment; no manipulation<br>3. Provide regular self-assessment evaluations to residents and review during bi-yearly feedback<br>4. Utilize 360$^o$ evaluations to correlate with self-assessments to assist residents in gaining self-observation skills | 1. Include a component of "facilitates a safe and open learning environment" in faculty evaluation ratings by trainees<br>2. Utilize a self-assessment form to be completed by the trainee at the beginning of training and twice yearly thereafter, and to be reviewed with the training director<br>3. Utilize 360$^o$ evaluations (self, multidisciplinary staff, patients, and peers) with feedback |
| Lifelong Learning Skills | 1. Begin a resident portfolio to be organized in a manner that may be added to for MOC<br>2. Incorporate Goals and Objectives for the Practice-Based Learning and Improvement Competency that specify increasing skill over the course of residency<br>3. Teach EBM and reading the scientific literature.<br>4. Institute journal clubs and literature reviews by the residents to facilitate integration of information<br>5. Initiate small group peer clinical supervision groups for peer feedback and learning<br>6. Encourage peer supervision for clinical and full-time faculty and residents when they graduate | 1. Review the resident patient logs and portfolios every 6 months<br>2. Give objective, specific, and constructive feedback on journal club presentations and literature reviews<br>3. Utilize resident course ratings to upgrade evidence-based medicine courses<br>4. Utilize resident program feedback on the use of peer group clinical discussions<br>5. Follow Board pass rates for graduates |
| Patient Care | 1. Review practice parameters and best practice guidelines<br>2. Utilize the Clinical Skills Verification credentialing evaluations to give frequent and objective feedback on interviewing, doctor-patient relationship, and organized case presentation skills<br>3. Gather patient feedback on satisfaction with physician care regularly in appropriate settings (such as feedback after inpatient stay, initial assessment, etc.) | 1. Review both individual resident scores and group norms on PRITEs<br>2. Teach faculty the skills for assessing and giving feedback on the Clinical Skills Verification examination; do reliability ratings for the core teaching faculty on this exam<br>3. Utilize patient feedback and 360$^o$ evaluations to assist residents in making personal quality improvement goals |
| Knowledge of MOC Requirements | 1. Add didactics, discussion, and an implementation plan to foster lifelong learning habits in residency education<br>2. Discuss MOC in preparation for practice seminars<br>3. Distribute MOC information to residents prior to graduation | 1. Survey graduates on their preparation for practice feedback about the residency training, including preparation for MOC |

Abbreviations: MOC = maintenance of certification, PRITE = Psychiatry Resident-In-Training Examination.

**Dr. Stubbe:** Many graduates are leaving training environments unprepared for maintaining their board certification. I strongly suggest that MOC be a significant module of residency training, so that graduates know what maintenance of certification is and how to plan for it.

**Dr. Winstead:** The specialty boards have hosted workshops at training directors' meetings and at the APA annual meeting, and I have done grand rounds to get the word out about MOC. But I agree that most diplomates are still unaware of or plead ignorant about the MOC guidelines and how to fulfill the criteria.

**Dr. Faulkner:** Communicating with diplomates in a timely way about the MOC requirements and changes in them has been difficult. Once the diplomates get certified, they often set their certification information aside. They may move and not give forwarding addresses, so when the time comes to be recertified, notifying them is difficult.

Currently, the ABMS is trying to encourage the member boards to establish a monitoring and feedback system for its diplomates about their performance in MOC, so that the process is ongoing. One useful communication tool, however, is their initial certification letter. This letter has their undivided attention and provides an opportunity to inform them of the MOC process.

## ENFORCING AND REFINING MOC COMPONENTS

**Dr. Ebert:** How does the ABPN continue to provide oversight for MOC?

**Dr. Faulkner:** For the first component, professional standing, frequent feedback from the FSMB is provided to the ABMS and then to the ABPN about whether any licensure issues for candidates need to be addressed, such as any restrictions that may cause a member to no longer be certified.

The ACP, APA, AACAP, and other subspecialty groups are in the process of developing self-assessment examinations. Continuing medical education is provided by many organizations and has been for many years.

To address part 3, we continue to have our committees work to develop MOC examinations. I might add that the ABPN is in the process of developing modular MOC examinations so that individuals who are board certified in multiple specialties might be able take exams in all of their subspecialties (up to 4) in 1 sitting.

For part 4, performance-in-practice, I am working with the APA, AACAP, and the American Academy of Psychiatry and the Law to encourage them to review


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existing practice guidelines to decide if they can be adapted to allow individuals to quickly identify whether their practices are consistent with those guidelines. Two sample performance-in-practice tools based on recommendations in the APA practice guidelines for major depression were published in *Focus*.[6] One issue for the APA and other groups that develop practice guidelines to determine is how material might be communicated to and used by their constituents. Including a brief summary in the form of a performance-in-practice checklist might be a way to not only help constituents meet ABPN requirements for performance-in-practice but also make those practice guidelines more user friendly.

Attention is being given to patient safety, communication, and professionalism. Some groups argue that fulfilling performance-in-practice requirements in the diplomate's area is not sufficient and that the diplomate should also review patient safety, communication, and professionalism at some point during MOC. We should expect more of those constraints as we move forward.

## CONCLUSION

**Dr. Ebert:** If MOC is effective, it could benefit psychiatry by addressing patient safety and uniformity of practice and quality in psychiatry in the United States.

**Dr. Stubbe:** Maintenance of certification programs would also help psychiatrists develop more positive habits with regard to keeping up with the literature, ensuring that they are providing the best treatments, and following best practices in general. I am hopeful that MOC will also engender an atmosphere of increasing openness about performance in practice. Self-reflection, peer feedback, and an overall transparency about our strengths and weaknesses will be extremely helpful in our research and practice.

**Dr. Winstead:** This may be somewhat controversial, but, for a long time, I have felt that psychiatrists may use legitimate concerns about patient confidentiality as a way to cloak their practices against peer assessment. I am hopeful that the MOC process will allow us to have the kind of transparency described by Dr. Stubbe and allow physicians to compare their practice patterns and outcomes with not only the treatment guidelines but also the experiences of others, without violating patient confidentiality. It seems that, often, the confident practitioner who feels that he or she is doing just fine is actually the one who is less up-to-date on best practices than other practitioners.

**Dr. Faulkner:** I agree. Many individuals are simply not proficient at self-reflection and may need an external, unbiased mechanism to help them engage in and benefit from self-assessment.

***Disclosure of off-label usage:*** The chair has determined that, to the best of his knowledge, no investigational information about pharmaceutical agents that is outside U.S. Food and Drug Administration–approved labeling has been presented in this article.

### ABBREVIATIONS

| | |
|---|---|
| AACAP | American Academy of Child and Adolescent Psychiatry |
| ABFM | American Board of Family Medicine |
| ABMS | American Board of Medical Specialties |
| ABPN | American Board of Psychiatry and Neurology |
| ACGME | Accreditation Council for Graduate Medical Education |
| ACP | American College of Psychiatrists |
| AMA | American Medical Association |
| APA | American Psychiatric Association |
| CME | Continuing medical education |
| CRN | Community research network |
| FSMB | Federation of State Medical Boards |
| MOC | Maintenance of certification |
| PIP | Performance in practice |
| PIPE | Psychiatrist In Practice Examination |
| PRITE | Psychiatry Resident-In-Training Examination |

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