

## **A Proposal to Create a National Alliance for Physician Competence**

### **Executive Summary**

The medical profession is under intense pressure to respond to public calls for increased accountability: The Institute of Medicine's series of reports on the state of the US health care system call for regulatory bodies to ensure the continuing competence of the health professions. Unacceptable levels of preventable medical errors, insurers' interest in pay for performance and public dissatisfaction with the health care system are additional developments prompting the medical profession to reexamine how it demonstrates accountability for the competence of its members' individual performance as well as team and systems interactions.

Complicating this scenario is the rapid pace at which the practice of medicine is changing, and the challenge this presents to the profession as it strives to uphold its social contract with the public. As a self-regulated profession, medicine is granted substantial societal privilege and, in return, is expected to set standards for entering licensed practice, for sustaining privilege to practice, and for sanctioning and removing from practice the small proportion of physicians who neglect or abuse that privilege.

Physicians and society place high value on the tradition of self-regulation. However, the public and other stakeholders now call for new approaches to accountability that include periodic demonstration of competence, performance measurement, and transparency. There is a concomitant need for relevant, efficient tools that will enable physicians to better assess and address their practice-related learning needs and to document their continued competence throughout their professional lives. Stated simply, to keep pace with rapid changes in medical practice and to meet increasing societal expectations and demands for accountability, the system of physician self-regulation needs to be reformed.

Numerous medical organizations have responded to this challenge by implementing initiatives aimed at assuring the public that practicing physicians are competent. What is missing is a mechanism whereby stakeholder groups may coordinate and achieve consensus on standards and processes to ensure the system of professional accountability both meets the needs and expectations of patients and the public and efficiently supports the efforts of practicing physicians' to deliver the highest quality health care.

This document proposes the formation of a National Alliance for Physician Competence to fill that void. An Alliance will provide a venue wherein diverse views on issues related to measuring and determining physician competence can be shared and problems resolved. If successful, the Alliance will align many independent organizations around the common goal of developing a meaningful, integrated, and non-duplicative system of accountability for physician competence across the education-training-practice continuum.

## **Section One: Background**

In response to public calls for increased accountability, representatives from diverse stakeholder groups are participating in a series of invitational summits to discuss how the medical regulatory community will determine, measure and provide information to the public about a physician's competence throughout his or her career. The first summit in March 2005 focused on developing various scenarios describing the US health care system in 2020. This exercise helped participants envision the health care environment in which physician competence must be assessed. The second summit in December 2005 produced a draft definition of physician competence, a draft outline for a document describing "good medical practice", and a beginning conceptualization of a National Alliance for Physician Competence (Alliance). During the third summit in June 2006, participants continued to develop the good medical practice document, created a basic plan for an Alliance, and proposed concepts for a portfolio tool that could be used by physicians both to provide information about their competence to the public as well as to reflect upon their performance. A fourth summit is planned for January 2007.

The summits have emphasized the need to formalize the partnership that has developed so that stakeholder groups have an ongoing vehicle for collaboration and dialogue. Formalization of this partnership will assure that the positive momentum gained through the national summits will continue. To date, these meetings have been funded on an *ad hoc* basis by a number of the participating organizations. An Alliance structure will confer stability on the process and allow mid- and long-term planning to occur.

## **Section Two: Mission and Purpose**

The mission of the National Alliance for Physician Competence is to assure the public and the health care community that individual physicians are competent to provide safe medical care of the highest quality. Through partnership and collaboration, the Alliance will 1) advocate continuity in the definition, measurement and determination of physician competence across the continuum of education, training and practice; 2) support seamless collaboration among organizations that contributes to physicians pursuit of lifelong learning and improvement; and 3) seek ways to enable reformation of the system of physician self-regulation so that it is efficient and effective.

## **Section Three: Activities of the Alliance**

Many benefits will derive from the creation of an Alliance. It will provide a forum through which the various groups composing medicine's system of self regulation may identify and resolve current and future gaps in the continuum of education, training, licensing and certification. It will facilitate sharing of resources and knowledge, thus expediting the development and implementation of strategies to assist physicians in their lifelong professional development. Finally, and perhaps most importantly, it will be a visible demonstration of medicine's accountability to the public for the competence of its members.

The National Alliance for Physician Competence will provide a mechanism for professional verification of physician competence. It will oversee the processes used to acquire and

verify physician competence data, and inform the public about the quality of those processes and the relevance of the data acquired. The Alliance will convene physicians, other health professions experts and members of the public to develop recommendations for interpreting physician competence data.

A core function of the Alliance will be to establish and maintain a “Trusted Agent,” i.e., a data exchange infrastructure built upon business principles agreed to by members of the Alliance and owners of existing data repositories. Such an infrastructure will allow data owned by multiple sources to be aggregated and reformatted in ways tailored appropriately for use by individual physicians, by the public and by credentialing bodies.

An example of data aggregation made possible through a Trusted Agent is a portfolio. Portfolios have gained popularity in recent years as a tool used by physicians to inspire reflection and self-directed professional improvement. If supplied with appropriate data, a portfolio could greatly simplify how physicians respond to what will be an increasing demand for information by various stakeholder groups. In the future, an individual’s portfolio could be a dynamic, virtual “folder” through which the physician manages supporting evidence documenting that he or she has met professional standards and is engaged in continuous improvement of practice-relevant skills. The role of the Trusted Agent would be to provide a view of the relevant data from the primary source; such data could include scores on standardized exams, certification status, hospital privileges, measures of practice performance, and results of self-assessments. With authorization of the physician, the Trusted Agent could aggregate and provide whatever information was necessary to satisfy the reporting requirements of various external entities.

The National Alliance’s work plan for the first 18 months will focus on the following activities: 1) developing and advocating endorsement of appropriate metrics for physician competence throughout the continuum of education, training and practice; 2) engaging in early, widespread and continuous communication with a range of stakeholders to convey the importance of and gain support for this work; 3) developing a framework for how data could be utilized by physicians both to support lifelong learning and to fulfill continuing competence requirements; and 4) identifying and participating in pilot projects to develop and promote portfolios and other activities. The following paragraphs detail the Alliance’s potential contributions in each of these areas.

**Defining and describing competence.** A fundamental component of the Alliance’s scope will be developing consensus among stakeholders regarding what is meant by “competent” medical practice. Participants in the summits have begun writing a document to describe the behaviors and values expected of competent physicians. The document draws on several existing resources<sup>1</sup> and is organized around the six core competencies developed by the Accreditation Council for Graduate Medical Education: medical knowledge; patient care; interpersonal and communication skills; professionalism; systems-based practice; and

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<sup>1</sup> Reference sources include *The CanMEDS 2005 Physician Competency Framework*; the Association of American Medical Colleges’ Medical School Objectives Project (MSOP) reports, the American Medical Association Council on Ethical and Judicial Affairs reports; and the UK General Medical Council’s (GME) *Good Medical Practice*.

practice-based learning. If widely endorsed and implemented, this document could serve as the foundation for how physicians in this country are educated, trained and regulated. A draft of the document will be available for distribution and discussion in early winter 2007. If constituted, the Alliance would assume responsibility for the document's completion, dissemination for feedback and endorsement, implementation and maintenance.

**Communication with stakeholders.** A second key element of the Alliance's scope of activities will be to develop and implement a communications plan that engages all stakeholder groups in a dialogue about the best means of assuring the American public that physicians meet standards of competence throughout their careers. A clear, thoughtful and inspired communications strategy will play a vital role in realizing the Alliance's vision of a credible, uniform and transparent process that provides assurance to the public that the medical profession is fulfilling its responsibility to warrant physician competence. It is particularly critical that practicing physicians and all who utilize and rely on health care services are involved in this dialogue and that they are routinely and concurrently provided information about what problems are being addressed, by whom, and what the process and timeframe look like.

**Pilot projects.** Gaining public and professional support for and buy-in to a cohesive system for measuring and documenting a physician's continued competence will be critical to the Alliance's success. To that end, the Alliance will develop evidence, through research or pilot projects, that the proposed system will be efficient and result in safer and higher quality medical care for the public. The following are examples of pilot projects that could be pursued by the Alliance.

*Pilot Project 1:* Organizations from multiple stakeholder groups collaborate to study the feasibility of creating a coordinated, seamless, trustworthy and credible electronic "trusted agent" infrastructure that facilitates a physician's lifelong professional development and ability to provide information about his or her competence as needed or requested. This project will have three objectives. One objective will be promoting the development of a high level policy statement describing the purpose and functions of an electronic portfolio system, including appropriate uses and protections for the data owner and public. As a second objective, the Alliance will support and serve a coordinating function for seed projects to facilitate development of portfolio prototypes. Such prototypes will grapple with challenges specific to different points in the practice-training continuum or particular to disparate viewpoints at one point in the continuum. A third objective will be to connect electronically extant portfolios to create an integrated, seamless resource that is longitudinal in design and supports each physician throughout his or her training and career transitions, from medical school through residency, and out into the many years of practice.

*Pilot Project 2:* Partner with a consumer organization to study how information about a physician's competence may be made available to health care consumers in a way that is meaningful to the public yet respects and preserves the confidentiality necessary to support quality improvement activities. The Alliance will pursue opportunities to partner with consumer groups such as AARP to pursue such a study in 2007. Participating in such initiatives will inform the Alliance's efforts to engage stakeholders at a national and state level, and will help to inform future discussions about data interpretation and transparency.



#### **Section Four: Governance Structure**

Appendix 1 describes four governance structures that could be used for the proposed National Alliance for Physician Competence. The Alliance's ability to achieve its mission will depend upon a governance structure that promotes "ownership" through sharing of authority and responsibility, facilitates maximum involvement by participating organizations, is based on clear business principles and criteria for participation, and allows for agility in decision making. In considering which governance model will provide the optimal structure for an Alliance, thought should be given to the following: in the immediate future, will the proposed governance structure facilitate rapid decision making and short-term progress, ensure inclusiveness, and be viewed as politically acceptable? In the intermediate future, will it ensure adaptability and promote broad acceptance and growth? And, in the long view, will the structure contribute to the objective: improving the safety and quality of health care.

#### **Section Five: Business plan**

Patients, the public, payers, hospitals, licensing bodies and others are hungry for data about physician performance. Existing data sources are fragmented, incomplete, frequently unverified, and of limited use. Data about the qualifications of physicians are available but there is no single source of data that speaks to individual physicians' competence, the types of patients they treat and their patient care outcomes. Further, physicians lack interactive tools for ongoing assessment and improvement of their performance, both for self-improvement and to meet the requirements of various regulatory and credentialing bodies. The business activities of the Alliance as described in section three of this proposal provide an approach to addressing these deficiencies.

**Customers for the Alliance:** The primary customers will be physicians themselves. Services provided to physicians include: interactive tools for ongoing professional development (reflective journaling, documenting authentic clinical and educational experiences and built-in assessment tools with comparative data); generation of data displays for credentialing authorities, résumé generation, and configuration of a customized public web site using verified data. Physicians could be charged an annual fee to obtain these services.

Hospitals, insurance companies, and other organizations interested in verified data about physician credentials constitute another major customer of the Alliance. At the request of the physician, selected data could be released to these organizations for a transaction fee.

Patients wanting to know a physician's credentials constitute the third major customer. Data about the physician could be made available to the public free of charge. For example, using a credit card analogy, a patient might "swipe a card" to see if the doctor has the necessary qualifications and experience to do gall bladder surgery. This latter determination would be made by a panel of experts convened by the Alliance.

A fourth potential customer would be the research and health policy community as they probe details of the physician workforce, seek aggregate data about practice profiles of the

nation's physicians, and examine the efficacy of current education and assessment paradigms.

The products and services of the Alliance will be marketed using multiple media. Key messages and marketing strategies would be developed to maximize awareness of the National Alliance's role as a reliable and trusted source of comprehensive and accurate information.

**Finance:** Sources of revenue for the Alliance could include: membership fees for member organizations; subscription fees from physicians using the service; transaction-based fees from hospitals and other credentialing agencies seeking verified data; and project-based fees charged to research and health policy analysts seeking aggregate data. Data repositories would receive revenues generated through the transaction fees levied on the trusted agent/portfolio infrastructure and related applications (e.g., portfolio service).

Start-up funds will be sought from major foundations. Support from the member organizations of the Alliance and major payers, such as insurance companies, will be sought but only after clear principles are established confirming the independent and not-for-profit status of the Alliance.

A monthly operating budget for the first year, projected quarterly balance sheets, revenue and expense reports, and projected monthly cash flow statements linked to projected revenue and expense reports need to be developed once further clarity about the business assumptions is achieved.

Because of the crucial nature of these estimates, it may be prudent to retain outside expertise to develop a more complete business plan.

**Management and Operations:** In the short term, operational management of the Alliance will be carried out by an interagency staff team. In the long term, a CEO may be hired and charged with assembling a management team capable of achieving the mission. Numerous operational issues ranging from standards for the verification of data, server and technology expertise, security, legal issues, and reliability of services will need to be addressed.

## **Section Six: Conclusion**

In the past, the medical profession has missed a number of opportunities to shape the practice of medicine and the structure of the health care system by being late to the table. Through the Alliance, we now have a chance to define the response to public concerns about safety, quality, and accountability that are unlikely to subside, and at the same time reinforce professionalism by asserting our collective responsibility for continued competence. The issues associated with assessing and assuring the competence of physicians throughout their careers are extremely complex. Many organizations hold a piece of physician self-regulation, but it will take collective action to develop a meaningful, integrated and non-duplicative system of accountability for physician competence across the education-training-practice continuum, a system that will serve the needs of public, physicians, health care organizations, and payers. If successful, the National Alliance for

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Physician Competence could assure physicians that the right data about their competence (recent, relevant, and reliable) will be available to the right party at the right time.

**APPENDIX 1**  
**National Alliance for Physician Competence**  
**Options for Governance**

This document describes four governance structures for a National Alliance for Physician Competence. It is likely, given the tax status of the participating organizations, that if an Alliance is incorporated it could receive 501(c) 3 or 501(c) 4 supporting organizational status. Legal counsel needs to be consulted regarding the exact corporate entity.

**Option #1: Oversight Board**

Description:

- Governed by a Board of Directors elected by the participating organizations.
  - In this membership organization, members elect 15-20 Directors to serve on the Board, with one vote per person; the number of Directors would be significantly smaller than the number of member organizations.
  - No organizations will have a designated seat on the Board.
  - Bylaws will specify a corporate class of members that would meet regularly and be responsible for decisions regarding organizational status, election of board members, and bylaws changes.
  - By-laws specify how officers are elected (usually by the Board), terms of office, and how Board committees are established (usually by the Chair), which can include non-Directors.
- The Board delegates the operations to a corporate staff headed by the President/Executive Director accountable to the Board. The Board is responsible for policy and strategic direction of the Initiative.
- Membership dues and revenue generation support the initiative.
  - Need to specify how dues are assessed, either equally or differentially (e.g., total revenue of the organization).

Strengths	Weaknesses
Strategic professional association model defines accountability, roles, and responsibilities of directors and staff.	Delegation to a President/staff might create less involvement of the organizations. New businesses require extension planning to determine operating principles and organizational relationships. Question whether this type of organization maximizes the collective strengths of participating organizations, including its human resources.
Organization is agile in decision-making because of the manageable size of Board.	Creates insiders and outsiders (organizations not elected to the Board might feel disenfranchised). Feelings of being threatened by the actions of a company in which they do not have a vote.
Lots of experience with this type of organization – members would have an easy time describing this organization to	Members often represent the interests of their organization and not the interest of the enterprise.

their respective boards, and external organizations would feel comfortable with this structure.	
Legal protection of the members of the organization.	Members are asked to provide membership dues without representation on the Board.
Election of Directors allows for selection of people with the right knowledge and skills.	Directors will not directly present each member organization (also could be strength). Maintenance of Board is a very costly overhead for the organization.

**Option #2: Membership Assembly**

Description:

- All members of the initiative have a vote in an assembly which approves policy and new products.
- An Executive Committee is established to work with the President and staff on management, finance, and leadership issues.
  - ↳ The by-laws would specify organizations having designated seats on the Executive Committee with some at-large seats being elected by the members or Executive Committee members.
- Similar attributes of Option 1: bylaws election of officers by the Executive Committee, terms for officers, specify committees, delegation of operational responsibilities to President/staff and membership dues collected by this new organization.

Strengths	Weaknesses
Key organizations are represented in the leadership of the organization.	Members may feel threatened by the actions of the Executive Committee if they do not have direct involvement.
Models of this type of organization have been used by medical professional organizations (ABMS, AMA) and are familiar with member organizations.	The level of performance of this model has been mixed. This model might not be the correct fit for an innovative and dynamic Initiative.
The Executive Committee, within this strategic professional association, can provide organizational agility.	The coordination and processing required between the Assembly and Executive Committee are difficult and time consuming. New businesses require extension planning to determine operating principles and organizational relationships. Assembly members lack the knowledge and information of the Executive Committee.
It permits matching of resources contributed to governance representation.	Members are serving by virtue of their organization rather than their suitability to meet the needs of the Initiative.

**Option #3: Board and Advisory Board**

Description:

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- Governed by a Board of Directors comprised only of physician standard setting organizations (e.g., ECFMG, NBME, ABMS, FSMB, AAMC, ACGME).
  - Each of these organizations has a seat on the Board.
  - Other interested organizations – societies, consumer groups, payers and purchasers would sit on an Advisory Board. Feedback and support of initiatives would be solicited by the Board of Directors to the Advisory Board.
  - The Advisory Board and the Board of Directors would meet together on a regular basis (at least twice a year).

Strengths	Weaknesses
Standard setting organizations, most impacted by the work of the Alliance, have the most influence and involvement.	It minimizes the role of other stakeholders and causes marginal involvement and engagement.
The Board is familiar with the issues and will be able to address the issues expediently.	Might not receive the multiple perspectives from diverse stakeholders (because they drop out or do not send top leaders).
These standard setting organizations should remain independent and autonomous.	Standard setting organizations could become too removed from the “communities” they oversee
These organizations are comfortable in working with each other.	The public and constituency bodies might view this organization as not fully accountable to the public because the standard setting organizations are “rounding up the wagons” and being insular from their constituencies and the public they serve.

**Option #4: Distributive Governance (Visa Model)**

Description:

- Based on organizing principles:
  - Everyone has a say and no one controls the initiative;
  - Everyone is free to voice an opinion but none have a final say, if a majority of the organizations vote in favor it passes;
  - No one organization is totally at risk;
  - No harm to the autonomy of the member organization.
- Bylaws specify the operations and strategy of the organization.
  - Bylaws specify who can join the initiative, under what conditions an organization can be expelled, how to split expenses and share income, the number and type of standing committees, business rules, and structure for day-to-day operations.
  - Generic rules of the business change only if a new activity is not addressed adequately (bylaws are changed by a majority of organizations).
- Participants in the initiative would be required to sign an agreement to adhere to the bylaws.
- There is no board of directors but committees formed to deal with specific tasks.

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- The organizational structure evolves over time and small steps are taken initially. For example, a board of directors could be established and dedicated resources retained to conduct the overall operations of the company at a point in time the member organizations determine such a structure is necessary.

Strengths	Weaknesses
Every participant organization is engaged in business relationship with other organizations. Direct investment and “ownership”.	No specific organizations are charged to provide overall leadership. Requires high level of trust that may be difficult to build among the organizations.
Business arrangements are predefined and prearranged (through bylaws and charter agreements). Behavioral expectations and member criteria are clearly delineated. Huge operational efficiencies.	No legal protection. External organizations may feel uncomfortable relating to this Initiative.
Values each organization’s contribution and aligns the dynamic mission of the Initiative with the governance structure. Creative contribution of organizations can be accommodated.	Accountability for performance of the organization is not directly controlled by membership organizations.
Agile and flexible organization, able to examine new lines of business/activity. Bylaws written for a wide spectrum of activity.	Creating support for bylaws changes may be difficult.
Appropriate people (staff) can carry out initiatives as needed.	Operations staff would be disconnected from member organizations.
Overall cost of business lower due to lower overhead.	