Boards Evaluate, Societies Educate

What About the American Medical Accreditation Program?

Is medicine about to end the millennium by making the same mistake it corrected almost a century ago?

A strange irony will be recorded by medical historians when they describe physician credentialing of the 20th century. It will be noted that as this century began, a chaotic era of the professional tradesman and self-proclaimed specialist brought medicine to an inordinately low level, a point at which no patient, indeed no institution, could be assured of the knowledge and skills of specialist physicians.[1] Fortunately, society was saved by the certifying board movement, which provided a mechanism by which the training and experience of physicians could be assessed by independent organizations that had no affiliation with professional societies. Thus avoided were the painfully obvious conflicts of interest that can characterize credentialing by a medical society in which mere membership in the organization, purchasable by payment of dues, could confer or appear to confer specialist status on a physician. For the better part of the century, therefore, because of the certification process as carried out by certifying boards representing all the old and new medical disciplines, our nation has enjoyed remarkable stability and patient trust in the credentialing of specialist physicians. As a result of this experience, a fundamental principle emerged that has generally defined the respective responsibilities of our major medical organizations—boards evaluate, societies educate.

Over the past 2 to 3 decades, however, the seeds were sown for a possible violation of this fundamental principle. The dramatic, steadily increasing cost of health care stimulated the search for less expensive health care payment systems or insurance. Fearful of the staggering costs as well as the problems and deficiencies inherent in national health care systems, neither the citizenry nor the government believed that a similar national system of socialized medicine was the answer in the United States. Private insurance, including that provided by managed care organizations (MCOs), became the popular alternative as a complementary system to Medicare and Medicaid and had the support of government. An inevitable consequence of this system has been the demand by the payers, essentially the federal government, private insurers, and MCOs, for physician accountability and confirmation of credentials, especially those of specialist physicians. Coincidentally, because of their privileges requirements, hospitals also became increasingly interested in the credentialing of physicians. It is not uncommon these days, for example, for physicians to be required to provide separate verification of credentials to 10 or 12 different insurers, MCOs, and hospitals, a costly and cumbersome experience. Board certification and recertification have been used as standards by many organizations but have not been accepted uniformly. Moreover, not all disciplines have recertification processes in place and operative or ones that are considered adequate. Although their high standards are widely acknowledged, board certification and recertification processes, even the most comprehensive, do not include routine reviews of practice settings, audits of medical records, assessment of physician clinical performance, and patient care results or outcomes measurements. While the boards recognized the importance of such data, they were deterred in their efforts to obtain them because of the costs and manpower requirements of any system that could properly provide this information. The boards could and do, of course, from their own databases or those of the American Board of Medical Specialties, supply generally verifiable basic credentialing information relating to the training, licensure, certification, and recertification of specialist physicians. Complicating the data-collection problem further was the variability of the forms or information requirements of different payer organizations, preventing the use of a universal response form or document. Not surprisingly, this problem spawned a new industry as many private companies sprang up to collect this information for physicians and send it to MCOs, other payers, and hospitals.

The existing environment was ripe for a program or system that not only could act as a repository for and supply primary verification of a physician's credentials and personal qualifications, but could also provide a newly expanded credentialing system that was more comprehensive than that of board certification and recertification. Into the breach stepped the American Medical Association (AMA), which saw the chance to assume both of these responsibilities, even though its credentialing standards could not be guaranteed to be as high or as consistent as those of the certification or recertification processes of the American Board of Medical Specialties certifying boards. As a result, in 1996, the AMA introduced the American Medical Accreditation Program (AMAP), which was envisioned as the vehicle for meeting all of the demands for physician credentialing in the current national health care environment (ie, a single repository or information source for the credentialing of physicians and the provider of a system of assessment or evaluation of the training and experience of physicians). It was noted that board certification and recerti-

fication could be used in this accreditation process, but that they were not to be requisite components of AMAP accreditation. Thus, the nation's 90 000 noncertified physicians could, by satisfying other components of the AMAP, attain AMAP accreditation. The distinction in satisfaction of AMAP requirements by different groups of noncertified physicians (ie, those who have or have not satisfactorily completed approved residency training, namely training in residency programs approved by the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada) may require further adjustment of the AMAP standards. Candidates with ABMS board certification and recertification, for which additional credit is given, can achieve AMAP accreditation more readily.

The following outline of the AMAP emphasizes its essential elements.[2] It is a point system and includes required standards that all candidates must "fully meet" and supplemental standards that permit different routes to AMAP accreditation. To date, over 3000 physicians have elected to pursue AMAP accreditation, which, as of December 1998, was operative in 7 states (Massachusetts, Connecticut, New Jersey, Montana, Idaho, Hawaii, and Utah) and the District of Columbia.

Described as a new national benchmark of physician quality, the AMAP is designed to define, demonstrate, and document quality physician care. It is available to all of America's more than 750 000 physicians, whether certified or not by ABMS certifying boards. Through the AMAP process, the credentials, personal qualifications, environment of care, clinical performance, and patient care outcomes of every physician who seeks AMAP accreditation will be reviewed and evaluated. The designation *AMAP accredited* will be assigned to those physicians who meet the standards.

The evaluation process of the AMAP consists of 5 elements or measurable components:

- **Credentials:** a primary source–verified repository of credentialing information, including medical school graduation, licensure, Drug Enforcement Agency registration or revocation, ABMS board certification and recertification, and record of professional liability claims and disciplinary action(s) as registered in the National Practitioner Data Bank.
- **Personal Qualifications:** ethical behavior, continuing medical education, peer reviews, and completion of AMAP-approved self-assessment programs.
- **Environment of Care:** practice site and medical records review.
- **Clinical Performance:** measurement of patient care processes and feedback to physicians on clinical performance.
- **Patient Care Results:** measures of clinical results, patient satisfaction, and health status; data and opportunity for continuous quality improvement.

While to date the AMAP has been introduced in only a limited number of states, it is expected to be fully operational in 3 to 5 years. It will function as follows:

- Physicians will apply for AMAP accreditation, pay a "small application fee," and agree to the release of the AMAP review and accreditation decisions to hospitals and other organizations they have identified.
- Each health plan and hospital authorized to receive AMAP results will pay a fee.
- American Medical Accreditation Program reports will be shared with the individual physician in each designated plan and hospital. A unified credentials form being developed by the Medical Society Credentials Verification Organizations of America will be used for the credentials data.
- Additional plans or hospitals, on request from the physician, may purchase an AMAP report.
- The AMAP will also be available to physicians who are not involved in MCOs or wish to pursue AMAP accreditation and not report it to other parties. A full fee will be charged to these physicians.

Implementation of AMAP will require the participation of medical societies (state and county), commercial vendors, and national accreditation or professional organizations in one of the following relationships:

- As *contractual partners* in verification of credentials, with office site visits (primarily for medical societies).
- As *recognized vendors* to execute standardized self-assessment of clinical performance and office operation.
- In *mutual recognition/exchange or sharing of data* on practice sites, physician performance, and patient outcomes for use in the AMAP accreditation process.

The AMAP is governed by an AMAP Governing Board (AGB) and 4 AGB advisory committees. Physicians and representatives from hospitals, MCOs, consumer groups, employers, and the Health Care Financing Administration will constitute the AGB.

It is to be emphasized further that only the first 2 steps or components of the AMAP, which are essentially responsibilities for data collection, have been implemented to this point. The AMA continues to iterate its intention to proceed with the other 3 components, although no firm timetable is yet in place. Worthy of emphasis is the planned involvement of national specialty societies and state and county medical societies as vendors or deputies of the AMA in the implementation process of the AMAP, specifically the last 3 components. These are assessment processes, it should be stressed, and they carry the same conflict of interest stigma for these societies as they do for the AMA and the AMAP system. The final step in the AMAP is the awarding of the AMAP accreditation certificate. Thus, the AMA, a professional society, through the AMAP, will now evaluate physicians and award certificates, formally credentialing those physicians who have satisfied AMAP requirements.

Watching the AMAP take shape and become established have been the federal government, health insurers, MCOs, hospitals, and the rest of organized medicine. The certifying boards, in particular, and the specialty societies have been especially concerned about the AMA's projected role as a major credentialing organization. They point to the problems of conflict of interest[3] and to the uncertainty of the level of the standards of the systems of assessment in the AMAP. They also emphasize the con-

fusion that will unquestionably result as patients, industry, and others attempt to distinguish specialty board certification and AMAP accreditation. Concern over an ultimate undermining of the processes of board certification and recertification is also understandable. Legal consultants are fearful of the possible increased risk of litigation for discrimination or monopoly that may ensue as the AMAP identifies physicians who meet its accreditation standards, thus enabling insurers, MCOs, and hospitals to use this single standard in determining who they should accept or employ. The ABMS boards have consistently maintained that board certification and recertification are but one credentialing route that can be used by these organizations.

Despite the above concerns, it is generally acknowledged that the AMA is to be commended for its recognition of the need for a central credentials verification source and the expansion of physician assessment to include reviews of practice settings and medical records, physician performance, and patient care results or outcomes. The proposed use of local medical societies and commercial vendors as deputized organizations that can carry out this assessment is also noteworthy since it obviates the need for a single organization, such as a certifying board or specialty society, even one as large as the AMA, to attempt to perform what surely would be a costly and Herculean task. Ideally, however, such use of professional societies in the assessment of physicians should carry the imprimatur of certifying boards, not another professional society, the AMA. Incidentally, the same system utilizing deputized professional societies could be employed in approaches to assessment that might be used for technique credentialing after residency.

Where do we now stand? How can medicine resolve the difficulties created by the introduction of the AMAP and yet take advantage of the opportunity it offers to simplify verification of physician credentials and augment the assessment processes of certification and recertification in order to satisfy the payers in our current system of health care?

An important effort is under way by the Quadri-Specialty Consortium, an ad hoc organization of representatives of specialty boards and professional societies from 4 of the largest medical specialties, internal medicine, pediatrics, family practice, and obstetrics and gynecology, to modify the AMAP or collaborate with the AMA in developing an alternative system that will divide the responsibilities for the performance of the various components of the AMAP. Any proposed plans will require the concurrence of all the AMBS certifying boards. An overriding objective of this initiative is to assure that the basic principle enunciated in the title of this article, one that has long governed assignment of the major responsibilities of *evaluation* (and credentialing) to *certifying boards* and *education* (and representation) to *professional societies*, will not be abrogated. On balance, it would seem eminently appropriate and possible to achieve a clean division of these responsibilities based on that governing principle. The lessons of the early years of this century should not be forgotten.

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The opinions expressed herein do not necessarily reflect the views of the American Board of Dermatology, other certifying boards, or the American Board of Medical Specialties. The Quadri-Specialty Consortium has been succeeded by the Joint Planning Committee of the American Board of Medical Specialties and the Council of Medical Specialty Societies.

REFERENCES

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2. American Medical Association. *The American Medical Accreditation Program.* Chicago, Ill: American Medical Association; 1997.
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