

# Future of Board Certification in a New Era of Public Accountability

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**The American Board of Medical Specialties and its member boards have been serving as a key foundation for professional self-regulation for the past century. During this time the standards for specialty board certification have evolved to meet the public's needs. Recent major changes have included time-limited certification status, the adoption of 6 core competencies, and the multifaceted recertification program termed Maintenance of Certification. During the past decade there has been a dramatic increase in the public's interest in improving the quality, safety, and efficiency of the US health care system. This article describes some of the milestones in the evolving public demand for physician accountability. The public's growing need for better health care delivery is, in turn, creating the need for the American Board of Medical Specialties and its member boards to evolve to meet the public's expectations of the profession of medicine to maintain its privileged status in specialty certification through self-regulation. (J Am Board Fam Med 2010;23:S32-S39.)**

## Evolution of Board Certification and Professional Self-Regulation in the United States

In the United States there has been a long tradition of shared responsibility for physician performance through a combination of state regulation and professional self-regulation. Dating back to the 1760s, the United States and territories have held the authority to license the practice of medicine. Although this authority has been the backbone of US physician regulation, it is broad in scope and serves as an overall safety net for medical care.<sup>1</sup> To provide greater assurance of the quality of physician practice, the medical profession launched the specialty board movement to assist the public in the identification of highly qualified health professionals in specialty-based practice. The Board of Ophthalmology was the first of the specialty boards to be created in 1917, with other boards soon following. In 1933, the boards joined together to form the Advisory Board of Medical Specialties, which was later renamed the American Board of Medical Specialties (ABMS), a national self-regulatory organization established for the purpose of credentialing

physicians in specialty-based medicine. In 1939 the ABMS published the Directory of Medical Specialists and the United States had its first comprehensive source for identifying physicians who had undergone consistent training and standardized assessment in specialty practice. The ABMS is currently composed of 24 member boards.

The process of self-regulation through voluntary specialty board certification has been quite successful; more than 750,000 US physicians currently hold one or more certificates from ABMS member boards. Certification's value is demonstrated by the ongoing public interest in seeking out board-certified physicians and by the number of hospitals and other health care organizations that make board certification a key qualification for medical staff privileges.

The medical profession's awareness of the need for public accountability has continued during the many decades since the start of the specialty board movement. When the American Board of Family Medicine was established in 1969,<sup>2</sup> lifetime certification gave way to the concept of a time-limited certification process, which required periodic recertification. Since then, all of the ABMS member Boards have adopted time-limited certification.

At first, time-limited certification was primarily composed of passing a knowledge-based examination. However, in the late 1990s the ABMS and the Accreditation Council for Graduate Medical Education designed a new competency-based training

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model based on 6 mutually agreed-upon core competencies, including patient care, medical knowledge, professionalism, practice-based learning and improvement, interpersonal and communication skills, and systems-based practice.<sup>3</sup> Such a complex set of core competencies made it clear that a medical knowledge examination by itself would be insufficient for the recertification process.

In 2000, the 24 member boards of ABMS agreed to evolve their recertification programs to one of continuous professional development known as ABMS Maintenance of Certification<sup>®</sup> (ABMS MOC<sup>®</sup>).<sup>4</sup> The program is designed to assure that participating physicians are committed to a process of lifelong learning and evaluation of competency by requiring ongoing measurement of the 6 core competencies. Although the assessment tools vary by specialty, all member board MOC programs adhere to a 4-part process that is designed to keep certification continuous. As of 2006, all member boards have received approval of their programs and are in varying stages of implementation. In 2009, ABMS adopted further standards for MOC that include new developmental standards for assessing patient safety, patient experience of care, and peer-to-peer evaluation.

ABMS MOC is designed to provide the public with assurance of high-quality health care. Yet, as the specialty board movement in the United States approaches its 100th year, questions exist as to whether or not ABMS MOC is sufficient to meet the public's current needs and how it should grow and evolve to meet the needs of the future. To better understand the answers to these questions it is useful to examine the recent evolution of public and market needs for physician and health systems accountability.

### **The Public's and Marketplace's Needs for Health System and Physician Accountability**

Although the public has always had a deep interest in the quality of care provided by physicians, both the marketplace and the government have, to a large extent, left it up to the medical profession to regulate itself. Although they operate in view of the public and often have some public member representation, the state and territorial licensing authorities are largely physician dominated activities. Similarly, the ABMS specialty boards are largely physician-run organizations. Within hospitals,

functions of medical staff also are overseen principally by the profession. This is of little surprise considering the technical and complex nature of clinical practice. To a certain degree, the physician's role in self-regulation would go largely unchallenged were it not for some very important emerging public concerns. There are 2 major sets of issues: (1) concerns about health care safety and quality, and (2) concerns with the overall rising costs of care. Taken together, it seems inevitable that the public and marketplace are seeking greater accountability from the profession.

It is unclear exactly when the concept of patient safety began to emerge as a broad concern in the public's eye. During the past 10 years there have been a series of cases that have drawn attention to issues of health care safety. Some of the sentinel cases include that of Libby Zion, who in 1984 died at the age of 18 within 8 hours of her emergency admission—her death was probably caused by medication error<sup>5</sup>; the artist Andy Warhol, who died in 1987 from sudden cardiac arrhythmia after a routine cholecystectomy<sup>6</sup>; and the 1994 case of Betsy Lehman, a 39-year-old health reporter for the Boston Globe newspaper who died from a complication of a chemotherapy overdose at the Dana Faber Cancer Institute, one of the leading hospitals in the country.<sup>7</sup> These high profile cases and others sent a repeated message to the public that the health care system may not be safe.

While evidence was mounting for the need to examine patient safety, other evidence was emerging about variability in the quality of health care. As early as 1973, Jack Wennberg and Alan Gittlesohn<sup>8</sup> began publishing on the high degree of variability in health care delivery and outcomes. In their first study of a population-based health data system in Vermont they reported wide variations in resource input, utilization of services, and expenditures for some common medical and surgical conditions among neighboring communities. During the 1980s and 1990s hundreds of studies built on that seminal report by demonstrating variations in care that cannot be explained by underlying sociodemographic or other epidemiologic characteristics. In 2003, McGlynn and colleagues<sup>9</sup> reported on quality measures and the poor performance of primary care in a sample of US physician practices. The evidence from this body of literature that has amassed over the decades has not gone unnoticed by the public.

Although a series of untoward, high-profile events have raised concerns about patient safety and a body of scientific literature has emphasized the need to examine quality, a very different concern about the cost of health care in the United States has been driving public demand for improved health system performance and professional accountability. The issues related to the rising costs of health care are well known. The United States is a country with a population of more than 40 million uninsured and health care costs that are some of the highest per capita in the world, yet the United States has similar if not worse outcomes on many health indices as compared with other countries.<sup>10</sup> Health care costs equal >14% of our nation's gross national product, and without significant efforts to control costs, it is estimated that the Medicare program will be insolvent by 2017.<sup>11</sup> In addition, the rising costs of health care in a primarily employer-sponsored health insurance system may be placing American businesses at a strategic disadvantage in terms of the international competitiveness. Any one of these concerns would warrant the attention of the public sector and marketplace; collectively, these cost concerns signal the need for much closer scrutiny of health care performance and the value it delivers.

### **The Response to the Emerging Public and Marketplace Need for Health System and Professional Accountability**

Although it is not possible to define just where the response to concerns for greater accountability in the health care sector began, one of the first reactions was the emergence of large-scale efforts aimed at performance measurement of health systems and hospitals. The 1980s and 1990s saw a series of rapidly evolving efforts toward further accountability among health plans. Organized measurement of health plans was largely prompted by employers' needs to better understand the value of the health care they were purchasing. In 1991, the health maintenance organization Kaiser Permanente worked with its largest purchasers (Towers Perrin, Bull HN, Digital, GTE Corporation, and Xerox) to establish the Health Employer Data Information System (HEDIS) to provide information about health plan performance.<sup>12</sup> Soon thereafter, the HEDIS program was turned over to the National Committee for Quality Assurance (NCQA).

Over the years, NCQA has continued to develop the HEDIS program, and many of the measures that were originally designed for health systems performance have become some of the same measures that health plans (and employers) use to directly assess physician performance.<sup>13</sup> To a large degree, the HEDIS measures have served as the first set of national tools to answer the marketplace's call for physician accountability.

Hospitals have also responded to the call for public accountability. They have a long tradition of regulation and self-regulation. Although there are many organizations that serve to inform the public about hospital performance, none are as influential as the Joint Commission, which has for many years (until recently) enjoyed deemed status from the federal government as the source of accreditation for participation in Medicare. Until recently, the performance measurement efforts of the Joint Commission focused mostly on structural measures of hospitals. However, in response to increased concerns about patient safety, quality health care, and costs, they are now advancing tools to address process and outcomes in health system performance (eg, their ORYNX measures).<sup>14</sup>

To date, the public's role (specifically the federal government's role) in hospital, health plan, and physician accountability has been relatively passive. They have principally relied on the tools and programs of The Joint Commission and its provisions for credentialing medical staff, the NCQA and its HEDIS measures, the states and their medical licensing boards, and the ABMS and board certification.

There was one early attempt to use the significant power of Medicare data to provide some transparency to health system performance. In 1984 the Health Care Financing Administration produced a public report of hospital mortality rates across all acute care hospitals in the Medicare program. However, this public reporting program was quickly discontinued in response to cries of "foul play" issued from the hospitals and the medical profession principally based on methodologic concerns about a lack of adequate case mix and severity adjustments.<sup>15</sup>

Although much of the early movement toward greater accountability was focused on the performance of health plans, hospitals, and health systems, changes were also taking place at the level of physician accountability. One of the defining mo-

ments occurred when several states began issuing reports of mortality outcomes for coronary artery bypass surgery. In the early 1990s, New York, and subsequently Pennsylvania, began publically reporting hospital-based outcomes.<sup>16</sup> These reports, in turn, stimulated the Society of Thoracic Surgeons to design and implement a national registry of performance measures for coronary artery bypass graft and (more recently) valve replacement.<sup>17</sup> Thus the first large-scale, national professional response to the need for transparency in performance measurement of surgical outcomes was created. Since that time, other national registries and databases have begun to emerge.

### ***Broadening the Awareness of the Need for Performance Measurement and the Call for Public Intervention***

In 1998, in response to the growing evidence and advancing public awareness of a health system with serious problems, the Institute of Medicine launched a major initiative to examine the health care of the nation. The first activity was a national roundtable about quality of care—an effort that resulted in several major reports, including “To Err is Human”<sup>18</sup> and “Crossing the Quality Chasm.”<sup>19</sup> These reports, along with many others, formed the basis for much of the subsequent national effort in the health care quality movement, including the creation of the National Quality Forum. One of the first notable reports from the National Quality Forum involved a strategic framework that defined 2 pathways for quality improvement: one based on intrinsic motivation and another based on accountability and selection.<sup>20</sup>

### ***The Veteran’s Administration: Demonstrating the Value of a Robust Quality-Improvement Program***

It is noteworthy that, despite the numerous examples of health systems problems, there are also organizations in the United States that serve as reminders that it is possible to dramatically improve quality and value in health care. Perhaps the most notable example comes from the federal government itself. The Veteran’s Administration proved that a public health system that seemed to be failing could reinvent itself. Today, the Veteran’s Administration is a high-performance health system committed to comprehensive performance measurement of its hospitals and physicians.<sup>21</sup>

### ***The Marketplace’s Ventures into Physician Accountability through Value-Based Purchasing***

The market has been the first to respond to the need for greater accountability from the health system and physicians. The market has used a number of tools at their disposal to identify what they define as high quality and efficient care. The most recent, well publicized, and controversial efforts have involved the use of strong financial incentives to reward physicians based on some type of performance measurement. This effort, commonly called “pay for performance,” has been in use by health plans for nearly a decade. There have been several large-scale efforts by purchasers to demonstrate the merit of “value-based purchasing” models. The results of these demonstrations are mixed; to date no definitive link between incentive payments and clinical outcomes has been demonstrated. However, it is clear that, because of the increasing demands of the big health care purchasers, the health insurance industry will continue to explore ways to advance the concept of “value-based purchasing” for the foreseeable future.<sup>22</sup>

### ***Congress Begins Using its Power to Advance Physician Accountability***

To date, Congress has continued to support the notion of self-regulation of the medical profession. However, in recognition of a faltering health care system, the 2006 Tax Relief and Health Care Act (PL 109 to 432) required the establishment of a physician quality reporting system,<sup>23</sup> including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries. The Centers for Medicare and Medicaid Services (CMS) initially called this program the Physician’s Voluntary Reporting Program and subsequently renamed it the Physician Quality Reporting Initiative (PQRI).

The PQRI required the creation of a broad range of physician performance measures to be able to make the program available to all health care providers. The American Medical Association responded to this need by funding the Physician’s Consortium for Performance Improvement<sup>24</sup> to design and promote condition-specific quality of care measures. In addition, the medical profession joined with other national organizations with a stake in health care to form a coalition called the AQA for purposes of reviewing and approving phy-



sician performance measures that could be used in the PQRI program.

To date, the CMS PQRI program remains voluntary, with incentives based on bonus payments. However, it is not hard to envision that, given the financial constraints on the Medicare program, in time voluntary participation could give way to required participation and bonuses could give way to payments based on performance rather than reporting, or it could even result in withholds for nonparticipation.

### The Public Demand for More Information

This overview would be incomplete without noting the growing demand of the public and the increasing capacity for consumer movement to drive physician accountability. The combined efforts of national consumer organizations such as the AARP and the Consumer's Union along with national business coalitions have contributed significantly to the strength and capacity of the National Quality Forum. Another coalition between the Consumer and Purchaser Disclosure Project and the Attorney General's Office of the State of New York has resulted in an initiative focused on improving health plan reporting of physician performance.<sup>25</sup> In addition, numerous public and consumer web sites are beginning to provide physician practice-level data, often free to the public, and many new web-based companies have made it a business to rank physicians in response to the public's desire to identify high-quality physicians.

### 2010: National Health Care Reform and Physician Accountability

At the time of the writing of this document, a national health care reform debate is requiring the country to rethink all of the major elements that make up our health care system. Although it is too soon to know the final outcome, the early legislative language from both the US House of Representatives and the Senate signal that they are supportive of the CMS plan to continue the advancement of physician accountability through PQRI. Although PQRI today is a voluntary program based on bonuses, a Congress focused on fiscal constraint could easily reverse this positive incentive, making participation voluntary in name only. Furthermore, although the current program is a pay-for-reporting model, it could easily be

converted into a public reporting program in response to pressures from public stakeholders. This is very likely to happen in the next few years as CMS gains enough experience with the PQRI data to produce valid public reports.

### The Future of Professional Self-Regulation and Voluntary Board Certification in Light of the Emerging Public and Market Drive for Increased Physician Accountability

Specialty-based care seems to be the incontrovertible bedrock in the landscape of the American health care system both now and for the foreseeable future. Although it is clear that there is a need for a larger primary care physician workforce, it would be difficult to imagine the devolution of our system into one of non-specialty-based care. In that light, the public and the marketplace will continue to need the type of accreditation that is provided by the ABMS boards. There is also little doubt that specialty-based physician certification will remain a self-regulatory function.

While it is theoretically possible that the 70 states and territories that make up the system of U.S. physician licensing authorities could evolve into a specialty based licensing system, this would require a level of public intervention that would be difficult to envision. Therefore, it is not clear if board certification will be sufficient to meet the broader public and market demand for physician accountability.

However, recent discussions with multiple stakeholders—ranging from consumer groups and health plans to national and regional employer coalitions as well as leaders in the federal government—suggest that that ABMS boards are, theoretically, well positioned to influence quality.<sup>26</sup> However, these many stakeholders are uncertain that current board certification and MOC programs will meet their needs for physician accountability.

Some of the principle critiques include:

- *The program is not patient centered.* Very little of the board certification and MOC processes reflect the patient's voice and concerns. Although physician communication skills are one of the ABMS's core competencies, they are not yet routinely assessed. Nor are continuity and transitions of care or the ability to assist in shared

decision making. Assessment of service needs, such as accessibility and timeliness, are also absent from the certification process.

- *Lack of transparency.* The public has only a very small window from which to view the board certification and MOC processes and outcomes. There are currently very few public seats in the governance and leadership of ABMS and its 24 member boards. There is also very little public information available about the processes and assessment methods that comprise board certification. Approximately 80% to 95% of all physicians who apply eventually attain board certification status, and nearly all of those who enroll in MOC are able to successfully complete the program. The result is that 85% of the US physician workforce has a self-regulation credential into which the public has little insight.
- *No assessment of the appropriateness of care.* One of the biggest concerns about the US health care system is the continuous and rapid escalation of the costs of care in both the public and private sectors. Much of this rise has been attributed to the unrestrained use of new technologies, unnecessary diagnostic services, unwarranted duplication of tests, and the use of new expensive therapeutics when less expensive therapeutics would be equally efficacious. To date, board certification and MOC provide little in the way of assessing physician performance in relation to these concerns.
- *Insufficient public input.* As noted above on the topic of transparency, only a few members of the public have seats in governance within the board environment, and there are currently no common pathways for public input to the board certification and MOC processes.
- *Insufficient system-based evaluation.* During the past few decades, health services research has clearly proven what many an astute observer would conclude: that physicians, although central to patient care, work within *systems* of care. Physicians working within different systems of care probably have very different capacities to deliver care. Patient care is, therefore, a combination of physician competency and health system performance. This is clearly evident in the use of health information technology, where the use of computerized order entry, electronic prescribing, and electronic medical records can enhance patient safety and improve clinical care. Currently, the

board certification and MOC programs have identified system-based practice as a core competency. However, to date there has been little assessment of physician knowledge and practice in this area.

### **The Future of Board Certification in the United States**

It is very likely that physicians will continue to participate in a board certification and MOC process both to demonstrate their chosen scope of practice and to be credentialed to practice in many health care settings. More specifically, hospitals, nursing homes, health plans, and academic institutions all need a certification process that they trust to credential physicians claiming to have specialty-based training. As such, ABMS and its member boards currently represent the most respected and subscribed to specialty-based certification program in the United States. Furthermore, the evolution of the ABMS specialty board certification program from that of an initial evaluation to recertification to the current MOC program has to a large extent ensured that the ABMS credential will be secure for the foreseeable future.

In this light, the key question before the ABMS and its member boards is not how it will meet the needs of the credentialing environment, but rather to what degree will it seek to be relevant in addressing the larger public concerns related to health care and physician accountability. Currently, board certification and MOC are aligned only modestly with the public's desire for physician accountability and the need for a safer and higher quality of care.

To meet the latter requirement, specialty-based board certification increasingly will have to focus on addressing the above-noted concerns of patient-centeredness, transparency, appropriateness, public input, and system-based practice. It is through enhanced public input that additional issues will emerge and evolve over time, thus supporting the need for increased public representation in the board certification enterprise.

Further evolution of the ABMS specialty board enterprise toward an alignment with a public accountability framework will not be easy. There is no single public organization or voice that speaks for all; rather, gaining public input will require the inclusion of a number of stakeholders. The many voices of the "public" will not necessarily share

common priorities for physician accountability, and at times will probably be conflicting. Finding the right partnership(s) with the public will need to take shape over time.

If one takes the perspective of the public as the primary customer of board certification, it would seem that the choice of whether or not to broaden the scope of certification processes to address the widening definition of public accountability is straightforward. The need of the public is great and they are expressing this need in their drive for increased reporting of physician performance both in the public (ie, PQRI and regional public reporting efforts) and private markets (value-based health care purchasing).

Alternatively, if one takes the perspective of the physician as the primary customer for board certification, it would seem that the choice of whether or not to pursue enhanced public accountability is more nuanced. In support of this evolution is the ethereal or lofty goal of improving health care in the United States. In addition, any alignment of board certification and MOC with value-based purchasing would probably result in multiple benefits, including financial rewards for participation in ABMS programs. Counterbalancing these benefits are the challenges that would come with participating in a more intensive and transparent board certification program—a potentially real burden given the other demands on the practicing physician.

## Conclusion

For most of the 20th century the profession of medicine has sought to provide assurance to the public about the quality and safety of physician care through self-regulation, which has been led by the specialty board certification movement. During the past decade, increased awareness of the need to improve health care quality and efficiency, as well as patient safety, has presented new challenges to self-regulation. The certifying boards of the ABMS have sought to address this changing environment by establishing ABMS MOC. With an ever-increasing public interest in a more effective and efficient health care system, ABMS and its member boards will need to continue to evolve to meet these increasing needs and expectations.

The ABMS and its member boards are left with a choice to design their future. The safe pathway is to stay focused on the credentialing environment;

however, this may not meet the larger needs of the public or build their trust in the profession. Alternatively, ABMS and its member boards may continue to embrace the larger public need to address the role of the physician in a complex and troubled US health care system that is struggling to improve. This latter and more challenging role of the certifying boards seems the best pathway to better health care outcomes and to assure the public's future trust in our profession.

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