American Board of Internal Medicine®

510 Walnut Street | Suite 1700 | Philadelphia, PA | 19106-3699 | 800.441.2246 | www.abim.org | request@abim.org

July 28, 2014

Dear Internal Medicine Colleagues:

We are writing in response to the letter dated May 7, 2014 sent by ACP on behalf of 14 medical societies outlining concerns vis-à-vis recent changes in the Maintenance of Certification (MOC) program. Since we received this letter, ABIM leadership has met with the leadership of many internal medicine societies and their officers to discuss MOC in greater detail. To further explore these issues, ABIM also convened a Summit Meeting on July 15th at which 26 medical societies sent representatives to share their thoughts regarding MOC.

Through these channels, the internal medicine community has collectively raised a number of valid questions and appropriate concerns about the revised MOC program. We address a number of them here, but we plan to be in ongoing dialog with the internal medicine community.

One of the major issues we heard during our conversations with societal representatives (and from numerous individual diplomates) is that there is a palpable level of anger among internists and internal medicine subspecialists. The dramatic changes and pressures that our colleagues are confronting currently include:

- dealing with the Affordable Care Act;
- incorporating computers at the point of care while fulfilling Meaningful Use requirements;
- responding to dramatic changes in payment that are reshaping the practice and professional landscape;
- an increasing emphasis on the role of systems, teams and technology that can be felt as a devaluation of the role of individual doctors;
- increasingly aggressive institutional compliance policies that are intrusive and sometimes counter-productive; and
- the "information-levelling" effect of the internet, dramatically changing the conversation between physician and patient.

Given these mounting pressures, the timing for releasing the changes in our MOC program was hardly propitious. Implementing the changes when our colleagues are dealing with so many other transformations in their professional worlds clearly magnified their sense of siege and stress. In addition, some of our colleagues have conflated various ABIM programs and processes with some of those demanded by government, payers, hospitals or health systems.

Indeed, in our ongoing commitment to "reduce redundancy" and decrease the reporting burden on physicians, we linked our credential to many of these other efforts. That has clearly been a double-edged sword, engendering confusion instead of good will. As an example, we often hear that ABIM is "promoting" MOC as a mandatory requirement for MOL. To be clear, ABIM does **NOT support using MOC as a requirement for** any maintenance of licensure program. On the other hand, we **DO** believe that any physician who chooses to engage in MOC should be *exempted* from any additional MOL requirements.

As the recipients of this letter know, ABIM was created by the medical community (AMA and ACP, to be precise) in 1936 as a standard setting organization. Its purpose was and is to issue a publicly recognizable credential that indicates an individual has met *professionally-determined standards* in a defined discipline. ABIM has always used, and will continue to use, a highly reliable assessment instrument for making those determinations.

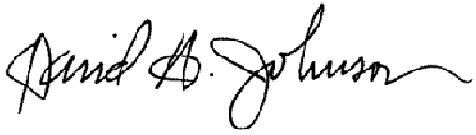
From the beginning, that instrument has been a secure exam, and we continue to use an exam (albeit a very different one from that offered in 1936 or 1986, and likely different from the one we will offer in 2018) to serve that role. We agree the exam must evolve with time as indeed it has and will continue to do. Whatever changes we make to the exam in the future related to content, format, delivery vehicle, feedback, etc. will need to support the use of the exam as a summative assessment tool that signifies competence in the disciplines of internal medicine. The community has requested a more modular, practice- relevant approach to summative assessment and we are convening a committee to explore how to move those ideas forward. As noted in the attachment, we will develop formal mechanisms for society input on these ideas either through the LCCR or a formal comment process.

The MOC program of ABIM (and all other ABMS Boards) also includes two components that are designed as *formative* rather than summative assessments: a self-evaluation of knowledge (Part 2), and a self-evaluation of practice assessment (Part 4). The latter represents a competence for physicians, one in which most of us were not formally trained, but which is now a core expectation of the good internist. Our effort to develop valuable Part 4 products has generated some of the most intense negative feedback. As a consequence, it has been the focus of some of our most intense reflection in the past year. It is the area of the MOC program that will change most dramatically in the next 12-24 months. It is also the aspect of the MOC program that will require the most collaboration and coordination with all of you. More specifics on that are shared in Appendix B.

In the feedback we have received, in addition to the questions and concerns about MOC, we also heard loud and clear that within the "House of Medicine" there is a shared commitment to lifelong learning and continued performance improvement, thereby helping to fulfill the physicians' societal contract of providing effective *self-regulation*.

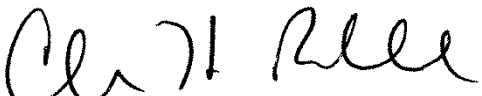
We have a collective interest in doing everything we can to amplify any pathway through which our colleagues can find self-affirmation and actualization and be better prepared to serve their patients in a dynamic, rapidly changing environment which feels very threatening. If we can chart a path together that helps colleagues, members, and diplomates achieve that, we will have fulfilled our responsibilities as leaders at a very challenging time.

We look forward to continuing the conversation.

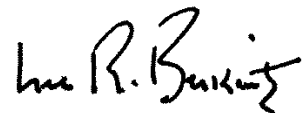


David H. Johnson, MD, FACP, FASCO
Chair, ABIM Board of Directors

Richard J. Baron, MD, MACP
President and CEO, ABIM

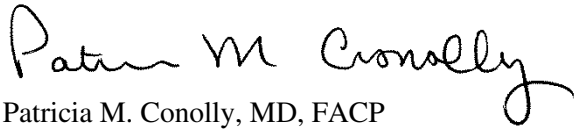


Clarence H. Braddock III, MD, FACP
Chair-Elect, ABIM Board of Directors



Lee R. Berkowitz, MD, FACP
Chair, ABIM Council

Stuart L. Linas, MD, FASN
Treasurer, ABIM Board of Directors



Patricia M. Conolly, MD, FACP
Secretary, ABIM Board of Directors

APPENDIX A - ABIM commits to the following:

PRODUCTS

- We will streamline the process for recognizing products produced by specialty societies and other organizations for medical knowledge (Part 2) credit:
  - ACCME-accredited product providers can register with us to have their products count in our program and will then be able to designate which of their products meet our standards. ABIM product standards will also be aligned with AMA PRA Category 1 credit standards for enduring materials, journal-based CME, test item writing and Internet point of care learning.
  - Detailed program policies and requirements will be released in mid-September, when we will begin accepting registrations and products from organizations with a proven track record of producing quality self-assessment products. A full- scale launch of the revised medical knowledge approval program will take place later in 2014.
- ABIM will continue to produce and offer medical knowledge modules and practice assessment options to ensure that all ABIM Board Certified physicians have access to specialty-relevant products.
- ABIM will explore pricing options whereby diplomates, over their 10- year exam cycle, can opt in or opt out of access to ABIM products and, if they opt out, get a discount on their MOC fee.
- Specialty society medical knowledge activities will be moved up on the list when presented to diplomates on the public side of the ABIM website as soon as is operationally possible.

ALIGNMENT

- ABIM does not believe that MOC should be required for MOL. In states where licensure includes required CME, MOC should count for those and any other knowledge or QI requirements.

SECURE EXAM

- Any diplomate who takes an exam before his/her examination is due and fails will get an additional year to pass before being reported as "Not Certified" or "Not Meeting MOC Requirements" (assuming all other MOC requirements are met).
- First- time MOC retake fees will be reduced from $775 to $400 beginning in 2015.
- ABIM will charter a committee which will include members of the Board of Directors and Council and explore options for offering psychometrically rigorous and clinically relevant modular exams. We will develop formal mechanisms for society input on these ideas either through the LCCR or a formal comment process.

WEB REPORTING

- The ABIM Board of directors will discuss website language for "Meeting MOC requirements" at their upcoming August meeting."

CERTIFICATION OPTIONS

- The Council will charge each specialty board with addressing the question of whether underlying certifications are required in each tertiary specialty and conjoint boards; decisions are expected by 2015 for the Boards which ABIM administers.
- A newly formed committee, established at the June Board of Directors meeting, will examine expanding MOC options for clinically inactive (and less clinically active) physicians, including researchers, academics and administrators and we will use the LCCR to inform those deliberations.

GOVERNANCE TRANSPARENCY

- The governance slides shared at the Internal Medicine Summit will be distributed to the specialty societies.
- A formal strategy for society/specialty board communication will be developed, in consultation with the specialty societies, beginning with a discussion at the LCCR meeting in September 2014.

APPENDIX B – Detailed Response to May 7 letter

The letter sent to ABIM on May 7th from a number of internal medicine specialty societies raises several specific questions/recommendations for ABIM. Because of the trouble you took to clearly define them, we wanted to offer a response to each of them.

We hope that this approach will provide a basis to continue our conversation. We agree completely with some of the suggestions you offered in the letter. Some of them have already been carried out or are in process of implementation; we present those first under the heading "Agree." Other issues raised in the letter are areas where solutions may be in development, even if they are sometimes slightly different from what you have proposed; these are grouped under the heading "In Process."

There is a third category of recommendations you have offered that raise substantive policy issues for the ABIM Board and Council that we need to address before we could take action on the specific recommendations; these we present under the heading "Further Deliberation."

Agree

Society Letter Recommendation - We suggest that the ABIM review the ABMS requirements for MOC with LCCR members at an upcoming meeting. As part of the that review, ABIM should compare and contrast how internal medicine and a few other selected specialties (e.g., family medicine, pediatrics, neurology, dermatology) are meeting the same ABMS requirements. Alternatively, representatives from those organizations can explain their MOC process to LCCR members.

- We welcome a conversation about the ABMS requirements as well as the requirements and fees of the other ABMS boards at a future LCCR meeting.

Society Letter Recommendation: Evidence supporting MOC: We believe that ABIM should make public the evidence-base for MOC. We understand that articles are available in the medical education literature addressing this subject, but they are not known or easily accessible to most practicing physicians. We believe that internists respond best to data and that repeated exposure to this data can only help ABIM make its case for MOC. At the same time, members tell us that they find papers written by ABIM and ABMS staff less persuasive because of the potential for conflict of interest.

ABIM should make the evidence supporting MOC more easily accessible to diplomates. While providing citations and reprinting pertinent articles is one approach, ABIM should consider other methods of informing busy clinicians of the evidence base for MOC. ABIM needs to "flood the zone" with this evidence.

If ABIM staff is considering authoring other evidence-based articles supporting MOC, inclusion of authors not associated with ABIM, ABMS, or other regulatory agencies should be strongly considered to increase the credibility among practicing physicians.

- We hear your concern that we may have swung the pendulum too far away from communicating about the research that does exist. Our focus groups with diplomates told us they wanted a focus on what they need to do to complete MOC and were less interested in the research base. It is clear from your comments that we need to listen to this other viewpoint.

- We have had a long commitment to research that both informs certification and MOC and examines its impact on internists and our patients. At the same time, we would welcome a conversation with societies and our broader communities about how to make that research more targeted and relevant to issues of broader concern. Further, although ABMS and ABIM have extensive research libraries on their websites, there are likely ways in which we can make the findings more accessible to those interested. More than half of the studies included are from non-ABIM researchers. We are very interested in any strategies societies might have for increasing awareness of the evidence that does exist.

- We have a simple research fact sheet that includes research studies done by authors not associated with ABMS. We would welcome that change to work with societies to develop the right message about our research base and get this more widely distributed.

- We would welcome partnering on research projects and a broader discussion of potential research agenda. We have a structured and rigorous process for reviewing all research with respect to alignment with strategic goals and research design quality for both internal and external projects. We currently collaborate on many research projects with research partners, including individuals at Yale, Dartmouth, Mathematica, Archimedes, and Duke. As we presented at the last LCCR meeting, we have also partnered with several societies for correlational studies on the In-Training Exams (e.g., IDSA, ASCO, ASH, etc.).

Society Letter Recommendation: ABIM should consider a higher degree of fiscal transparency by providing information on how fees are used to support the program.

- We agree that fiscal transparency is important and have recently posted on our website information about how fees are used. As with all non-profits, our 990s are publicly available on guidestar.com.

Society Letter Recommendation: we recommend tighter oversight of ABIM's products, ideally by a physician knowledgeable in self-assessment who can judge the clinical relevance of a question, recognize flaws in format, has the professional standing to negotiate the needed changes with the question author, and has the authority to exclude questions that do not meet the ABIM standards for self-assessment questions.

- While we have confidence in our existing processes in this area, we commit to reevaluating our approach as ongoing quality improvement. Currently, every module produced by ABIM is created and reviewed by clinical physician experts in that domain who understand ABIM standards and self-assessment objectives for ABIM modules. We routinely survey physicians who use our products; we are tracking those results as an internal ABIM performance metric. Physicians who complete our products rate them highly both on content and value, though not universally: 6% of users of ABIM medical knowledge modules (N= 50,637) Disagree or Strongly Disagree with the statement "This module was relevant to my practice"; 5% of ABIM module users (N= 52,247) Disagree or Strongly disagree with the statement "This module was a valuable learning experience." We will work to better understand the specifics of the concerns to which these users are reacting.

- Every ABIM module includes an explanation of the module's focus on recent advances (as opposed to comprehensive review) and a disclaimer explaining the difference between module and secure exam content, and that the modules are not designed for exam preparation. Also included is an invitation to diplomates to share their feedback on module questions with ABIM to help us keep the content current. ABIM staff and physician Self-Evaluation Process committees review all diplomate comments monthly and remove outdated or controversial questions from scoring until they can be replaced in our next scheduled version change.

- We agree that having practicing internists represented in our ABIM team is vitally important, and as such are in the process of substantially enhancing our physician staff capacity at ABIM, actively recruiting for a Senior Vice President of Doctoring and expecting to have a Medical Affairs department that consists of six FTE physicians, in addition to the CEO; the highest it has been in the past was three.

Society Letter Recommendation: We would like to see the ABIM develop a process whereby professional societies can contribute to the agenda by proposing items that represent issues of concern. If ABIM staff attending the LCCR meeting do not have the authority to respond to concerns and suggestions and make proposed changes because of established policy, we desire that our recommendations be heard at the level of the ABIM Board of Directors or ABIM Council. ABIM and the professional societies should develop and agree to an action item list at the end of each LCCR meeting along with a timeline that is published in a meeting summary, with follow-up provided at subsequent LCCR meetings.

- We agree that an important positive that can come from this interchange is a constructive conversation about how to enhance the value of the LCCR for all participating parties. The role of the LCCR is communication, feedback and discussion. We are very interested in developing a process to have societies participate in developing the LCCR agenda, and our current LCCR Chair (Jeannie Marrazzo, the Council Chair-Elect) has already started acting on this feedback and is recruiting society representatives to an LCCR Agenda Planning Committee.
- Our Board and Council Chairs attend the LCCR meetings and are aware of the society discussions and share them with the full Board and Council. In addition, many Council and specialty board members attend LCCR. Our new governance structure better reflects the diversity of internal medicine practices and specialties; over 35% of new specialty board members came from names put forward by the professional societies.
- Every specialty board has a formal responsibility now for managing/maintaining relationships with relevant societies, and most have current or immediate past society leaders on them, so we expect that, over time, some of the work done at LCCR will move to the specialty boards.

Society Letter Recommendation: ABIM should consider convening a conference or dedicating an LCCR meeting to addressing these [MOC] burdens. The conference should focus on working with medical societies to identify problems along with potential solutions that can be collaboratively developed and implemented across the subspecialties with the support of the ABIM.

- We welcome this idea and look forward to planning such a meeting in collaboration with multiple stakeholders.

Society Letter Recommendation: ABIM should consider taking into consideration developing a systematic process of obtaining input and suggestions from LCCR members on the current communication strategy, with emphasis on the ABIM web site.

- We welcome your suggestions about how our web site could be better; we are planning a substantial re-design effort over the next year or so, so this feedback will be particularly timely.

- We regularly monitor the questions fielded by our call center to hear what the most frequent questions are; this informs our communication and web strategy. We could build stronger links with society staff who field member questions so that we are able to incorporate your feedback as well.

Society Letter Recommendation: The ABIM should reserve time at an upcoming LCCR meeting to discuss development of the examination, including generation of the exam blueprint and its level of granularity; how the pass rate is determined; how examination relevance is assessed; and the recent trend of increased failure rates on the certification and MOC examinations and explanations for this trend. We would like to know the pass rate and pass rate trends on the MOC exam for other specialties, e.g., family medicine, pediatrics, neurology, dermatology. ABIM

should seek input from professional societies on the future of the MOC examination at an LCCR meeting. This input could be reported back to the Assessment 2020 Task Force by the ABIM staff liaison and/or task force ex-officio member, Patrick Alguire, MD, FACP. A modular examination, with a required "core" component complemented by a variety of options suitable for each diplomate's scope or type of practice, should be strongly considered.

- Similar concerns have been raised by APDIM and others. We agree and welcome the chance to discuss the variety of exam issues raised in this recommendation at an upcoming LCCR. As the current Board Chair attends LCCR and sits on the Assessment 2020 Task Force, he can take responsibility for bringing these concerns back to the Task Force.

- This issue also has caused us to consider whether we can be clearer in our communication about pass rates, since there appears to be some confusion distinguishing initial/first- time taker pass rates from ultimate pass rates. The former have been declining from a peak achieved 5 years ago (after several years of increases preceding that peak). The exam content and characteristics have not changed over this time period and we use a sophisticated linear programming algorithm to maintain comparability from administration to administration. First- time taker pass rates vary because we use an absolute standard (we don't grade on a curve with a pre-defined number/percent passing), which is guaranteed to assure variation in pass rates driven by candidate variation in ability, training, motivation and preparation. Ultimate pass rates have remained fairly constant at 95-98%. We are preparing to report on our web site first- time taker and ultimate pass rates by specialty, and would welcome suggestions about how we can more clearly communicate these distinctions.

- We will be releasing more detailed blueprints on our website this year and will be giving more detailed performance feedback on the score reports in 2015, including a high-level description of the questions that were missed. We tested out these new score reports on focus groups of internists who responded very favorably to them and made some improvement suggestions.

Society Letter Recommendation: We understand that the ABIM is assessing a process by which professional societies with a history of producing consistently high quality products may approve their own medical knowledge products for MOC subject to ABIM audit. This is certainly a step in the right direction. We believe that this process should be implemented as quickly as practicable and that it be extended to the Innovative Pathway and to Practice Assessment products. We also support the creation and implemented of the MOCAM system. We urge the ABIM to implement the MOCAM for AQI proposals and Medical Knowledge modules as soon as possible.

- We agree we need to speed up the approval processes for products. Our Council gave us authority to redesign the Medical Knowledge (Part 2) approval process with this in mind. We believe the new process will be considerably less burdensome and faster and should be in place by September 2014.

In Process

Society Letter Recommendation: For the Part 4 and Patient Survey requirements, ABIM should work with societies to ensure that the diversity of physician practices and professional activities has been taken into account. This ideally should have been done before implementation of requirements, but since that was not the case, ABIM should work collaboratively with societies to assure that physicians in all types of professional roles and activities are able to find appropriate options for fulfilling these requirements.

- The nomenclature ABIM has used - patient survey - for this requirement is incorrect and has caused confusion and concern. This requirement will be focused upon ensuring that physicians have incorporated the *patient voice* in their work. While surveys are one option to meet this requirement, there will be others and they will not require physicians to share any data survey information with ABIM. We are changing the name of this requirement to "Patient Voice," and there will be at least 4 different pathways to meet it before 2018, the deadline for completing the requirement.

- Our new specialty boards will begin to tackle the question of what are the appropriate patient voice options in each specialty and practice types. As part of their responsibilities, the boards are charged with liaison with the medical societies in their clinical domains.

- We agree that the options for the clinically inactive are not as strong as they need to be. We also believe a discussion is in order about reporting "clinically inactive" status publicly and modifying or eliminating practice assessment (Part 4) requirements for those diplomates who are no longer clinically active. Our Council created a committee to work on this issue, and we welcome input.

Further Deliberation

Society Letter Recommendation: We also recommend that ABIM consider innovations in its fee structure such as allowing a credit for not using ABIM medical knowledge, practice assessment, or patient survey modules. We also recommend that ABIM discuss with its governance a policy of not producing self-assessment products and reducing the MOC enrollment fees accordingly.

Society Letter Recommendation: ABIM should consider eliminating its production of self-evaluation of knowledge modules, relying instead upon societies' question-based resources. This should be accompanied by an appropriate adjustment of the registration fee for diplomates.

- We have had much debate on this issue over the past years, with reasonable positions on either side. Ultimately, we concluded that once they have paid a fee to ABIM, all diplomates should be able to complete MOC without having to pay additional fees outside the program.

- We recognize other educational programs for MOC credit and leave the choice to the diplomates about which pathways they want to use. We also heard clearly at the Summit

from some of the smaller societies that they did not have the resources to develop a complete suite of MOC products on their own. We may be able to design an "opt-in/opt-out, all- or- nothing" fee structure in where diplomates decide up front whether or not they want to use ABIM products. Because the cost of developing the ABIM medical knowledge modules is not high, we would not be able to offer a very steep discount. However, we are open to discussing this option further. This is a consistent issue we hear from medical societies, and we will commit to researching and brainstorming other fee structures.

- We believe that our medical knowledge (Part 2) modules add value in this arena, in that these products are consistently among our most popular among our diplomates, especially when delivered as learning sessions at society and society chapter meetings.

- Many diplomates have asked us to broaden their ability to use CME, wherever they get it, for MOC credit.

Society Letter Recommendation: Our information on the impact of MOC on the physician workforce is anecdotal but potentially an important signal. ABIM should consider working with the professional societies to collect reliable information on the impact of MOC on the workforce that will inform MOC policy and programs.

- While we are open to research projects examining workforce and would welcome working with the societies, in the past we have believed that using workforce as an influence on our standards is a conflict of interest. We also believe that any putative linkage between MOC and workforce trends is likely to overlook much more potent factors which influence workforce, such as the payment system, the systems of academic promotion, institutional status, etc.