AAIM
Alliance for Academic Internal Medicine

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Richard J. Baron, MD
President and Chief Executive Officer
American Board of Internal Medicine
510 Walnut Street
Philadelphia, PA 19106

Dear Dr. Baron:

On behalf of the Alliance for Academic Internal Medicine (AAIM), thank you for the opportunity to review and comment on the ABIM Assessment 2020 Task Force Report. The Alliance applauds the task force for a very thoughtful document.

As you are aware, AAIM surveyed its members in spring 2015 about their opinions regarding some aspects of maintenance of certification (MOC). The survey received 973 responses, representing 17% of AAIM physician members. In general, the responses to the survey showed a broad range of opinion. The Alliance shared the results of this survey with you in June and the leadership is pleased that you shared the data with ABIM leaders.

At the AAIM Leadership Summit in July 2015, the Alliance also conducted focus groups addressing various aspects of MOC. The focus groups participants were composed of members of the AAIM Board of Directors, members of the constituent organization's councils, and AAIM committee chairs. Each focus group had 12-14 participants and representation from each constituent organization. All participants had been provided the results of the AAIM MOC survey and were asked to voice the opinion of their constituents (as opposed to their personal opinions).

The questions addressed by each focus group and the results of their discussion are attached. The Alliance offers these results as AAIM's response to your invitation to comment upon ABIM's Assessment 2020 Task Force Report. The general observations are that the AAIM focus group comments are highly consistent with the results of the task force deliberations.

It is important to emphasize several themes that have emerged from the AAIM focus groups and discussion that has followed. The Alliance feels strongly that MOC should:

- Be a rigorous process.
- Not try to measure everything that is part of "keeping up" and being a good physician. For example, competence in communication is very important but currently it is near impossible to measure this competency accurately and non-intrusively without being overly burdensome. AAIM suggests that it is better to allow local practices to prevail in such circumstances.
- Strive to minimize the burden on a physician's time.
- Be flexible to accommodate unique styles of practice and niches into which some physician careers/practices have evolved.

Again, thank you for the opportunity to comment. The Alliance looks forward to continuing to work with you and others to map the future of MOC in internal medicine. If you have questions or need additional information about the survey results, the focus group results, or the Alliance, please contact me at (202) 355-5903 or dbrater@iu.edu or AAIM Deputy Chief Executive Officer and EVP Bergitta E. Cotroneo at (703) 341-4540 or bcotroneo@im.org at your convenience.

Sincerely,

D. Craig Brater, MD
President and CEO

Attachment

Focus Group # 1

Topic

Assuming a desired outcome is a reliable, credible knowledge assessment that is more frequent and less burdensome than a once every 10 year secure exam, what form would that assessment take? For example, what role does CME play? Is CME in its current form sufficiently robust? If not, how can it be made more robust? What should be employed in addition to CME?

Results

- CME is not sufficiently robust. It must require assessment to confirm learning occurred (weighted values).
- Leadership of a learning event should have a weighted value (National > Regional > Local) and count towards CME & MOC.
- High stakes (re-certification) testing every 10 years is okay. Lower stakes assessments to measure knowledge and level of confidence in knowledge could be done every 2-3 years with feedback regarding learning objectives and where to focus additional learning (formative assessment). This should apply for multiple Boards within Internal Medicine so as to not over-burden physicians.
- There should be a menu of options that includes lower stakes assessments, CME, etc. so that diplomates can adapt MOC to the specifics of their practice.
- The time demands on physicians are increasingly burdensome. Effort should be made to decrease that burden. For example, ABIM is a member of The Council of Medical Specialty Societies (CMSS), [*a consortium of accrediting and certifying organizations, the 24 key medical specialty societies, and other related entities*]. As a member of the council, ABIM should propose the organizational members of CMSS develop standardized licensing and certification/recertification protocols across all jurisdictions to ease this burden.

Focus Group # 2

Topic

Procedures have historically evolved rapidly over a physician's career; presumably this will continue to be the case. Is it important to assess whether an individual has "kept up" and whether they are adequately adept in performing procedures relevant to their area of practice? If so, how does one assess this competency? For example, can one rely on local credentialing processes to monitor and determine competency? If so, how does one assure the robustness of this local monitoring? If one cannot rely on such local processes, how can one assess procedural competency?

Results

- Providers should maintain competency in procedures. Specialty societies (including general internal medicine) rather than (or in collaboration with) ABIM should determine what procedures require ongoing competency assessment. They should also determine how to recognize competence in a procedure; for example, a certificate that is then renewable as part of MOC.
- Specialty societies should establish the minimum threshold for the number of required procedures as well as quality measures such as the threshold for complication rates.
- Assessment of competence could model an approach like ACLS or some other peer-reviewed direct observation system.
- Simulation centers should be considered as a potential venue for assessments of competency for procedures amenable to simulation.
- Procedural certification should strive for alignment between certification requirements, institutional credentialing requirements, and state licensure requirements.
- A national database should be considered that tracks providers, the procedures for which they seek competency certification and their specialty (ies).

Focus Group # 3

Topic

Is it important to assess the ability of an internist to engage in quality improvement? If so, how can that assessment be done? For example, are the CLER evaluations, Joint Commission evaluations, etc. conducted at a hospital or system level sufficient? For internists who are not in a setting where such evaluations occur, how can they be evaluated? If system evaluations are not sufficient, how does one assess competency in this area?

Results

- It is important to assess the ability of an internist to engage in quality improvement. Lack of doing so strains credibility with the public.
- A focus should be on meaningful engagement of the individual in QI.
- Guidelines should be developed for regulation of QI assessment and should incorporate activity at the levels of both the institution and the individual. A pathway recently developed by ABMS may represent a solution to this challenge:

  http://mocportfolioprogram.org/

- CLER and Joint Commission evaluations are not sufficient to attest to QI competency of individuals. Whatever mechanism is used to assess competence in QI must be practical and useful and should strive to find a way to standardize quality improvement. Some individual systems may be able to reliably monitor QI at the individual level. In such settings individuals should be able to receive MOC credit through their system and not have to duplicate effort. This implies some mechanism for validating the reliability of the assessment at the system level.

Focus Group # 4

Topic

Should MOC attempt to determine communication skills of practicing internists? Are hospital and system assessment of patient satisfaction sufficient to evaluate this competency? For internists who are not in a setting where such evaluations occur, how can they be evaluated? If system evaluations are not sufficient, how does one assess competency in this area?

Results

- Communication skills should not be included in the MOC assessment. Though communication skills are important and essential, a reliable, non-intrusive way to assess those skills for MOC is not currently possible. Therefore, assessment and monitoring should remain local. Communication skills are emphasized during medical school and residency training and should be subsequently addressed within the practice organization and/or health system rather than by a governing body as part of physician certification.
- A variety of assessment tools are used currently for measuring patient satisfaction. Different organizations use different tools. Patient satisfaction is determined by multiple factors only one of which is the communication skill of the physician. None are adaptable to a process such as MOC to assess communication skills.
- Communication skills competency should be addressed using milestones and perhaps implementing communication training as faculty/professional development modules.

Focus Group # 5

Topic

How does one assess teamwork skills? How does one assess ability to practice? Can such assessments be done in non-burdensome ways? If so, should this assessment be a component of MOC?

Results

- Teamwork skills are important but a reliable, non-intrusive way to assess those skills for MOC is not currently possible and should not be attempted.
- The skills vary based on the setting (academic, community vs private). The assessment is very subjective. Attempts to measure teamwork skills would be cumbersome.
- Teamwork skills are embedded in quality improvement so it may not be necessary to be concerned about not measuring teamwork more directly.
- Another reason to not be concerned about measuring teamwork is that once teamwork skills are learned, only rarely would they be lost. Thus, is it necessary to be re-certified?
- There is a precedent that Residency and Fellowship standards are set on the national level: while the execution is carried out on the local level. The same principle applies to teamwork skills assessment.

Focus Group # 6

Topic

Many internists and particularly those in academia have practices that evolve over time and many in academia have highly focused areas of practice—for example, the senior endocrinologist who only sees patients with thyroid disease, the physician scientist, etc. How does one assess "keeping up" for such individuals in a fashion that has validity?

Results

Any assessment or certification for "keeping up" for sub-subspecialists should incorporate the following concepts:

- Rarified specialization needs to be recognized, but it should not be in a form that absolves the diplomate from responsibility for knowing broader content.
- A single "assessment/certification" would still be required but it would contain material of general competence within that specialty. For example, a thyroid focused endocrinologist should be expected to maintain at least a modicum of confidence in endocrinology broadly.
- The degree of breadth (see above) should be determined collaboratively with the relevant specialty.
- Knowledge assessment must be relevant.
- The creation and evaluation of any assessment/certification system should remain dynamic.