MOC Question 1

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?

MOC Question 1

- To ease the burden on physicians, the Council for Medical Specialty Societies should lead the discussion to coordinate the 'requirements' for licensing and certification so that they are aligned and considered for MOC.
- CME at current state is not robust enough. It must require assessment to confirm learning took place (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 assess 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. It would be beneficial if this applied for multiple Boards so as to not over-burden physicians.
- Lower stakes assessments and CME should be part of a menu of options, not one or the other.

AAIM

MOC Question 2

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?

MOC Question 2

- Providers should maintain competency in procedures, but specialty societies (including general internal medicine) should determine what procedures require ongoing competency.
- Specialty societies should establish the minimum threshold for the number of require procedures and maximum threshold for complication rates for a given time period.
- Assessment of competence could model an approach like ACLS or some other peer-reviewed direct observation system.
- Sim centers should be consider as a potential venue for providers to use for competency assessment.
- All procedural certification should result in alignment between certification requirements, institutional credentialing requirements, and state licensure requirements.
- A national database should be developed that tracks providers and their certified specialties.
- Specialty societies should determine an approach to recognize procedural certification (e.g., certificates, etc.)

AAIM

MOC Question 3

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, UHC evaluations, etc. that are 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?

MOC Question 3

- It is important to assess the ability of an internist to engage quality improvement. Many patients would not want to be seen by any physician that isn't involved with QI and process improvement.
- Guidelines should be developed for regulation of QI assessment and should incorporate activity at both the institution level and individual physician level.
- CLER and UHC evaluations are not enough. Whatever mechanism that is used must be practical and useful and should find a way to incorporate EMRs in QI process. Is it possible to get ABIM live feed with feedback? Possible for electronic coach with real-time feedback? Possible to standardize quality improvement? ABIM -> system level -> individual level
- Challenge would be to get a system base standard to all organizations on any EMR and those not on an EMR being able to have access to the standards list. If an individual system is already performing self imposed QI checks make sure that they can and will get credit.
- If the system level isn't enough then QI regulations and monitoring would need to be done at the individual level. Possible to have a QI central website tthat everyone could go to; to look up metrics for systems? Focusing on meaningful engagement.

AAIM

MOC Question 4

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?

MOC Question 4

- Communication skills should not be included in the MOC assessment. While all agree that communication skills are important and essential, an assessment of those skills is difficult to manage. Therefore, the assessment should be left to local control and monitoring within the local organization. Communication skills are emphasized during medical school and residency training and should be subsequently addressed within the practice organization rather than by a governing body as part of the physician certification.
- There are some assessment tools that are efficient and sufficient for evaluating this skill but varies based on the organization. There are multiple facets for gauging communication skills and patient satisfaction is only one aspect, since patients' satisfaction is based in part on the patients' experiences.
- For internist not in a hospital environment, the suggestion was to seek tools from survey organizations that can serve as a guide for areas of communication that would again be addressed locally within the organization.
- Communication skills competency should be addressed using milestones and perhaps implementing communication training faculty/professional development modules.

AAIM

MOC Question 5

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?

MOC Question 5

- All agreed teamwork skills are important.
- The skills vary based on the setting (academic, community vs private). The assessment is very subjective. It will be impossible not to be cumbersome if the data is collected as part of MOC.
- Teamwork skills are embedded in quality improvement. Is it necessary to separate the teamwork skills? What about leadership skills? It could be a slippery slop to include teamwork in MOC.
- Once you learned teamwork skills, is it necessary to be re-certified?
- There is a precedent that the Residency and Fellowship standards are set on the national level: while the execution is carried out on the local level. It was suggested the same principle applies to teamwork skills assessment as part of MOC.

AAIM

MOC Question 6

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?

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

- Rarified specialist needs to be recognized, but it should not be in the form of an idiot-savant. Needs broader based knowledge.
- A single "assessment/certification" would still be required but it would contain material of general competence within that specialty.
- All knowledge assessment must be relevant.
- The creation and evaluation of any assessment/certification system will remain dynamic.
- The assessment/certification system will be defined within, and by,each specialty.
- It needs to be understandable to public.