November 7, 2016

Marcy Bolster, MD; Chair, ABIM Rheumatology Board & ABIM Council Member
C/o Richard Baron, MD; ABIM President and Chief Executive Officer
American Board of Internal Medicine
510 Walnut Street
Suite 1700
Philadelphia, PA 19106-3699

Dear Drs. Bolster,

Thank you for taking the time to speak with us on October 28th. Your feedback and insights regarding the two possible models for an alternative to the 10-year secure ABIM MOC examination were greatly appreciated. Based on the conversation, we understand the ABIM remains resolute in its commitment to announce this month which assessment - the 2-year pathway or the 5-year pathway - will be launched in 2018, alongside the current 10-year secure MOC examination.

We understand this is an evolving process; however, we are extremely concerned that if the ABIM moves forward with one of the proposed models without modifications, it will be perceived as further marginalizing the feedback from physicians and the medical societies and may result in a divided internal medicine community.

Potential for Divided Internal Medicine Community
On September 15, 2016, the ACR participated in a meeting convened by the American College of Physicians and the Alliance for Academic Internal Medicine to discuss a potential alternative to the ABIM’s MOC high-stakes secure examination. The first part of the meeting was attended only by the society representatives. Staff leaders of ABIM attended the latter part of the meeting.

The societies proposed a more continuous model, with the requirement that a diplomate correctly answer a threshold number/percentage of questions over a defined period, e.g., every 2 years. It is envisioned this would be an iterative process, such that diplomates are able to demonstrate that identified areas of knowledge deficiency have been rectified. The assessment could be developed to merge Parts 2 (formative) and 3 (summative) of MOC, since both Part 2 and Part 3 components would be integrated. The broad framework of the societies’ proposal and the division of responsibilities were:

- The medical professional societies would be responsible for identifying important and relevant clinical content. They would then develop self-assessment questions based on that content, with provision of short-term feedback and links to supporting educational material.
- The certifying board (ABIM) would assure credibility of the society-produced programs, set the passing standard, and issue the documentation of satisfactory completion.

In response, the ABIM representatives expressed potential interest in the societies identifying content, developing assessment questions, and linking to educational resources. However, based on ABIM’s timeline it was stated that any movement towards the societies’ proposal would need to occur in parallel as ABIM was moving forward with their proposals.
On **September 16, 2016** ACR representatives attended the ABIM’s Liaison Committee on Certification and Recertification (LCCR) meeting. During the meeting, 26 societies presented their preference for the two proposed models: 17 societies, including the ACR, stated neither model was adequate. The main concern was that the two proposed ABIM models are not different enough from the current model, and it appeared that the ABIM had taken the 10-year exam and proposed to offer it every 2 or 5 years. Those that selected the 2-year or 5-year pathway stated the need for additional information before confirming their choice, e.g., information on cost, decision on open-book, and reassurance that “more frequent” would not be more burdensome.

**ACR’s Position**

The **ACR’s position** that the current secure, closed-book, high-stakes 10-year MOC examination is not an appropriate means for assessing clinical knowledge or decision-making for the purpose of **recertification** and should be eliminated is in alignment with the ABIM’s decision to offer an alternative. We believe current CME activities that include assessment and demonstrate educational benefit should be considered appropriate assessment tools for MOC. This position aligns with the broad framework of the societies’ proposal stated above.

Although we were encouraged by your comment that many of the details related to the new assessment are still “on the table” and Dr. Baron’s comment during the LCCR meeting that “it is envisioned the program will continue to evolve,” **we are extremely concerned that the medical societies’ feedback and the ABIM’s actions are disparate**. This lack of a shared vision and timeline makes it more difficult and potentially more costly for the ACR to support the ABIM proposals.

As previously stated, it is the ACR’s preference to collaborate with the ABIM to eliminate the 10-year secure ABIM MOC examination, replacing it with a convenient, less costly, and more meaningful approach to continued education. We believe if the goal is to ensure physicians are practicing the most current medicine the process should be interesting and useful, and not punitive. We understand ABIM does believe it is currently possible to explore alternative models and meet their stated 2018 release. In an effort to move forward we have listed seven key issues which we believe would reflect meaningful progress towards a more ideal model and would result in a satisfactory initial step, if incorporated into the ABIM assessment. We respectfully ask the ABIM Council to consider and respond to the following key issues:

**Key Issues**

1. **Offer “Untimed” Assessment**: The current rheumatology MOC exam allows an average of two minutes per question. The practice of rheumatology covers a diverse spectrum of complex multi-system diseases and is not subjected to stringent time constrictons. Inherent in the specialty is a laudable penchant for thorough investigation of the clinical question at hand utilizing written and electronic resources and/or discussion with trusted colleagues in other specialties. We believe the MOC assessment should reflect this important practice and should not be timed. We understand that the ABIM does not share this perspective and therefore, if the first iteration of the new assessment must have a time limit, we request the ABIM Council consider the diversity of sub-specialties and release an assessment with an extended time allotment per question, e.g., 5 minutes per question. With a 2 minute per question time restriction, the new assessment will not reduce physician anxiety and the intended benefits of adding open book will not be realized.
2. **Confirm Open-Book Access**: We are encouraged the ABIM is considering offering open-book access for the MOC exam. We believe this step will encourage deeper learning and knowledge retention. We request the ABIM Council confirm this option and provide information on the resources that physicians will be permitted to use during the assessment. As previously noted, an inherent linked concept is designing an assessment that offers adequate testing time so that the intended educational benefits of open-book access to educational resources will be realized. Without adequate testing time, the introduction of open-book access will not reduce physician anxiety and will be perceived as a disingenuous addition.

3. **Validate Identification for Assessments Completed at Home/Office**: We believe an online proctored exam with a webcam observing a physician is unnecessarily intrusive, detracts from ABIM’s goal of providing a comfortable testing experience, and is not appropriate for recertification. We request the ABIM Council approve a process that validates a physician’s identification and utilizes less intrusive technologies to ensure the security of the assessment, e.g., tracking key strokes, secure browsers.

4. **Offer Modular Options**: We do not believe that increasing the frequency is consonant with decreasing the burden of the assessments, nor do we believe that it is necessary to test physicians on the entire breadth of the discipline every two or five years. We recommend that the ABIM Council consider modular options, to be completed on a cyclical basis, based on the MOC blueprint content areas.

5. **Offer Option for Immediate Remediation**: For the assessment to be most effective, we believe physicians must be provided with the opportunity for rapid remediation if performance is not satisfactory. We understand that the ABIM distinguishes a high-stakes assessment from a low-stakes assessment by how the results are used (e.g., what are the consequences, is the information shared publically) and not how the assessment was designed. We believe physicians will continue to put forth maximum effort in preparing for any assessment and as such, each low-stakes assessment will be perceived as a high-stakes assessment. We encourage the ABIM Council not to dismiss this perception and offer physicians the option for immediate remediation or the option to test within the next “testing window.” Physicians should not have to wait for the next scheduled interval, i.e., 2 or 5 years.

6. **Summative vs. Formative**: The ACR believes a formative assessment is more appropriate for recertification. We believe assessment drives learning and should be used to guide physicians’ self-directed study. We understand ABIM currently requires that a summative component be incorporated into the new assessment, and are concerned that the current summative proposals maintain the high stakes nature of recertification. If summative assessments are maintained, we strongly recommend that ABIM help physicians identify knowledge gaps by providing feedback reports with recommendations for specific educational resources within weeks of completing the assessment. As suggested by several societies during the LCCR meeting, we recommend the feedback report, at a minimum, include learning objectives and teaching points. A topline report based on the blueprint content areas will not facilitate a physicians’ self-directed study. We would also strongly recommend the ABIM Council engage with the medical societies regarding the educational recommendations provided in the feedback report.
7. **Transparent Pricing**: Before instituting a new MOC assessment, we believe a full and transparent accounting of ABIM costs and an estimate of the costs to be borne by individual physicians is essential.

We believe that releasing an appropriate new MOC assessment is the most urgent step needed to restore confidence in the ABIM’s MOC program, and we applaud the ABIM Council for prioritizing this task. Before instituting a new assessment model, we implore the ABIM Council to solicit buy-in from the medical societies. We believe this will help expedite meaningful change and may help to resolve the mounting frustrations.

If you have questions or would like to schedule a follow-up meeting, please contact ACR’s vice president, education, Donna Hoyne, via email: dhoyne@rheumatology.org or telephone: 404-633-3777 ext. 327.

The ACR sincerely appreciates the work that you and the ABIM Rheumatology Board members do in promoting MOC change. Thank you for your continuing collaboration with the ACR.

Sincerely,

Carol Langford, MD; Juliet Aizer, MD, MPH;
ACR Committee on Education, Chair ACR Continuous Professional Development, Chair

Cc:
Richard Battaglia, MD; ABIM Chief Medical Officer
Eric McKeeby, Director of Community Engagement
Craig Brater, MD; President, Alliance for Academic Internal Medicine
Darilyn V. Moyer, MD; Executive Vice President and CEO
Steven Weinberger, MD; Associate Executive Vice President
Joan Von Feldt, MD, MSEd; ACR President
Sharad Lakanpal, MBBS, MD; ACR President-Elect
David I. Daikh, MD, PhD; ACR/Foundation Secretary
Paula Marchetta, MD, MBA; ACR/Foundation Treasurer
Eric L. Matteson, MD; Foundation President
Elizabeth A. Schlenk, PhD, RN; ARHP President
Mark Andrejeski; Executive Vice President
Donna Hoyne; ACR Vice President, Education
Ashley MacDermott; ACR Director, Certification

**ABIM Rheumatology Board Members**

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atul Deodhar, MD</td>
<td>Robert M. McLean, MD</td>
</tr>
<tr>
<td>Elana Eisner, MD</td>
<td>David Shuey, MS</td>
</tr>
<tr>
<td>Salahuddin Kazi, MD</td>
<td>Benjamin Smith, PA-C</td>
</tr>
<tr>
<td>Kristine Lohr, MD</td>
<td></td>
</tr>
</tbody>
</table>