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Testimony – Continuing Board Certification:

Vision for the Future Initiative Commission

Monday, March 19, 2018

Dr. Colenda, Dr. Scanlon, and distinguished members of the Commission, thank you for the opportunity to speak before you today. My name is Dr. David Daikh, and I am a rheumatologist at the University of California, San Francisco (UCSF), where I serve as director of the Rheumatology Fellowship Training Program. I also serve as chief of the Rheumatology Division at the SFVA Medical Center, where I direct the Rheumatology Clinic. I am the current president of the American College of Rheumatology (ACR), which serves over 7,200 rheumatologists, the majority of whom are certified by the American Board of Internal Medicine (ABIM), which represents approximately 3.5% of ABIM's 200,000 diplomates.

Rheumatologists provide ongoing acute and chronic care for people with complex conditions that require specialized expertise beyond that of primary care providers. Rheumatologists provide face-to-face, primarily non-procedure-based cognitive care, and serve patients with serious conditions that can be difficult to diagnose and treat including rheumatoid arthritis, systemic lupus erythematosus and other debilitating diseases. Early and appropriate treatment by rheumatologists slows disease progression, improves patient outcomes and reduces the need for costly downstream procedures and care that is complicated and made more expensive by advanced disease states.

The Centers for Disease Control and Prevention (CDC) recently released a study[1] that tabulated the annual costs of arthritis in the United States at over $300 billion. Arthritis not only

has a high economic cost, but personal and societal costs as well, for the 1 in 4 Americans living with physician-diagnosed arthritis.

Given the importance of the specialized care and services provided by rheumatologists, which can be provided only by rheumatologists, the ACR is highly concerned about the growing shortage of providers with expertise in rheumatology and how the maintenance of certification (MOC) program is adversely contributing to the shortage.

Rheumatology is one of the subspecialty boards of the ABIM. While there has been longstanding confidence in the value of the ABIM certification exam in rheumatology, as for many other subspecialties, dissatisfaction with the ABIM MOC program has been persistent for many years. The ACR has been actively advocating the ABIM for MOC reform since July 2014 and it has been more than three years since ABIM's Feb. 3, 2015 "we got it wrong" announcement.

The ACR believes rheumatologists and the public continue to support and value specialty and subspecialty board certification in rheumatology. We believe the ACR and the ABIM share the same goal of ensuring patients receive the highest quality of care available. The ACR also believes that a robust independent certification process is necessary to ensure quality and public confidence in specialty physician care. However, the ACR has identified numerous areas where the current ABIM MOC program hinders this goal while substantially adding to rheumatologists' administrative and cost burdens. The changes ABIM released in 2014 led to increased frustrations and resulted in many rheumatologists retiring earlier than 65 years of age, which in turn amplified the rheumatology workforce shortage that threatens access to high quality care for all affected individuals.

Value of the Credential

In August 2015, the ACR released a statement outlining the ACR's position on the ABIM's MOC requirements. The position statement was drafted and vetted during a three-month collaboration between ACR leadership and its members, where nearly 1,100 rheumatologists provided feedback that was used to formulate the final statement. Throughout this process, rheumatologists reaffirmed their belief in the value of continuing medical education. However, they stated that the ABIM MOC program not only fails to appropriately assess their competence, but also lacks evidence that patients are benefiting from their involvement with the program.

Our position statement contains several points the ACR requested the ABIM consider when developing any future MOC requirements. Highlights include strong beliefs that a future MOC program should: 1) allow physicians to develop and implement a continuing professional development plan relevant to his/her professional roles and responsibilities; 2) eliminate the secure, closed-book, high stakes MOC examination, because it is not an appropriate means of assessing clinical knowledge or decision-making for the purpose of recertification; 3) not include the Practice Assessment, Patient Voice and Patient Safety requirements of the recertification process as they are redundant with existing requirements. The position statement also addressed the redundancy of physicians being required to obtain both CME and MOC medical knowledge credits, the need to reduce program costs, and the desire for evidence that the program is improving physician competence.

On Sept. 7, 2016 the ABIM sought the communities' feedback on an additional option to the 10-year secure ABIM MOC examination. ABIM proposed a new assessment consisting of either a 2-year pathway or a 5-year pathway that would be launched in 2018, alongside the current 10-year secure MOC examination. In response, 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 proposal on Sept. 15, 2016. 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 was envisioned that this would be an iterative process, such that diplomates could demonstrate that identified areas of knowledge deficiency had been rectified. The assessment could be developed to merge Parts 2 (formative) and 3 (summative) of MOC. The broad framework of the societies' proposal and the division of responsibilities were:

- Societies would be responsible for identifying important and relevant clinical content and they would then develop self-assessment questions based on that content, with provision of short-term feedback and links to supporting educational material.

- ABIM would assure credibility of the society-produced programs, set the passing standard, and issue the documentation of satisfactory completion.

In response, ABIM stated it was committed to the 2-year or 5-year pathway and the 2018 release date.

On Sept. 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 ABIM proposed models. Consistent with direct feedback obtained from a membership survey, the ACR stated neither model was adequate, which was similarly expressed by a total of 17 societies. The main concern was that the two proposed ABIM models were 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 societies 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.

Following these meetings and in response to the announcement in December 2016 of the ABIM decision to proceed with the 2-year knowledge check-in pathway as an alternative to the 10-year exam, the ACR expressed additional concern to the ABIM about the potential for these issues to divide the internal medicine community.

The Future of the Program

The ACR advocated that the ABIM consider recommendations to approve meaningful open-book access, introduce unobtrusive security features for assessments completed at home, offer immediate remediation, provide detailed feedback reports that allow physicians to recognize and address knowledge gaps, and transparent pricing with the new assessment.

The ABIM plans to release a 2-year knowledge check-in assessment option for internal medicine and nephrology in June 2018. Based on information published on the ABIM website there will be a total of 90 multiple-choice questions to be answered in a three-hour time span resulting in an average time allotment of two minutes per question per knowledge check-in. Should this time allotment be applied to the detailed questions required for an adequate rheumatology 2-year knowledge check-in, the ACR does not believe this time limit will allow for realistic approximation of the cognitive and deliberative aspects of medical assessment and decision making that characterize the modern practice of rheumatology. As a result, while maintaining the high pressure, high stakes experience that physicians find abhorrent, the exam will not provide a valid assessment of physician competence. In addition, the 10-year and 2-year options for internal medicine and nephrology will allow use of a single-source information resource, which will not reflect way that rheumatologists access current specialty information.

ABIM has indicated additional resources may be added in the future; however, any additional resources will be determined by the ABIM and it is not envisioned that a true “open-book” format will be provided in the future. The 2-year knowledge check-in option for rheumatology, with a single-source resource feature, is scheduled to be released in 2019.

The ACR believes that increasing the frequency of assessments is not consonant with decreasing the burden of MOC, nor do we believe that it is necessary to test physicians on the entire breadth of the discipline every two or five years. The ACR has advocated the ABIM consider modular options, to be completed on a cyclical basis, based on the MOC blueprint content areas.

ABIM has confirmed assessments completed at home will be recorded via webcam but will not be proctored live. The ACR believes 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 have advocated ABIM 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.

The ACR believes for the assessment to be most effective, 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. The ACR has advocated the ABIM not to dismiss this perception and offer physicians the option for immediate remediation. Physicians should not have to wait for the next scheduled interval, i.e., 2 years.

The ACR believes assessment should drives learning and that MOC 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 new summative assessment maintain the high stakes nature of recertification. To help ease this burden we have advocated for ABIM to 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, 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 engage with the medical societies regarding the educational recommendations provided in the feedback report.

Best Practices

In response to the ABIM's changes and concern expressed by rheumatologists, the ACR formed a taskforce in December 2016 to further analyze the impact of the changes on rheumatologists and their patients as well as the approach to MOC being taken by other member boards within the American Board of Medical Specialties (ABMS).

Taskforce recommendations and our shared interest in immunologically mediated disease led the ACR leadership to contact the American Board of Allergy and Immunology (ABAI) to learn more about their MOC program. Of specific interest to the ACR was the continuous assessment program being launched by ABAI in 2018 that is a longitudinal summative assessment based on recently published medical literature and general knowledge questions. This program appears to address many of the learning goals directly expressed by ACR members while also providing a meaningful model for rheumatologists to demonstrate continual professional development with the application of evidence-based standards.

During a meeting with ABIM leadership in the September 2017, we had discussed the feasibility of piloting a similar program with the ABIM. ABIM responded that this model does not align with ABIM's MOC principles.

Although one cannot deny the meritorious goals that are at the core of the ABIM principles, the issue remains whether there are other ways to embrace the spirit of those principles, through different actions that advance the education that can improve the care of patients with rheumatic disease.

The ABMS standards state that: "These standards contribute to improved patient care through the development of rigorous and relevant Programs for MOC that continuously improve and assess the knowledge, skills, and professionalism of diplomates who care for the patients, families, and communities of the United States." A point of discussion has long been whether the ABIM approach has truly resulted in improved patient care.

The ACR believes a model based on the principles of physician self-regulation that assesses knowledge while providing ability to improve knowledge in a manner that not only meets but enhances this standard, is a worthy pursuit.

The ACR appreciates the Commission's work in seeking clarity related to MOC so all stakeholders understand what ongoing certification means, and so that ongoing certification does not mean something different for different types of physicians. We look forward to working with you to achieve appropriate standardization and assure that ongoing certification is relevant to the practices of physicians without undue burden, and that necessary changes will be implemented in a timely manner. Thank you for accepting this testimony and I am happy to address any questions Commission members may have.

Reference: [1:] Murphy, L. B., Cisternas, M. G., Pasta, D. J., Helmick, C. G. and Yelin, E. H. (), Medical expenditures and earnings losses among US adults with arthritis in 2013. Arthritis Care Res. Accepted Author Manuscript. doi:10.1002/acr.23425