American Board of Internal Medicine CEO Responds to Questions about Changes in Recertification

Editor’s Note:

Following is a condensed text of an interview by SLMM with Richard J. Baron, MD, MACP, president and CEO of the American Board of Internal Medicine (ABIM) and the ABIM Foundation. The ABIM oversees certification in internal medicine and 20 sub-specialties; over 200,000 physicians hold ABIM certification. Dr. Baron, of Philadelphia, became president and CEO in June 2013 after serving in private practice for almost 30 years. He was Chair of the ABIM Board of Directors in 2008 and also recently led the development of innovative ACO models for the Centers for Medicare and Medicaid Services Innovation Center. A graduate of the Yale University School of Medicine, he is certified in internal medicine and geriatric medicine. Questions for this interview were provided by members of the SLMMS Council.

SLMM: Why have the ABIM MOC standards changed?

Dr. Baron: Since 1936 the ABIM has regularly changed what we do to ensure we achieve the mission of enhancing the quality of health care by certifying internists and specialists who have the knowledge, skills and attitudes essential for excellence in care. The major change we are implementing in January 2014 is to make sure our process is more continuous. Starting in 1990 the Board formally acknowledged that issuing a credential for life was not very credible. So the Board came up with a time-limited approach with a certificate a doctor could hold for 10 years. Our experience has been that most doctors do not engage with the program until year 8-1/2. From a public credibility point of view and a workflow point of view, it’s not credible to say doctors only need to do something once every 10 years. The purpose of board certification is to create a credential that distinguishes in a publicly recognizable way one group of doctors who choose to meet a set of standards set by their peers, from another group of doctors who do not. The board credential was designed to say, “Let’s get the leading national physicians in the room and let’s try to figure out what our expectations are for an internist. Let’s turn them into a set of assessment tools.” That’s still the core work of the Board. So, in a world where doctors may be asked to demonstrate all sorts of things at more frequent intervals than once every 10 years, the idea that board certification would be just a once-every-10-year credential, is not something that consumers would have confidence in, nor is it something patients would have confidence in, nor would it be very useful to hospitals and medical staffs in sorting out the doctors they want to work with. The Board credential communicates the currency of a physician. Our Board feels strongly that going to a more continuous program is a very important and powerful thing to do.

SLMM: Has the ABIM done any pre-testing or research regarding the time commitment by members to complete the changes to the MOC program?

Dr. Baron: The amount you need to do hasn’t changed that much. What has changed is the frequency with which you do them. Our studies show that physicians will invest between 5 and 20 hours a year to complete the new requirements. Those estimates are based on survey responses and CME submissions for the current MOC products. The year you take your exam, which is still every 10 years, doctors will get credit for the time they presumably spend preparing for it.

SLMM: Can you describe the governance structure of the ABIM?

Dr. Baron: ABIM’s governance structure changed earlier this year to include a Board of Directors and an ABIM Council. The role of the ABIM Board of Directors is to oversee the overall strategic direction of the organization and support efforts to make MOC and the certification credential relevant and valuable to the broader health-care community and to all the internists who participate in it. The newly formed ABIM Council will guide the policies and procedures for Certification and MOC in all of the disciplines of internal medicine, and ABIM Specialty Boards will develop the standards for the 20 specialties of internal medicine. ABIM also recently adopted new policies to expand our governance to include a wider range of perspectives. In September, the ABIM Council voted that each ABIM Specialty Board will include at least two non-internist members, including both a member of the interprofessional health-care team and a public member with a patient/caregiver perspective. Additionally, in an effort to ensure that Board governance represents the voice of the physician in practice, the Council voted that each of the ABIM Specialty Boards will
include a minimum of one practitioner whose primary practice is in a non-university, community setting. At its October meeting, the ABIM Board of Directors unanimously approved a governance initiative to seek for the first time at least two non-internist members for the Board of Directors.

**SLMM: How did the ABIM and ABMS solicit physician leadership organizations’ input into this initiative prior to its announcement?**

**Dr. Baron:** We regularly meet with and are in communications with the staffs of the American College of Physicians and other internal medicine societies. We have a twice-yearly communications meeting where we hear their concerns about the certification program and we update them on new developments. Many of the things that doctors do for credit under the MOC program are developed by the specialty societies. Many of our board directors and subspecialty directors are officers in subspecialty societies. Physician leaders from these organizations gave input in the process in the sense there are ongoing conversations.

**SLMM: What has been the feedback from ABIM diplomates since the changes to the MOC process were announced?**

**Dr. Baron:** We’ve heard a lot of different things as you can imagine. A lot of doctors are not particularly enthusiastic about what they perceive as one more organization making rules. However, most of the doctors we work with actually are performing the activities we are asking of them. Many doctors are using the ACP medical knowledge self-assessment program to stay up to date on internal medicine. I and our staff agree with a lot of the criticism we are hearing, and we are in the process of making some fairly big changes in the program. But we also know that the program in its current form is providing value for the internists who go through it. For example, we’ve had over 6,000 diplomates respond to surveys about their experience with ABIM’s Practice Improvement Modules (PIMs), and 84% indicated that their practice changed as a result of completing the module. Also, 84% responded that they would recommend the module to a colleague.

**SLMM: The AMA House of Delegates in June adopted a resolution encouraging the ABMS and all its specialty boards (including ABIM) to provide full transparency regarding the costs of administering MOC, and requesting that the process does not result in significant financial gain to the specialty boards. What is ABIM’s response?**

**Dr. Baron:** We have a major transparency initiative under way. As a nonprofit, our IRS Form 990 already is in the public domain in Guidestar (www.guidestar.org). Next year, on our website you will find financial and governance information our committee charters and more information on our process for developing questions. We are investing significant organizational resources in putting more information on the website.

**Local Leaders Share Concerns on MOC**

Local physician leaders are responding to concerns about Maintenance of Certification requirements.

Joseph Drozda, MD, (SLMMS), director of outcomes research for Mercy, has been involved in the issue as a member of the American College of Cardiology board of trustees. “The leadership of the ACC has heard loud and clear the concerns of our members over the burden and cost of MOC and has transmitted those concerns to the ABIM. We are at this point optimistic that we have been heard and that ABIM is willing to discuss modifications of the program,” he said.

Dr. Drozda also serves on the board of the National Cardiovascular Data Registry and the ACC’s Clinical Quality Committee, and is on the ACC’s new Education Quality Review Board which is bringing together the ACC’s continuing education and clinical quality programs and the NCOR registries to help support members’ MOC efforts.

A key concern is recognizing the daily learning activities that physicians perform as part of practice. Victoria Fraser, MD, (SLMMS), chairman of the Department of Medicine at Washington University, said, “The boards need to do more to allow physicians to demonstrate their ability to incorporate knowledge into their practices and not be so restrictive as to what physicians need to be recertified. Physicians almost every day do research online in best practices and therapeutics.”

She added, “These programs are very expensive and time-consuming. It is not always feasible for a physician to take significant time away. They have to be designed with a realistic time frame in mind.”

The quality improvement component of MOC should link closely with the physician’s daily practice, Dr. Drozda said. “The ideal maintenance of certification tool would provide a snapshot of what the physician and care team are actually doing in the process of providing care to their patients.”

MOC also needs to take into account different practice settings, Dr. Fraser noted. “Physicians in an academic setting regularly conduct knowledge-related activities such as presenting lectures. The programs should be flexible to account for this. It shouldn’t be a lot of extra work.” The Medical School is working on applying to the ABIM for an MOC module that would apply to the academic setting.

“I think that all of this is fixable and that ABIM is listening,” Dr. Drozda said. “Professional societies need to step forward and represent their membership and work with the boards to come up with creative solutions. They also need to assist their members by finding ways to make it easy for them to meet their MOC requirements.”
SLMM: The great majority of physicians’ CME activities do not qualify for MOC credit, such as real-time bedside activities including PubMed searches, reading textbooks, and using medical reference tools embedded in many EHR systems. How does the ABIM plan to help bridge this gap and reduce the extra work for physicians?

Dr. Baron: ABIM currently offers over 200 non-ABIM options for MOC credit, while in 2008 a diplomate only had about 20 non-ABIM options for MOC credit. We are evolving our criteria as rapidly as we can to recognize additional products, as well as activities that doctors may be performing in the hospital or in their practice. But these must be meaningful activities with a meaningful level of physician engagement. That is not always easy to discern. We are moving quickly in this area because we know doctors are doing a lot of things that are relevant, but at the same time you have to have standards.

SLMM: Can you give some examples?

Dr. Baron: The ABIM Point-of-Care Clinical Question Module, a web-based tool available to all diplomates enrolled in MOC, provides MOC credit for documenting the pursuit of clinical questions that arise from physicians’ day-to-day practice. ABIM is also in the process of reviewing non-ABIM point-of-care modules and clinical decision support tools for potential MOC credit. In addition, starting in 2014, diplomates in fellowship training will earn MOC points upon completion of each eligible fellowship year. Diplomates can also earn MOC points in the year in which they study for and take the exam.

SLMM: Does the ABIM credit activities certified by the ACGME for MOC points, such as specialty educational conferences and grand rounds?

Dr. Baron: Although diplomates do not earn MOC credit for attending conferences, they can earn MOC points by participating in Maintenance of Certification Learning Sessions, which are often offered at medical society meetings. Some medical societies have also developed "core curriculum" products closely linked to their conferences. ACCME-accredited activities are not automatically granted MOC points, but the provider of the activity can submit an application to ABIM for consideration.

SLMM: The AMA also asked that any changes in MOC policy not result in significantly increased cost or burden to participants. Our physicians believe that doubling the number of hours of MOC credit required is more burdensome. How does the ABIM plan to address this?

Dr. Baron: We have heard that concern. Again, it appears that most of our diplomates are earning their 100 points in one to two years. In some ways, enforcing a two-year cycle makes it less burdensome because it will spread out the work. Some additional work is expected and we are changing the point scoring. We are requiring 100 points in five years; it was 100 points in 10 years. At the same time we are giving points for things we didn’t use to, like studying for the exam. It’s not a straight one-for-one proposition. But most importantly, spreading it over time will make the process feel less impossible for people. Also, our fees are among the lowest of all specialty boards. We are not planning to raise our fees any time soon; we plan to make the program work with the resources we have.

SLMM: What is planned to address the concerns of physicians who carry multiple board certifications?

Dr. Baron: If you have multiple ABIM certificates or are dual-boarded by ABIM and another ABMS member board, in most cases the only difference is the person with two certifications has to take two exams. All points count toward both certificates. It is important to remember that this is a voluntary program. People need to decide which certificates they will maintain. For the purposes of their practice, most doctors don’t need to maintain more than a couple.

SLMM: Is there any other information you want to add?

Dr. Baron: We know that physicians are frustrated and feeling under the gun. We believe they have a stake in this enterprise. I was in community practice for 30 years and voluntarily recertified in 1998. I wanted to see if I knew what I needed to practice. It did take a lot of time studying. But that professionally driven process gave me an enormous amount of pride. ABIM is of the profession and serves a public mission. We work with the internal medicine societies but are also independent. We are driving a lot of changes toward transparency and in the structure of our product. It’s never as good as it needs to be. It will be better than it is, and we will keep trying to make it better.