American Board of Internal Medicine®

Liaison Committee on Certification and Recertification (LCCR)

November 5, 2018

American Board of Internal Medicine®

Welcome

Dr. Bruce Leff
Chair, ABIM Geriatric Medicine Specialty Board
Chair-Elect, ABIM Council

Today's Agenda

- 8:00 am Light Breakfast
- 8:30 am Welcome and Introductions
- 8:40 am Update from the President
- 9:20 am Maintenance of Certification (MOC) Update
- 10:00 am Break
- 10:15 am Innovations in Continuing Medical Education
- 12:00 pm Lunch
- 12:45 pm Society Partnership Opportunities – Range of Co-Creation
- 2:00 pm Break
- 2:15 pm Communications Update: Working Together to Deliver a Unified Message
- 3:00 pm Open Discussion/Town Hall with Members of the ABIM Council

Program Planning Committee

Thanks to a great team for planning and participating on this important committee!

Ed Dellert, American Society of Gastrointestinal Endoscopy

Dolores Jones, American Association of Clinical Endocrinologists

Nancy Lundebjerg, American Geriatrics Society

Margaret Wells, American College of Physicians

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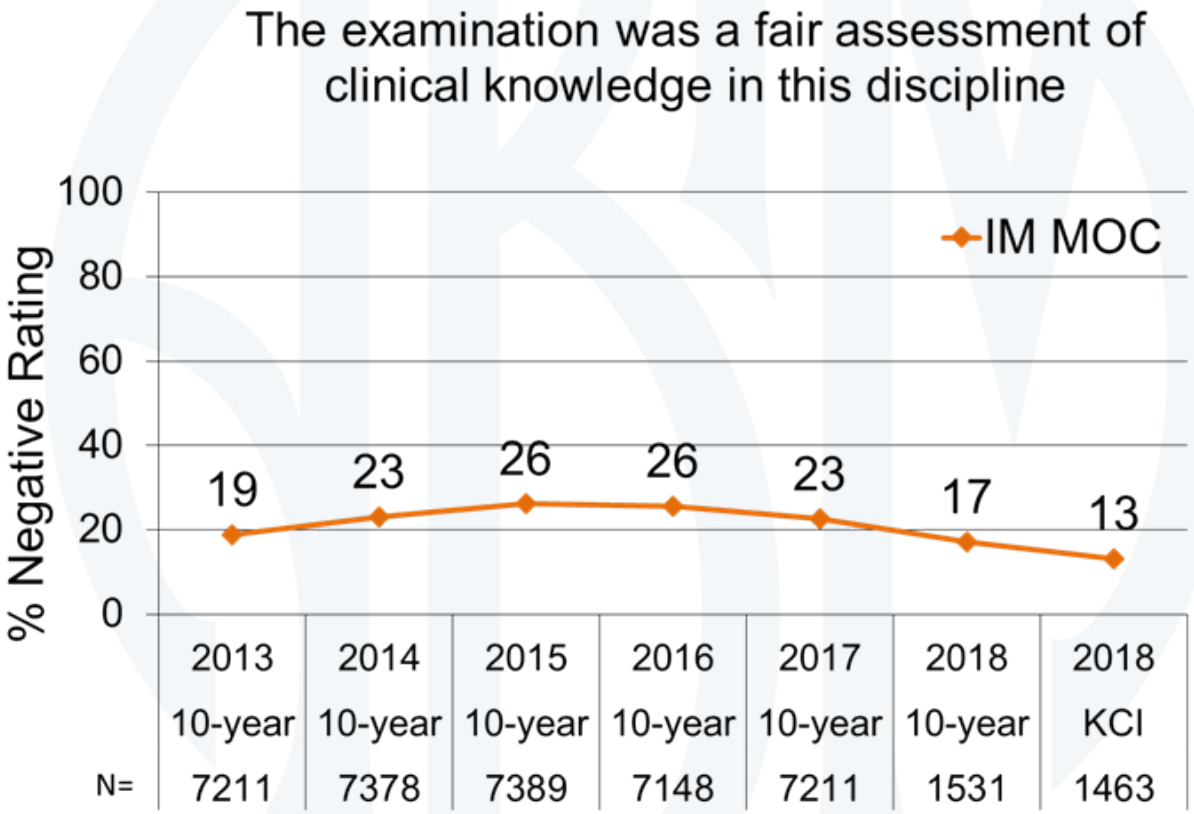
Update from the President

Dr. Richard J. Baron
ABIM President and CEO

IM KCI – Examinee Feedback (June + September 2018)



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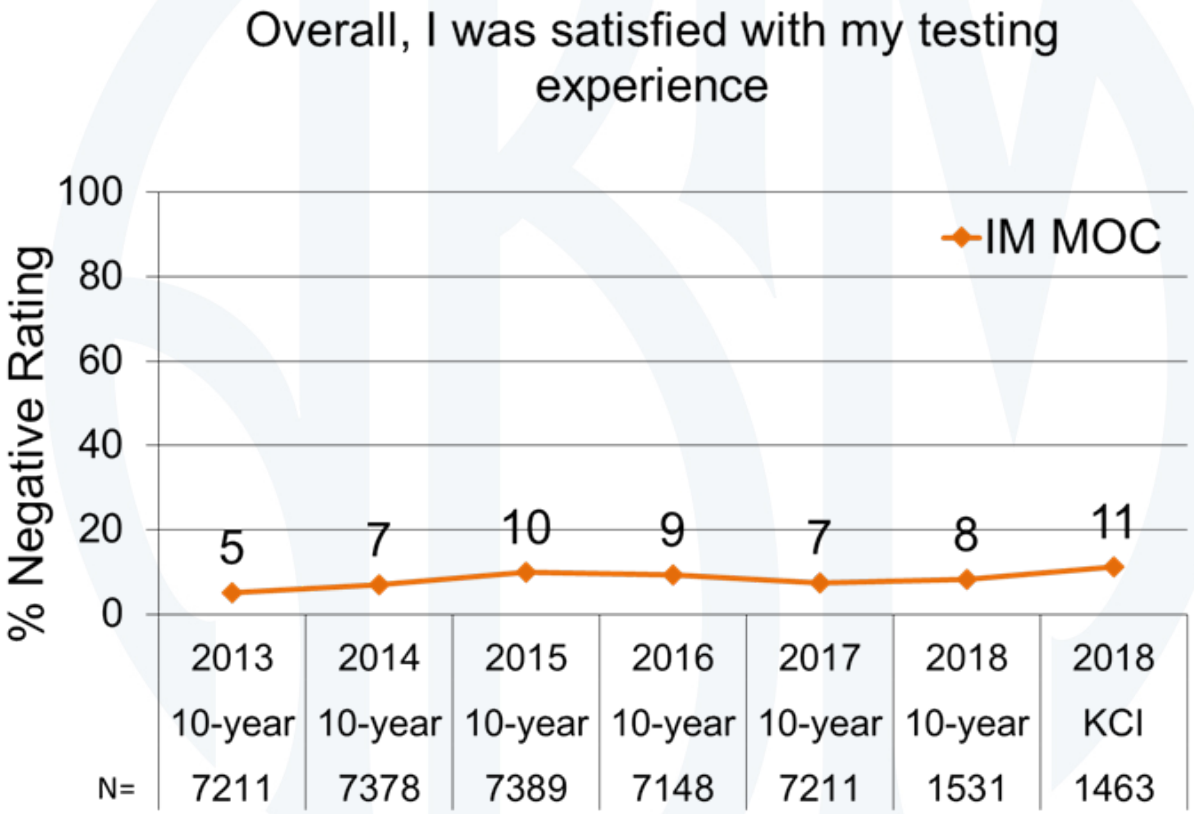
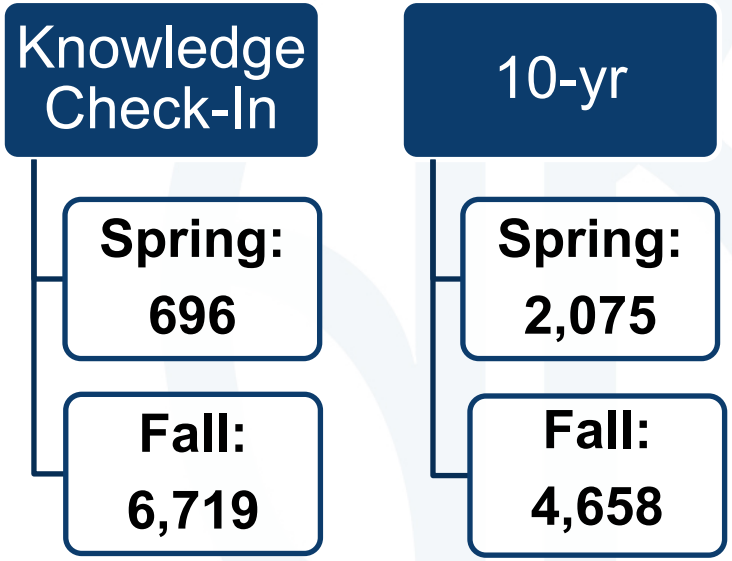
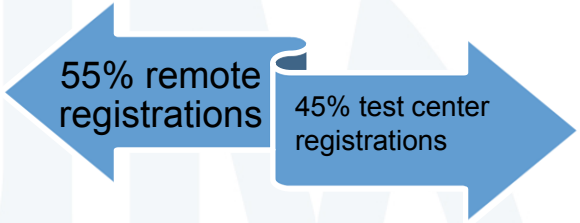


KCI Metrics

2018 Knowledge Check-In and 10-yr registrations:



2018 Knowledge Check-In Remote and Test Center registrations:



Breakdown of diplomates registered for 2018 Knowledge Check-In:

58% due in 2018
31% due in 2019
7% due in 2020
3% due in 2021 - 2027
<1% Grandfather

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MOC PROGRAM UPDATES

ABIM

MOC PROGRAM UPDATES

New Certification Re-entry Pathway Coming in 2019

Physicians that have had any certificate lapse will be able to meet their assessment requirement by passing two consecutive KCIs.

This new pathway was communicated to diplomates in October 2018.

Ways to Reinstate a Lapsed Certificate

PHYSICIANS	2019	2021	NEXT STEP
A 	 PASS TRADITIONAL MOC EXAM	 No Assessment Required	 2029 Certified, Assessment Due in 10 Years
B 	SPRING  PASS KCI FALL  PASS KCI	 PASS or FAIL Knowledge Check-In	 2023 Certified, Assessment Due in 2 Years
C 	 PASS Knowledge Check-In	 PASS Knowledge Check-In	 2023 Certified, Assessment Due in 2 Years
D 	 PASS Knowledge Check-In	 FAIL Knowledge Check-In	 Not Certified, must pass TWO CONSECUTIVE KCIs to become certified again
E 	SPRING  PASS KCI FALL  FAIL KCI	SPRING  PASS KCI FALL  PASS KCI	 2023 Certified, Assessment Due in 2 Years

Changes Going into Effect in 2018

- Diplomates will be able to take the **KCI and the 10-year MOC assessment** and/or **multiple KCIs in the same year**.
- Diplomates will be able to be **unsuccessful on multiple KCIs** without being forced to the 10-year MOC assessment, as long as it has been **less than 10 years since they last passed an assessment**.
- Diplomates will be able to **switch from the KCI** back to the 10-year pathway **without loss of their original assessment due date** as long as it has been < 10 years since they last passed an assessment.
- Diplomates will be able to meet their 100 MOC point requirement using **any combination of Medical Knowledge and Practice Assessment points**.

Diplomates will be able to take the KCI and the 10-year MOC assessment and/or multiple KCIs in the same year

2010	2020		NEXT STEP
Earned Initial IM *Due 2020* 	**FAILED** Spring KCI 	**PASSED** Fall KCI 	**Certified**, *Assessment Due in **2 Years*** 
Earned Initial IM *Due 2020* 	**FAILED** Spring KCI  	**PASSED** Fall MOC exam 	**Certified**, *Assessment Due in **10 Years*** 

Fail multiple KCIs Before Due Year, No 10-year

2014	2020	2022	2024
Earned Initial IM *Due 2024* 	**FAILED Fall KCI** 	**FAILED Fall KCI** 	**PASSED Spring KCI**  **Certified**, *Assessment Due in **2 Years***

Switch Back to 10-year Without Losing Time

2013	2020	2022	2023
Earned Initial IM ***Due 2023*** 	**PASSED Fall KCI**  *Assessment Due in **2 Years***	 *With switch, assessment Due in **2023***	**PASSED Fall MOC exam**  **Certified**, *Assessment Due in **10 Years***

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Innovations in Continuing Medical Education

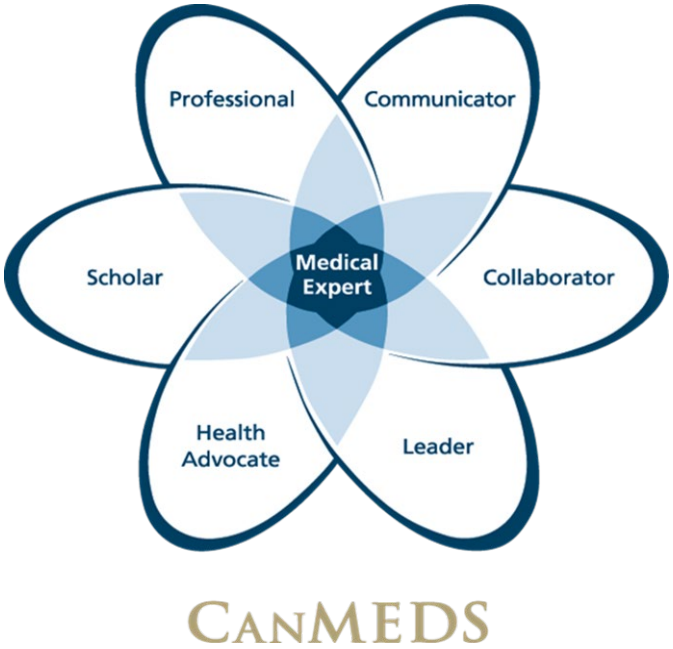
Liaison Committee of Certification and Recertification

November 5, 2018

My outline…

1. Setting the stage
   - A bit about Royal College and me
   - Purpose or anticipated goals for this session
2. Setting the context
   - Challenges to the current CPD system
3. Describe 3 educational practices to help physicians identify and address their individual practice needs
   - Scope of practice
   - Simulation
   - Question asking / goal setting

Setting the stage



My Conflict of Interest

1. I am a full time employee of the Royal College of Physicians and Surgeons of Canada
2. I practice ambulatory general internal medicine at the Ottawa Hospital
3. I have no affiliations or financial relationships with any industry partners
4. I do not hold any grants funded by industry
5. I have numerous biases about Continuing Professional Development

The purpose or goals for this morning

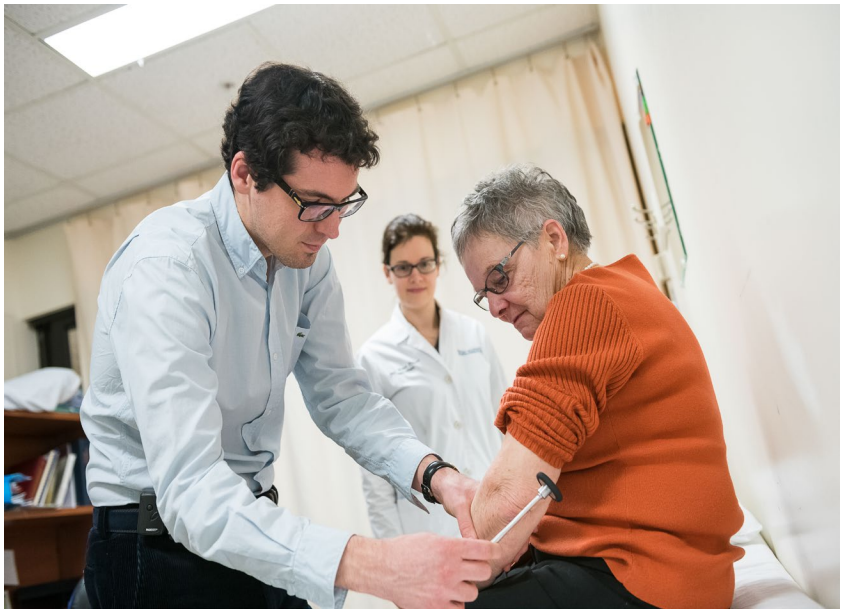
Build upon the April 2018 session provided by Drs. McMahan and Dunning to:

1. Share three (practical) educational strategies designed to support physicians to identify and address their individual practice needs
2. Provide an opportunity for you to consider these strategies in your
   - personal practice or role and
   - Specialty society's educational programs

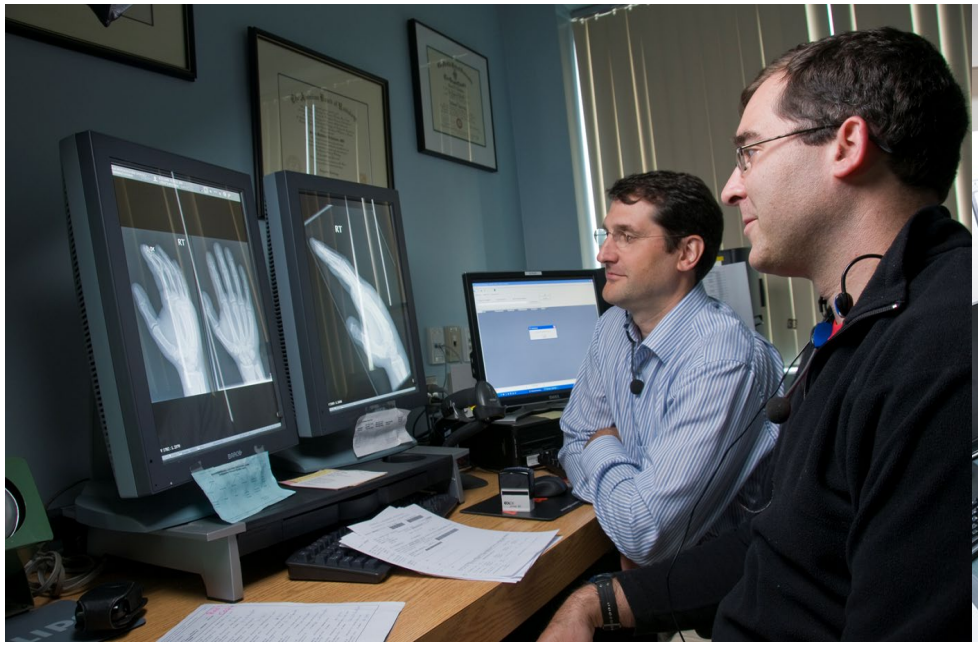
When you think about your continuing professional development what is the first image that comes immediately to mind?

How many of you thought of this?

Or did you think about learning with and from patients?



Or engaging in teaching or collegial conversations?



Traditional Model of CME

Based on an intensive short course model – which is getting shorter!!

Focus: Information (knowledge) dissemination

Given by experts to largely passive participants (limited interaction)

Clinical domain / medical expert

From this picture - what challenges can you see to measuring the impact of formal CME?

Impact of Formal Continuing Medical Education

Do Conferences, Workshops, Rounds, and Other Traditional Continuing Education Activities Change Physician Behavior or Health Care Outcomes?

Dave Davis, MD
Mary Ann Thomson O'Brien, MSc
Nick Freemantle, PhD
Fredric M. Wolf, PhD
Paul Mazmanian, PhD
Anne Taylor-Vaisey, MLS

Context Although physicians report spending a considerable amount of time in continuing medical education (CME) activities, studies have shown a sizable difference between real and ideal performance, suggesting a lack of effect of formal CME.

Objective To review, collate, and interpret the effect of formal CME interventions on physician performance and health care outcomes.

Data Sources Sources included searches of the complete Research and Development Resource Base in Continuing Medical Education and the Specialised Register of the Cochrane Effective Practice and Organisation of Care Group, supplemented by

Our data show some evidence that interactive CME sessions that enhance participant activity and provide the opportunity to practice skills can effect change in professional practice and, on occasion, health care outcomes. Based on a small number of well-conducted trials, didactic sessions do not appear to be effective in changing physician performance.

Davis D, JAMA 1999

Impact of Formal Continuing Medical Education

Forsetlund L, Bjorndal A, Rashidian A

Continuing education meetings and workshops: effects on professional practice and health care outcomes.

Cochrane Systematic Review

First published 2001 32 trials

Update 2009 81 trials

More than 11,000 health professionals

Any intervention including educational meetings compared to no intervention

Median Adjusted RD: 6%

(IQR 1.8 to 15.9%)

Median Adjusted % change: 10%

(IQR 8-32%)

Interactive + Didactic	RD 13.5
Complex Behaviors	RD -0.3
Serious Outcomes	RD 2.5

The contemporary challenges to traditional CME

- Impact on physician performance or patient outcomes is small
- Outcome measures focus more on participation in CPD activities and self-reports of learning or change.
- Limited focus on inter-professional or team-based practice
- Persisting gaps in quality of health care / patient safety

among others…

Graham's point – need a CPD system that supports and nurtures us….

Enhancing Physician Learning to Improve Practice

What defines the concept of curriculum in CPD?

Practice needs of each specialist's (scope of) practice:

Learning and improvement need to be

1. Responsive to patient, population health needs; personal interests and career development plans;
2. Reflective of the competencies required to deliver high quality, safe care.

All practice is contextual. Each practice has unique elements.

Definition of Scope of Practice

A term used to describe:

"the clinical and non-clinical professional roles, responsibilities, activities, abilities, interests, and demonstrated competencies of a health care practitioner"

Royal College working group

2017

Scope of Practice

Includes 4 dimensions:

1. Clinical practice
2. Educational practice
3. Research practice
4. Administrative practice

Over time

- Tends to narrow
- Influenced by changes in
  - Practice context
  - Health system change
  - Population heath needs
  - Scientific evidence
  - Professional interest
  - Age / health status of physicians

Scope of Practice
Some potential practical advantages

Guides reflection on what CPD is required to respond to the needs of practice

Anchors learning and improvement in a workplace

Scope of Practice:
Some potential concerns

Could a focus on 'scope of practice':

1. Undermine sustaining foundational skills or competences expected of all physicians in a specific discipline .
2. Result in an excessively individualistic approach to practice - leading to further 'sub-specialization silos'
3. Fail to address the 'needs' of patients or populations

Graham's message on defining core knowledge or skills

One View of 'Curriculum'

Competences specific to evolving nature of practice

Competences independent of scope of practice

Some potential implications or applications

Scope of Practice: A foundation for developing practice improvement plans

- Description of our scope of practice may helps us to

1. Reflect on practice needs
2. Define goals for improvement
3. Select learning activities to achieve the goal

Focuses CPD on the what physicians are already intending to improve

Practice improvement plans

Responsive to multiple sources of needs (not just interests or wants)

1. Practice context needs
   - Needs defined by patient, population health, institutional requirements
2. Specialty defined needs
   - Competencies relevant to all specialists in a discipline; defined by the discipline
   - Integrating new evidence; learning new things
3. Personally defined needs
   - Interests, curiosity, aspirations, career goals

Translating practice needs into goals for improvement – a new challenge

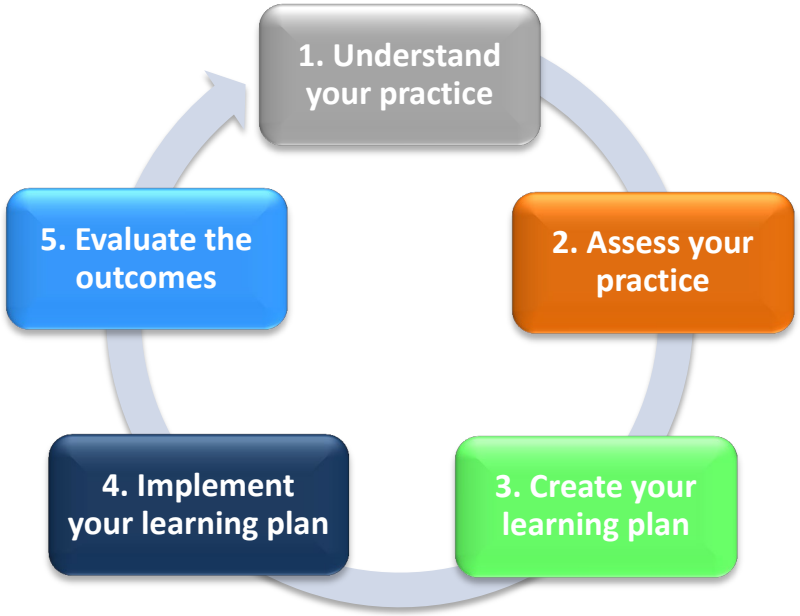
Royal College - Practice Improvement Goal tool

- What aspect of practice is identified for improvement
- The competencies that will be addressed by pursuing this goal
- The plan to improve (includes the selection of CPD activities)
- The anticipated barriers and measures of success
- A timeline for completion

THEN – reassess to determine the degree of improvement

Re-defining Revalidation (2016)

FMRAC's Physician Practice Improvement Cycle



http://fmrac.ca/wp-content/uploads/2016/04/PPI-System_ENG.pdf

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Scope of Practice: some practical implications for CPD

- Create tools to support descriptions of scope of practice
  - Create sessions designed to respond to physician identified goals for improvement
- Refine our approach to needs assessment:
  - Sample across each sub-domains of a specialty
  - Curriculum map based on the specialty's sub-scopes of practice
- Refine our educational development strategies
  - Curriculum map based on the specialty's sub-scopes of practice

Deliberate practice

"Excellence demands effort and planned, deliberate practice of increasing difficulty."

K. Anders Ericsson

How physician's learn new skills, abilities and competencies in practice

When you hear the word “simulation’ what immediately comes to mind?

What is simulation?

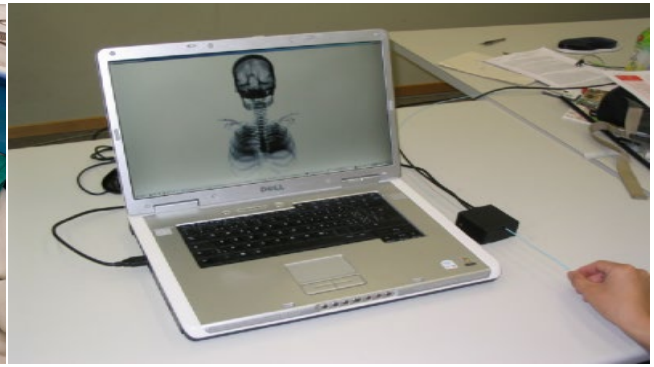
- “Something that is made to look, feel, or behave like something else especially so that it can be studied or used to train people”

www.merriam-webster.com

What is simulation-based education?

- Simulation-based education is the use of a number of modalities to re-create some component of the clinical encounter for the purposes of training or assessment.





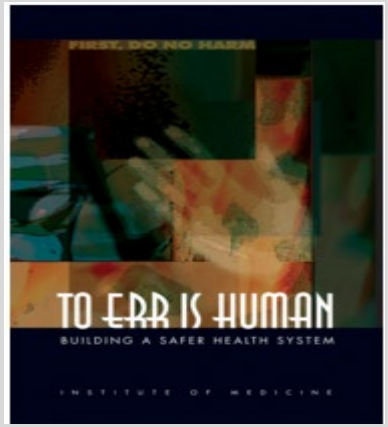
LeBlanc VR (2012) Review article: simulation in anesthesia: state of the science and looking forward. *Canadian journal of anaesthesia* 59(2): 193-202.

Feedback and Coaching

- “They observe, they judge, and they guide”
- “That one twenty-minute discussion gave me more to consider and work on than I’d had in the past five years”
- “Medical practice is largely unseen by anyone who might raise one’s sights. I’d had no outside ears and eyes.”

Atul Gawande, New Yorker 10/3/2011

Why Simulation: Drivers



Quality health care and Patient Safety

Competence by Design
EXCELLENCE ACROSS THE CONTINUUM

Competency based medical education

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MOC PROGRAM
LE PROGRAMME DE MDC

Lifelong learning

Increasing focus on assessment of competence

The social aspect of learning

- Simulation as social practice

Dieckmann, Gaba & Rall (2007). Deepening the Theoretical Foundations of Patient Simulation as Social Practice, *Simulation in Healthcare*, 2: 183-193.

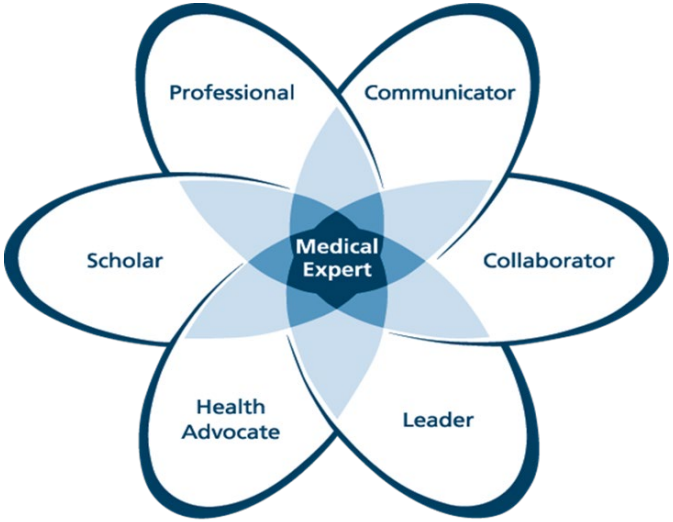
The applications for simulation training

- Procedural skill development
- Critical Incident analysis
- Leadership skills
- Communication Skills
- Decision Analysis / clinical judgment
- Team-based care
- The patient's journey

Frequently includes direct observation with debriefing (feedback)

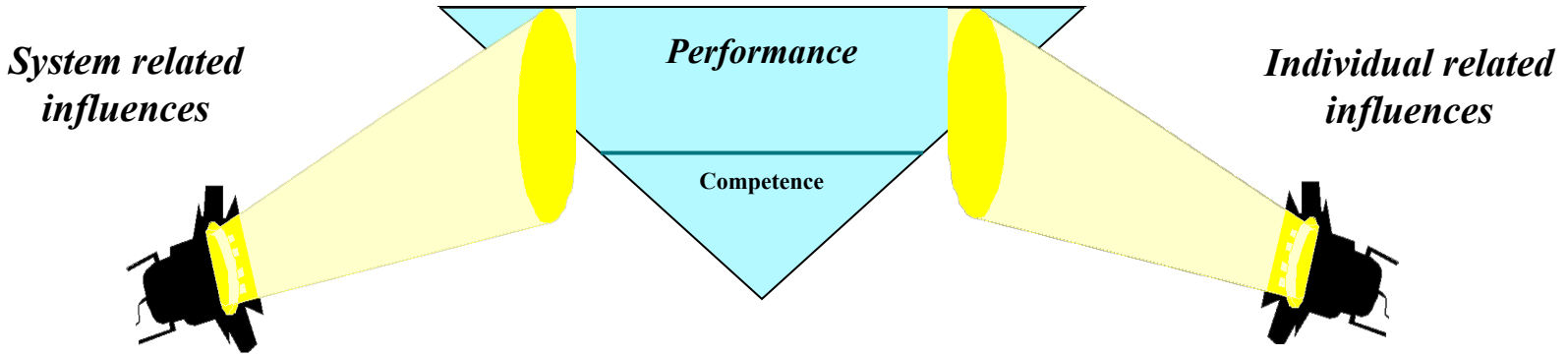
Simulation and Competency-based Continuing Professional Development

Component of a ‘program assessment’ model that aligns multiple data sources with specific CanMEDS competencies



Role for simulation will vary across specialties

Cambridge Model: "Righting" the Pyramid



Work-based assessment has to be a larger part of our future if we are to make meaningful gains in quality and safety

Rethans, Norcini, et al, 2002

Work-based Assessment ‘for Learning’…

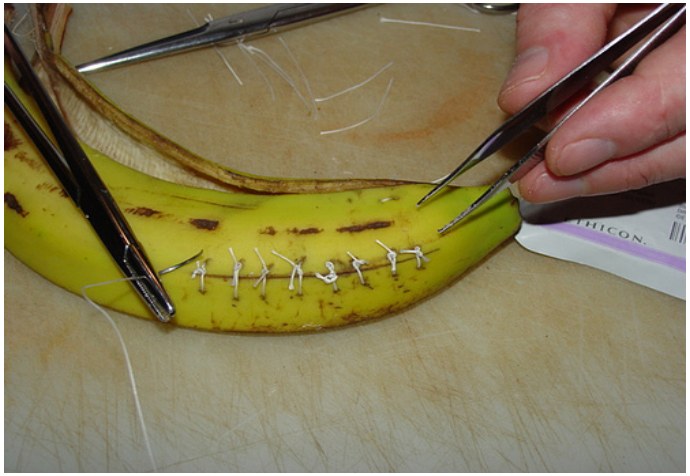
- Practice audits
  - Patient Registries
  - Prescription Monitoring Programs
- Multi-source feedback
- Simulation- based education
- Direct Observation – including videotaping
- Patient experience surveys
- Patient-reported outcome measures
  - Functional status

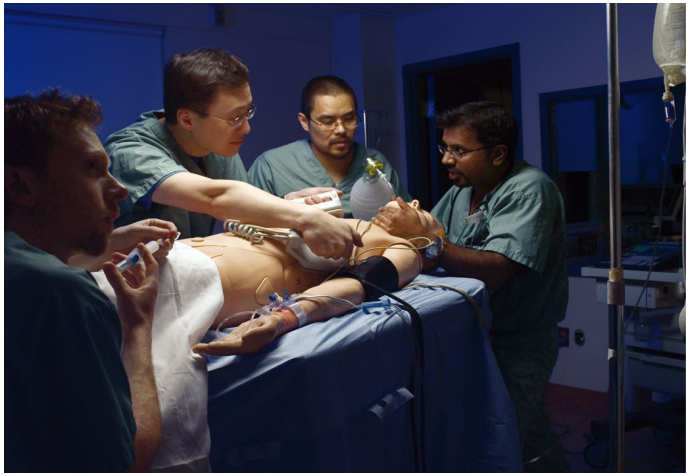
Simulation – is not just one thing

- Standardized patients
- Virtual reality task trainers
- Task trainers
- Screen-based simulations / virtual patients
- Theatre based
- Hybrid simulation

Variety in the complexity of the technology used

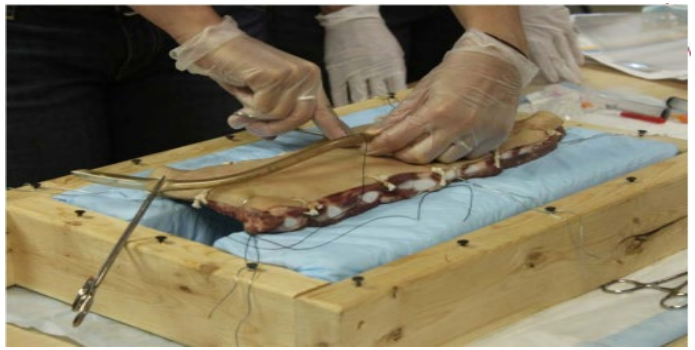
The many modalities of simulations

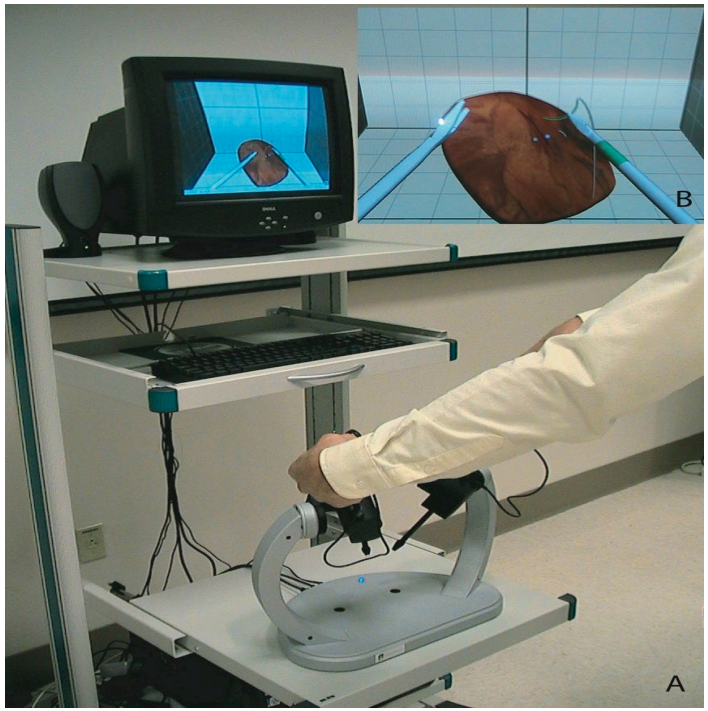




Variety in the complexity of the technique and technology used

Task Trainers

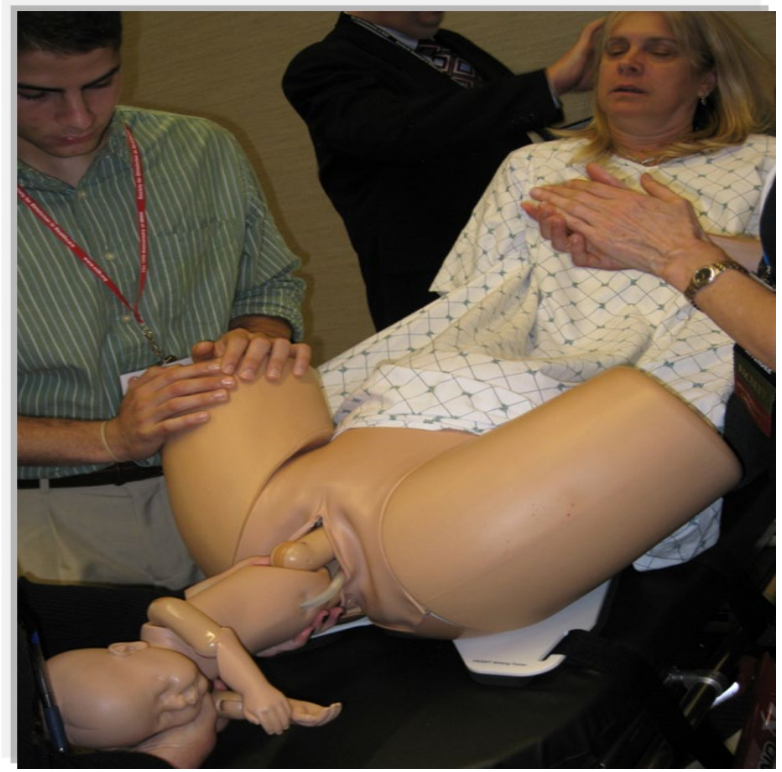




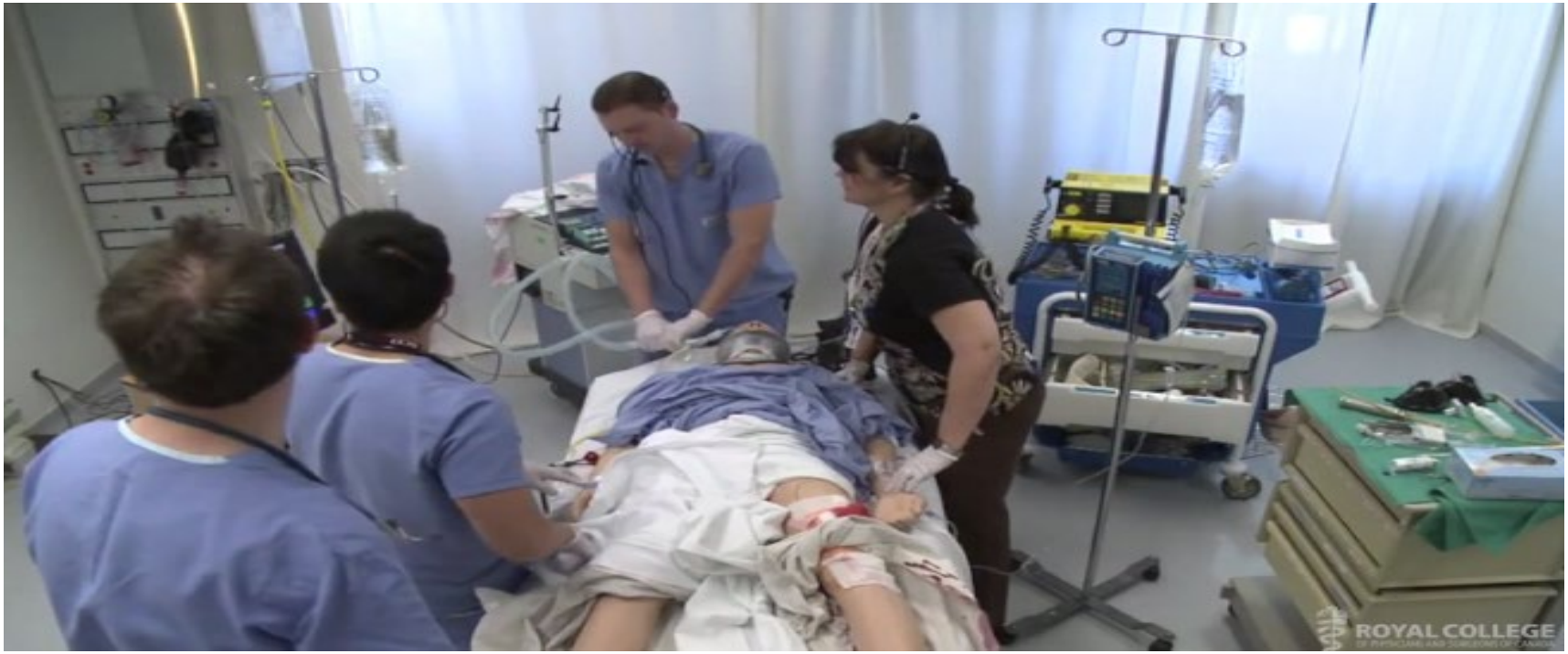
Standardized Patients

- Trained lay people
- Well established for training and assessment

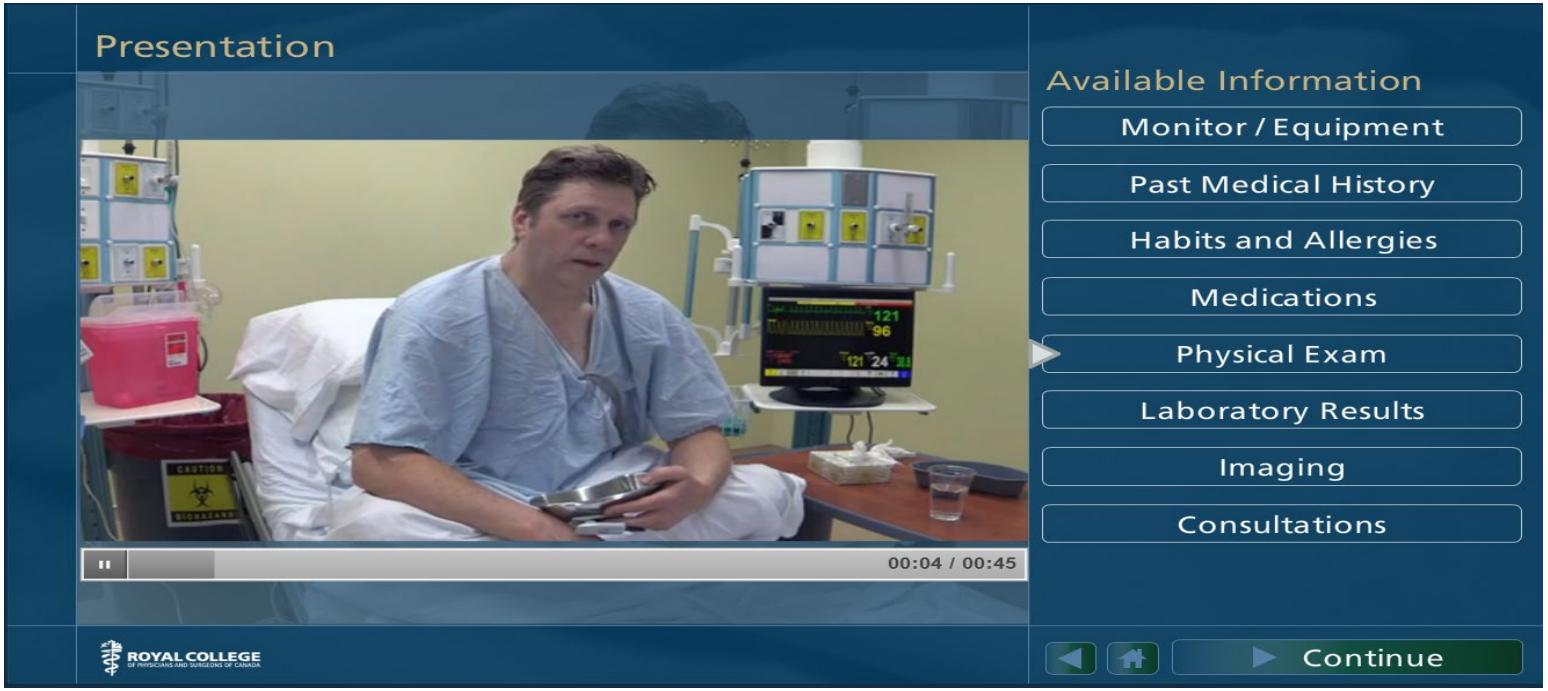
Hybrid – Be creative



Team training

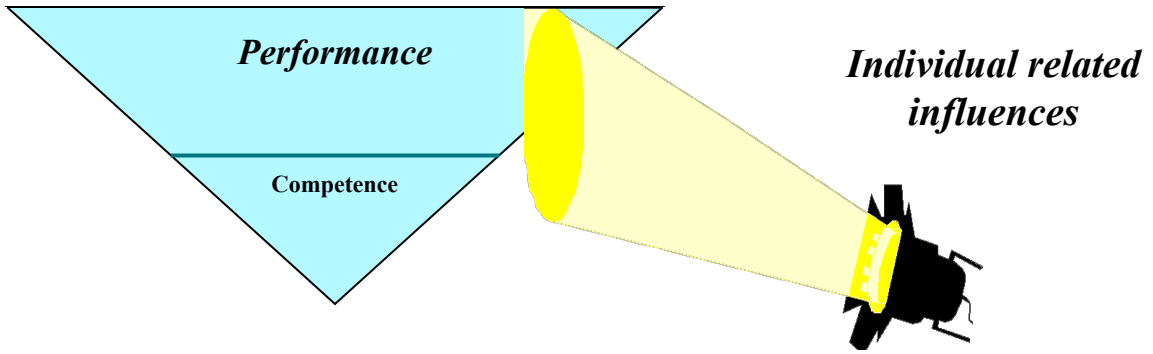


Virtual patients



http://www.royalcollege.ca/portal/page/portal/rc/resources/ebola/e-learning_modules

Cambridge Model: "Righting" the Pyramid



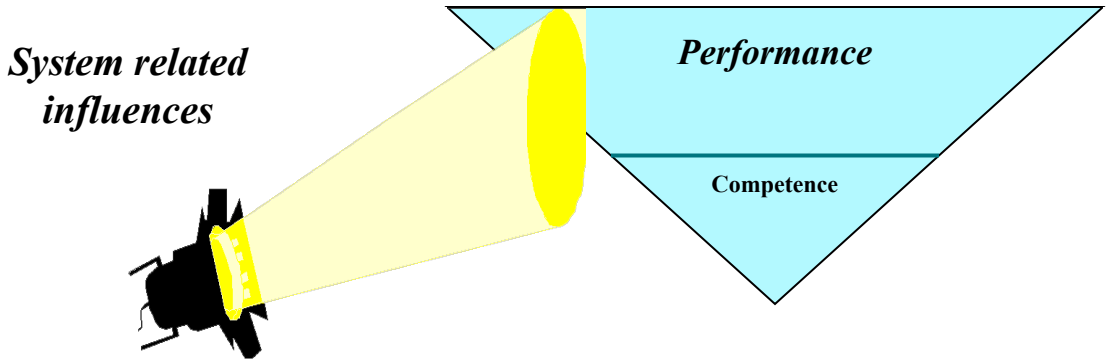
Virtual Patients; Standardized Patients; Games, Case-based CPD

A strategy for physicians to reduce diagnostic error

Assess the application of best evidence

How we can best explain the evidence to patients / families

Cambridge Model: "Righting" the Pyramid



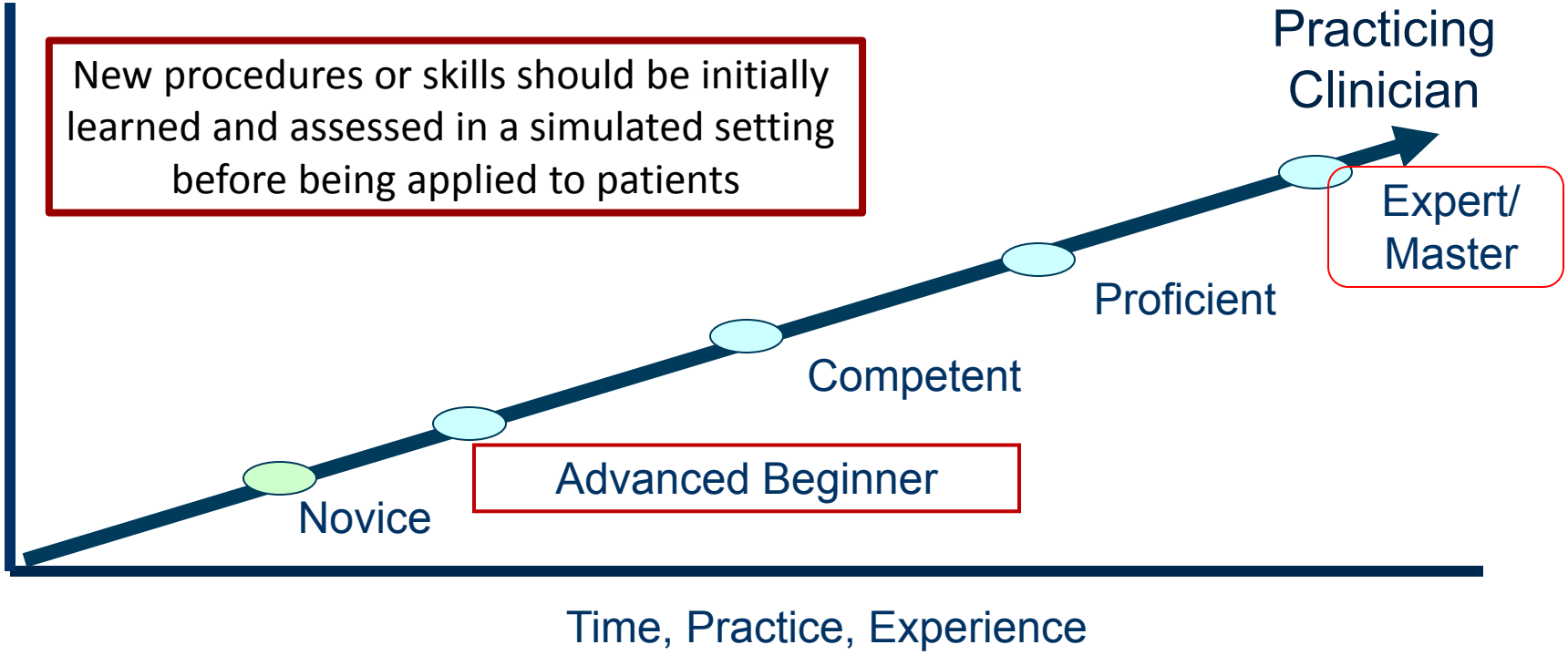
In situ simulation; high fidelity simulation

Assess the efficiency of health care delivery processes;

Facilitate the consistent application of patient safety measures

Promote team-based communication and care delivery

Simulation – A Critical Role when learning new things!



Dreyfus SE and Dreyfus HL. A 1980
Carraccio CL et al. Acad Med 2008;83:761-7

Rationale for simulation / work-based assessments in CPD

To enable us individually and collectively to pursue important outcomes

Donald Moore's Framework

CME Framework		Description
Participation	**LEVEL 1**	The number of healthcare professionals who participated in the CME activity or program.
Satisfaction	**LEVEL 2**	The degree to which the expectations of the participants about the setting and delivery of the CE activity or program were met.
Learning	**LEVEL 3a** Learning: Declarative Knowledge	The degree to which participants could demonstrate that they **know what** that the CE activity or program intended them to know.
	LEVEL 3b Learning: Procedural Knowledge	The degree to which participants could demonstrate that they **know how** to do what the CE activity or program intended them to know how to do.
Competence	**LEVEL 4**	The degree to which participants could **show** in an educational setting **how** to do what the CE activity or program intended them to be able to do.
Performance	**LEVEL 5**	The degree to which participants could **do** what the CE activity or program intended them to be able to do in their practices.
Patient health	**LEVEL 6**	The degree to which the health status of patients improves due to changes in the practice behavior of participants.
Community health	**LEVEL 7**	The degree to which the health status of a community of patients changes due to changes in the practice behavior of participants.

(Moore et al., 2009)

Some potential practical implications

Embed simulation within group learning – practice the skills / competencies in the educational setting

- Task Trainers
- Standardized patients / role play
- High fidelity – where applicable….

Use virtual platforms – to assess application of evidence / skills learned in CPD

- Virtual cases – responsive to your decisions or actions

Self-Assessment in CPD

Self-assessment is conceptually viewed as an entry step into a learning cycle…

To identify an area of professional weakness

To guide selection of CPD activities

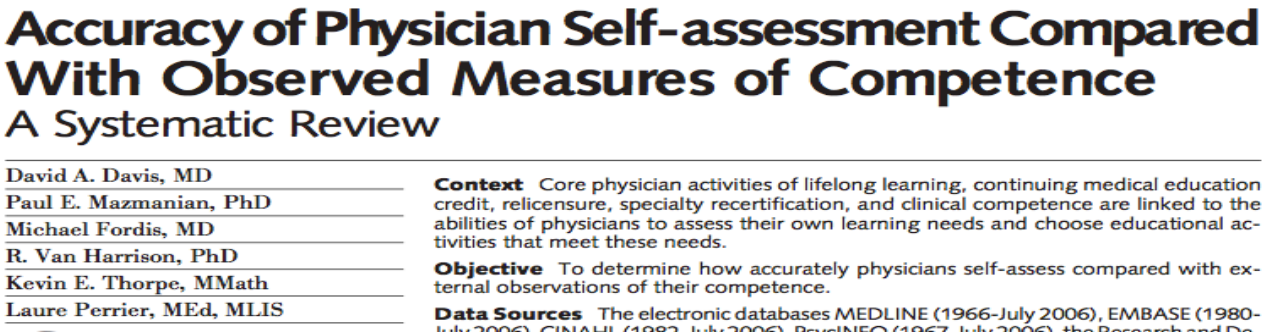
To enable address practice gaps

Self-assessment is used to describe an ability to reflect on and make overall judgments on performance or ability

Eva K. JCEHP 28 (1) 2008

Think of the research provided by Dr. Dunning!

Davis et al JAMA 2006



Accuracy of Physician Self-assessment Compared With Observed Measures of Competence

A Systematic Review

David A. Davis, MD
Paul E. Mazmanian, PhD
Michael Fordis, MD
R. Van Harrison, PhD
Kevin E. Thorpe, MMath
Laure Perrier, MEd, MLIS

Context Core physician activities of lifelong learning, continuing medical education credit, relicensure, specialty recertification, and clinical competence are linked to the abilities of physicians to assess their own learning needs and choose educational activities that meet these needs.

Objective To determine how accurately physicians self-assess compared with external observations of their competence.

Data Sources The electronic databases MEDLINE (1966-July 2006), EMBASE (1980-

- While suboptimal in quality, the preponderance of evidence suggests that physicians have a limited ability to accurately self-assess.
- The processes currently used to undertake professional development and evaluate competence may need to focus more on external assessment.

Self-Assessment in Practice

How accurate are decisions to pause and learn before acting?

"Knowing when to look it up: a new conception of self-assessment ability."

Eva, Regehr, Academic Medicine 2007

Focus on:

- Situational awareness when at the limits of knowledge, ability, experience OR
- When confidence in ability is lacking.

Definition of Self-Monitoring in Practice

"the moment-by-moment awareness of the likelihood that one has the requisite knowledge / skills to act in a particular situation."

Conclusion:

Greater accuracy in self-monitoring than any global aggregation of performance.

Eva and Regehr

Adv Health Sci Educ Theory Pract. 2011

So what do physicians frequently do when they come off auto-pilot?

They frequently ask themselves a question!
or
Frame the issue or concern as a problem statement

In the past week – can you identify a question
you have raised but not yet answered?

Questions: A strategy to translate reflection into action

Why questions?

- A common practice among physicians
- An expression of one's identified need
- Help us to resolve 'uncertainty'

Fundamental skill of effective lifelong learners

The Importance of Questions

- Although estimates are variable, physicians ask an average of 15 questions/25 patients seen.
- Approximately 2/3 of questions generated at point-of- care go unanswered
- Barriers include a lack of appropriate resources, time, and an inability to formulate answerable questions

Key Authors: Ebell, Covey

Learning from questions: requires multiple competencies

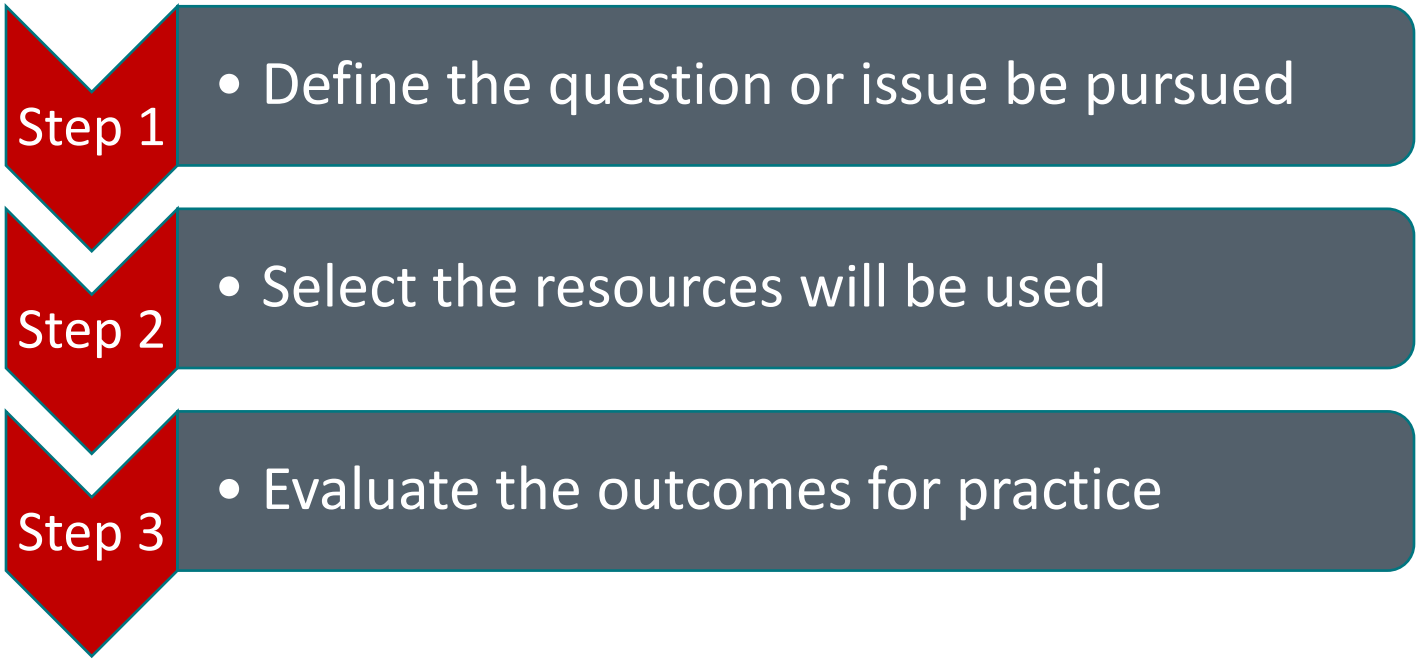
1. Recognise a potential gap in knowledge or skill
2. Formulate an answerable question(s)
3. Search for and track down relevant information / best evidence
4. Critically appraise the evidence
5. Formulate an answer to the question
6. Apply what was learned.

Royal College's CPD Framework

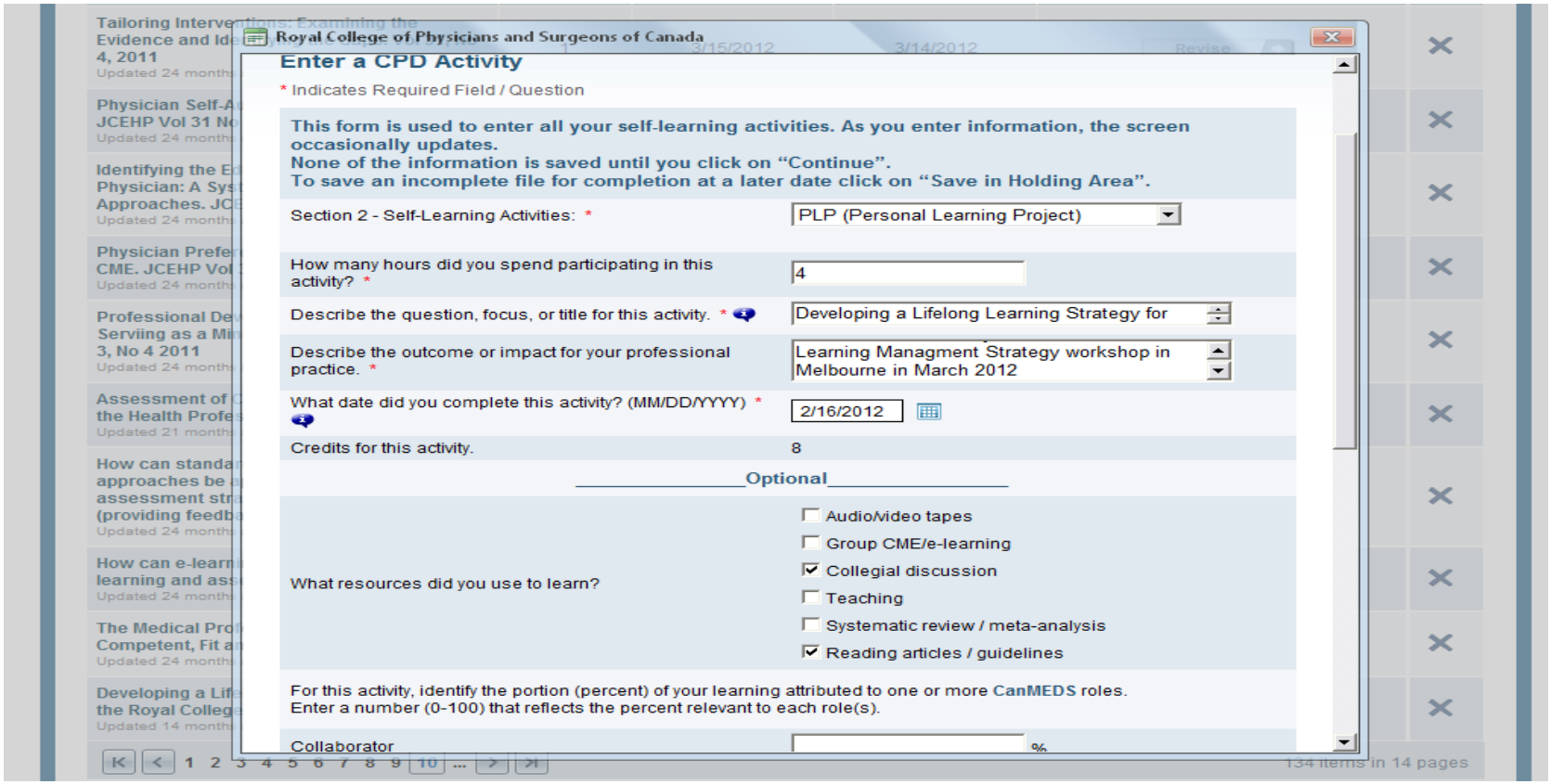
Section 1 Group Learning	Section 2 Self-Learning	Section 3 Assessment
Accredited Group Learning	Planned Learning	Knowledge Assessment
Unaccredited Group Learning	Scanning Activities	Performance Assessment
	Systems Learning	

The Structure of a Personal Learning Project

- The physician is responsible to:



Recording Personal Learning Projects



MAINPORT Mobile App – Side Toolbar

Tools to support question asking (PICO)

Framing a question or problem statement should consider describing:

✓The population of interest

✓The intervention you are considering

✓The alternative treatment or comparator and

✓The outcome of interest

Tools to translate experience into learning

Multiple options to promote reflection….

1. Tools / apps to capture potential questions – on the run!
2. Tools to document reflection on a question for future learning at the end of:
   - Formal CPD (Conferences, courses, grand rounds, journal clubs, seminars)
3. Reflections on learning or change as part of the evaluation of CPD
4. “Commitment to Change” forms
5. Learning plans.

Questions: A generalizable inquiry based learning strategy

Enables physicians to reflect on …

1. Has my performance improved?
2. Does the care I provide patients reflect best evidence?
3. Are my patients better off?
4. Is where I work safe for patients?

Educational Outcomes

Patient and Health System Outcomes

Small Group Discussion: Questions for you to consider are provided at your tables….

Report Back: Your reflections / discussion on….

1. Scope of Practice
2. Simulation
3. Question asking / goal setting

Need for Culture Change

Building a System of Continuous Learning and Practice Improvement

1. Focused on enhancing competence, performance, patient outcomes
2. Context is one's scope of practice
3. Content is based on evidence, experience
4. Learning process intentionally integrates
    - Formal learning
    - Directed self-learning
    - Assessment

Thank You

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ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA
COLLÈGE ROYAL
DES MÉDECINS ET CHIRURGIENS DU CANADA

American Board of Internal Medicine®

Range of Co-Creation and Collaboration

Richard G. Battaglia, MD, FACP
Chief Medical Officer

Range of Co-Creation and Collaboration

Communication of and engagement in ABIM initiatives

- Standard setting*
- **Blueprint review***
- Offering MOC points for applicable CME activities*
- Governance Recruitment*
- New Approach to Item Development*

Enhancement of programs through an advisory role

- Specialization (Practice Profiles)
- Procedural requirements*
- Blueprint review*

Integration of Formative and Summative Activities

- "Learning links"
- External resources during summative assessment

Collaborative Maintenance Pathway*

- Formative materials
- Content development
- Summative component
- Delivery platform

Resource Commitment

Structured Blueprint Review

- American Society of Hematology
  - Charles Clayton, Chief Professional Development and Diversity Officer

American Society *of* Hematology

Helping hematologists conquer blood diseases worldwide

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Resource Commitment

ACP Podcasts
CME and ABIM MOC

David Disbrow
Director, CME and Education Meetings
American College of Physicians

LCCR | November 5, 2018

American College of Physicians
Leading Internal Medicine, Improving Lives

Podcasts


FEATURED LEARNING
NEW
Podcasts
Touching on a wide range of medical topics, ACP now offers free monthly podcast episodes for ACP members.
THE CURB SIDERS INTERNAL MEDICINE
BEDSIDE
ROUNDS
Annals On Call

Process

At least 5 business days prior to podcast release date, the following info is approved by two external reviewers:

- CME Application
- COI disclosure forms (guests, quiz writers, etc.)
- Signed letter of COI resolution
- In-depth Show Notes

Key Benefits

- Inexpensive
- Popular learning format – *over 2500 MOC points*
- Quick process turnaround allows for timely information

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GOVERNANCE

ABIM's governance structure consists of more than 350 members on more than 50 boards and committees and includes physicians, allied professionals and public members. Individuals who are appointed to serve on ABIM boards or committees are expected to have ABIM's mission as their primary interest when contributing to ABIM's work and therefore must adhere to our Board Policies. In order to more effectively achieve its mission, ABIM has adopted a governance structure that consists of six entities:

Board of Directors

The size of the ABIM Board of Directors varies from 12 to 15 members. Membership is comprised of leaders in quality improvement, health delivery systems, medical education and other important aspects of internal medicine. A majority of Directors must have current clinical practice experience and at least 30 percent of the Directors have experience with ABIM exam development. Up to 20 percent of members may be non-internist or public Directors. All physician Directors must meet the requirements of the Maintenance of Certification program.

The Board of Directors' role is to:

- Determine and advance ABIM's mission and strategic policies, and to ensure the primacy, relevance and value of ABIM Certification.
- Be external-facing and future-focused in setting the direction and strategy for the organization, including setting overall goals and long-range plans for the organization.
- Establish fiscal policy and provide adequate resources for the activities of the organization.

GOVERNANCE OPENINGS

- About ABIM
- Mission
- Governance
  - Governance Openings
  - Board of Directors
  - ABIM Council
  - Specialty Boards
  - Exam Committees
  - Self-Assessment Committees
  - Board Policies
- Executives
- Revenue and Expenses
- About ABIM Exams
- Statistics & Data

Participating in ABIM governance provides a meaningful and rewarding opportunity to join outstanding professional colleagues in service to our patients.

Governance members help define breadth of knowledge of the Board certified internists or subspecialist, provide perspective on trends and scope of their discipline and collaborate with peers to develop the fairest and most up-to-date assessments possible.

If you have a genuine interest in professional development and standard setting for internal medicine and its subspecialties, please consider sharing this site with a colleague or applying yourself to be appointed to an ABIM board or committee.

ABIM strongly encourages candidates from groups under-represented in medicine, as well as physicians who practice in smaller communities or safety-net institutions.

Learn more about these open roles:

EXPAND ALL | COLLAPSE ALL

ABIM Board of Directors

ABIM Council

Range of Co-Creation and Collaboration

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Resource Commitment

New Approach to Item Development

- New strategy for developing exam content
  - Becoming more common
  - Reduce cost and increase productivity
- Models represent a **family of potential items**
  - All items assess the **same testing point**
  - All items considered **interchangeable**

Item Writing Task Forces

- The Item Writing Task Forces are made up of unpaid **volunteers**.
  - There is one Task Force for each examination.
  - **MOC points** are provided for their efforts
- The Task Forces work both independently and in small group webinars to develop and review questions.
- The time commitment is roughly **4-6 hours per month**.
- Societies are encourages to **recommend candidates**. Interested parties can apply through the governance openings portion of our website.

Range of Co-Creation and Collaboration

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Resource Commitment

Specialization/ Practice Profiles

- Endocrine Society:
  - Wanda Johnson, Chief Program Officer
- American Association of Clinical Endocrinologists
  - Dolores Jones, Director of Clinical Education

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Resource Commitment

American Board of Internal Medicine®

Interventional Cardiology Procedural Requirements in Maintenance of Certification (MOC)

History

- SCAI sent a request to the ABIM Cardiovascular Medicine Specialty Board in Spring 2017 to examine current procedural requirements in Interventional Cardiology.

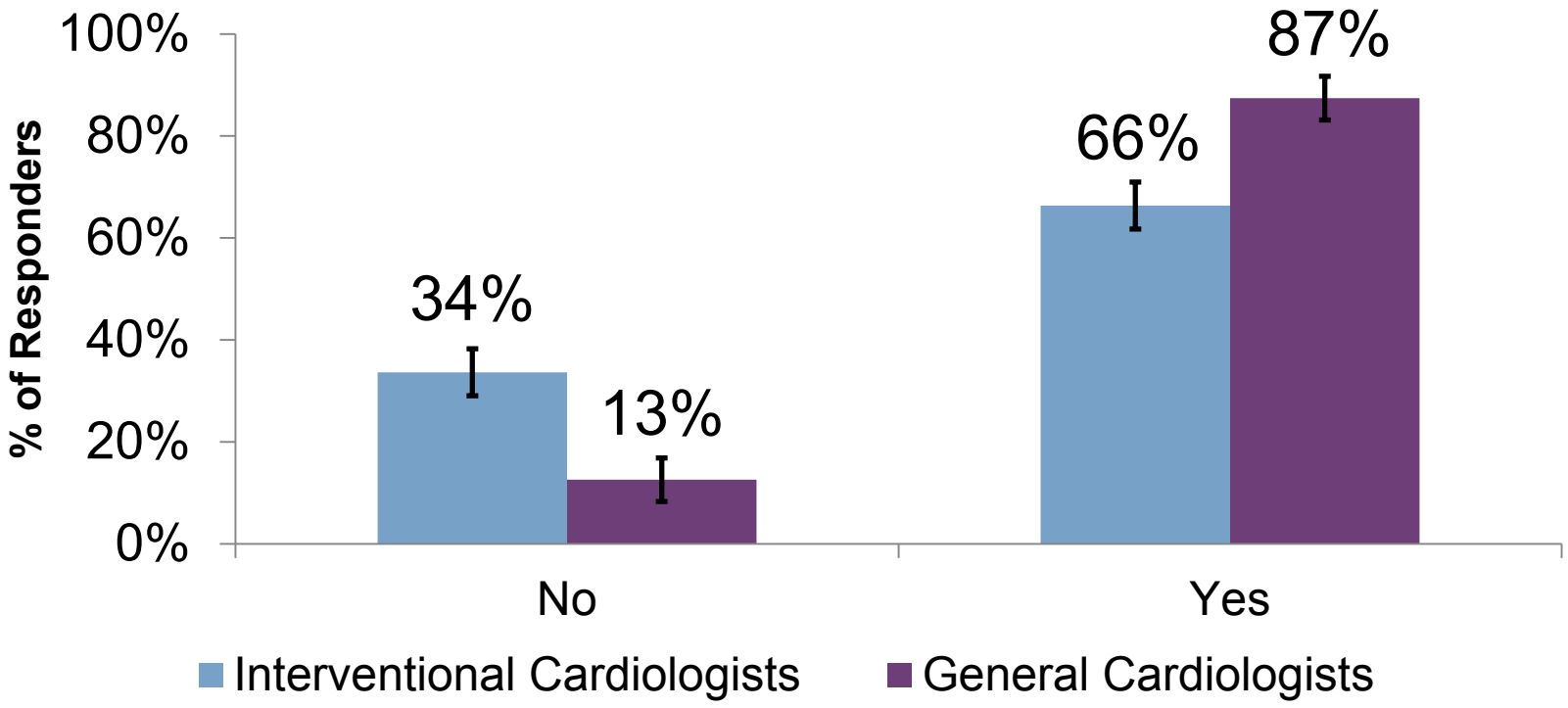
- The topic was discussed at the Spring 2017 Specialty Board meeting. It was agreed to ask for feedback on the topic from the community.

- A letter, jointly developed by SCAI and ABIM, was sent to SCAI members, on behalf of Kirk Garrett, President of SCAI, asking members for their feedback on the current requirements.

Questions to the Community

- Change the procedural requirement?
- Accept new procedures towards the procedural requirement?
- Discontinue the procedural requirement?

Q14: Should There be a Procedural Requirement for MOC?[1]



1. *ICARD: N=300; General Card: N=270*

Error bars are 95% CI's

Outcome

- Specialty Board kept procedural requirement in place (both pathways)

- Specialty Board expanded types of procedures that could be counted toward the requirement

Range of Co-Creation and Collaboration

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Resource Commitment

Learning Links

- Benefit for educational feedback both before and after ABIM assessments
  - Opportunity for a **partnership between ABIM and societies**
- ABIM identifies and communicates physician's areas of strength and **opportunities to close medical knowledge gaps**
  - Offers opportunity for society partners to **create personalized educational paths** to support a physician's in lifelong learning

Society Considerations and Questions

- Range of potential Learning Links collaboration:
  - **List of key references** within a discipline to both drive content development and support studying
  - **Linking/tagging of educational products to the ABIM blueprint**
    - Facilitate tailored education paths for physicians
  - Collaboration on rationales explaining correct answers for released test questions (similar to ABIM's Self-Assessment modules)
  - **Co-branded pre-assessment** allowing physicians to gauge preparedness for an ABIM assessment
- Prototypes are in development
  - Ready for discussion in early 2019

Range of Co-Creation and Collaboration

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- **External resources during summative assessment**

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Resource Commitment

Society Considerations for External Resources

- **Log-in**
  - Users should not have to use individual log-in credentials to access the resource
- **Searchability**
  - Users should be able to use a search function to find something specific they are looking for within the resource
- **Content Access**
  - Content should be accessed without the need for pop-up windows, or new pages
- **Easy Navigation**
  - Users should have the ability to navigate easily from place to place within the resource
  - Hyperlinked table of contents
- **External Links**
  - Users should not be able to access a feature that will allow them to email
  - Users should not be able to access social media (no links to these pages)
  - External links to other content should be as limited as in the first two bullets

Updated External Resources Timeline

- **November to December 2018**
  - **Survey diplomates** in each specialty to ask for input on resources to build on what we learned from societies
  - Gather additional information about access and importance
  - **Select technical solution** for delivering multiple resources
- **January to March 2019**
  - Begin development of technical solution for delivering multiple resources
  - **Materials provided to societies** and other organizations **explaining initial requirements** for external resources that could be incorporated into the assessments
- **May to July 2019**
  - **Submission period** for potential external resources to ABIM for consideration
- **August to October 2019**
  - Identification of resources, and number of resources, to be included for each specialty
  - **Collaborative work with owners** of resources to prepare for inclusion
  - Continued development and technical activities for implementation
- **November to December 2019**
  - Completion of initial development activities and **user testing**
- **March to May 2020**
  - **Potential implementation** for select disciplines with continued roll-out

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Resource Commitment

Collaborative Maintenance Pathway

- American College of Cardiology
  - Janice Sibley, Senior Vice President, Education
- American College of Physicians
  - Davoren Chick, MD, Senior Vice President, Medical Education
- American Society of Clinical Oncology
  - Jamie Von Roenn, MD, Vice President, Education, Science and Professional Development

Questions?

American Board of Internal Medicine®

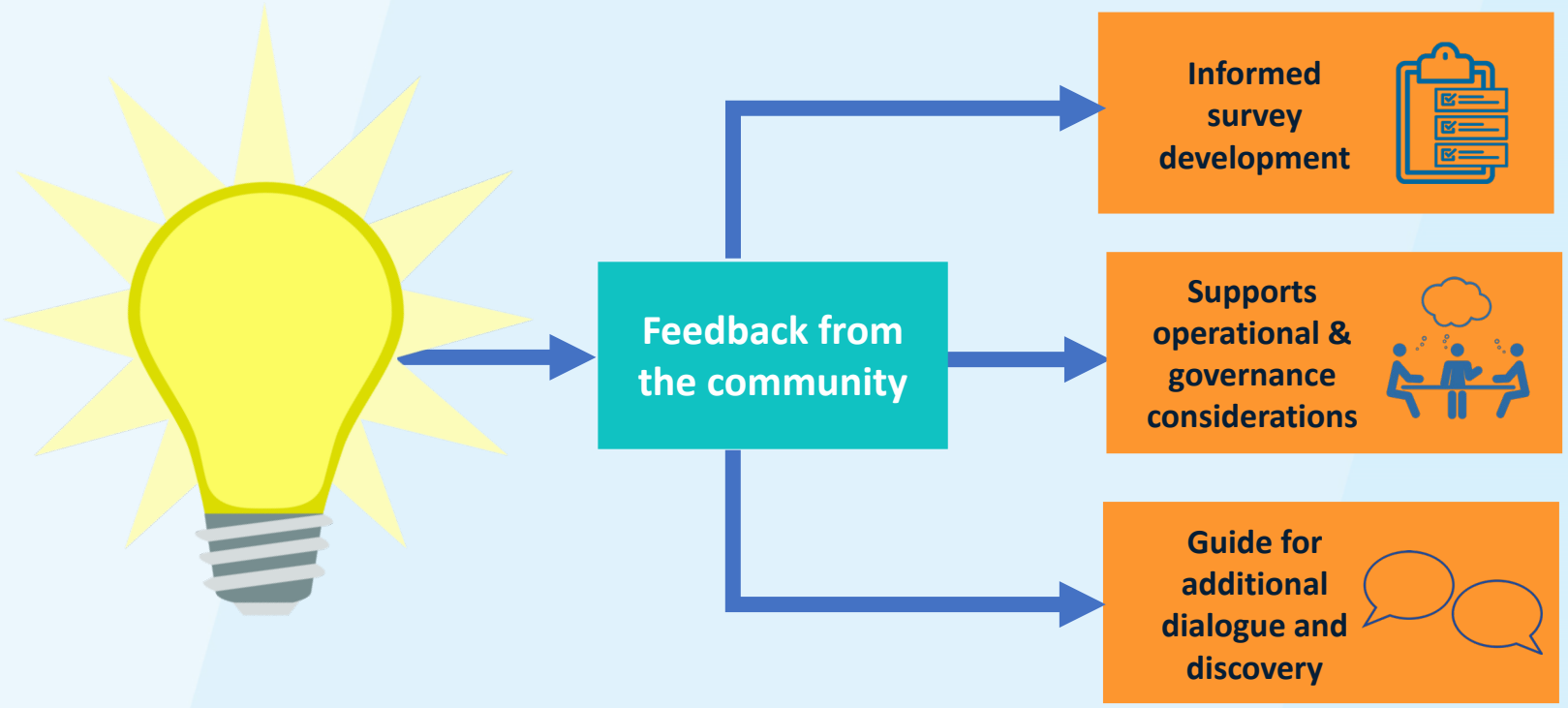
COMMUNICATIONS UPDATE

David Buckman
Program Manager, Society and Governance Communications

Continued Engagement with the Community

- Two-way dialogue with diplomates and partner professional societies to:
  - Share information
  - Listen empathetically
  - Deepen connections
  - Capture feedback that leads to program changes

How Do We Use the Feedback?



Insights → Programmatic Change

- Example: becoming board certified again by passing two consecutive Knowledge Check-Ins:
  - This new policy was a direct result of feedback ABIM received from the physician community.
  - Many physicians told ABIM they would like to take the Knowledge Check-In but were unable to because the former policy required a diplomate to be certified to be eligible.

Societies can help facilitate even more of this by continuing to remain engaged with us and sharing your feedback

A LIFELONG RELATIONSHIP

Welcome Kits for Newly Certified Physicians

Digital Promotion Kit

Community Engagement Activities

- Social Media
- Customer Experience
- Community Insights Network
- ABIM ENGAGE community
- User Testing
- Surveys
- Focus Groups
- Interviews
- Society Meetings

Community Engagement at Society Meetings

- Booth in Exhibit Hall
- MOC Update Presentations
- Town Hall Q&A
- Discovery Sessions
- Interviews

So What's Hot Right Now?

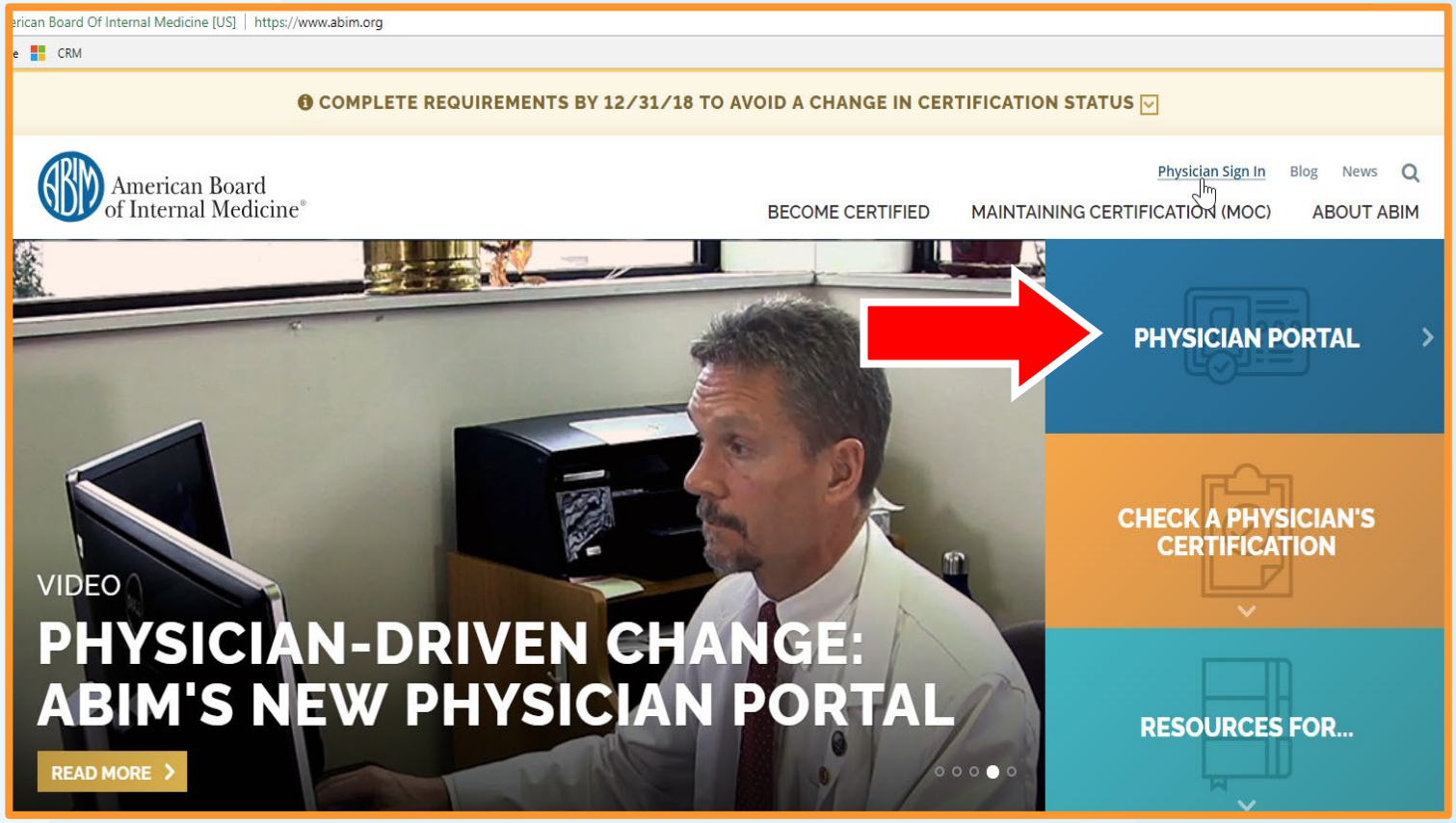
ABIM Quarterly News and Notes – Shared with diplomates on October 24

So What's Hot Right Now?

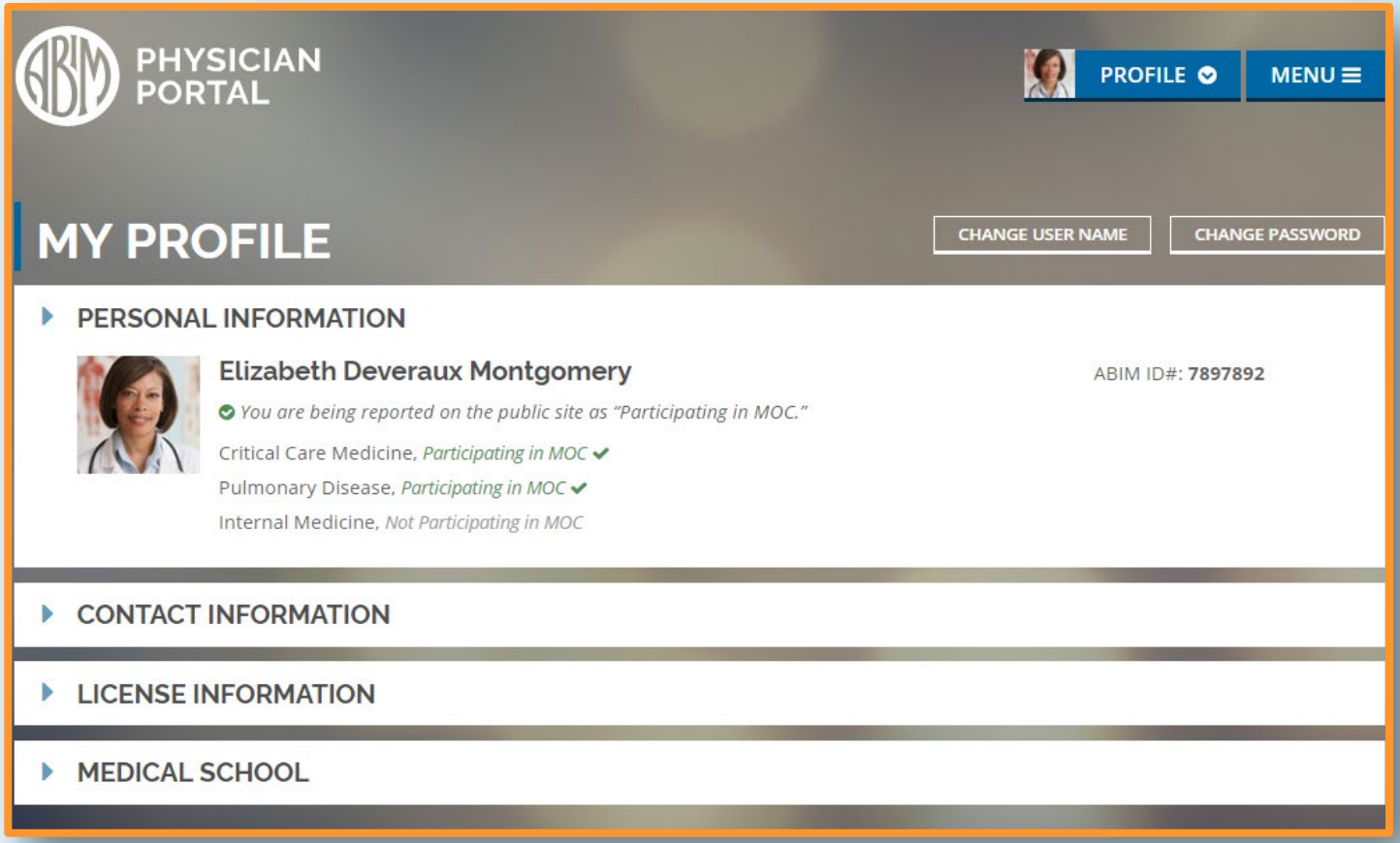
Reminders to check

PHYSICIAN PORTAL

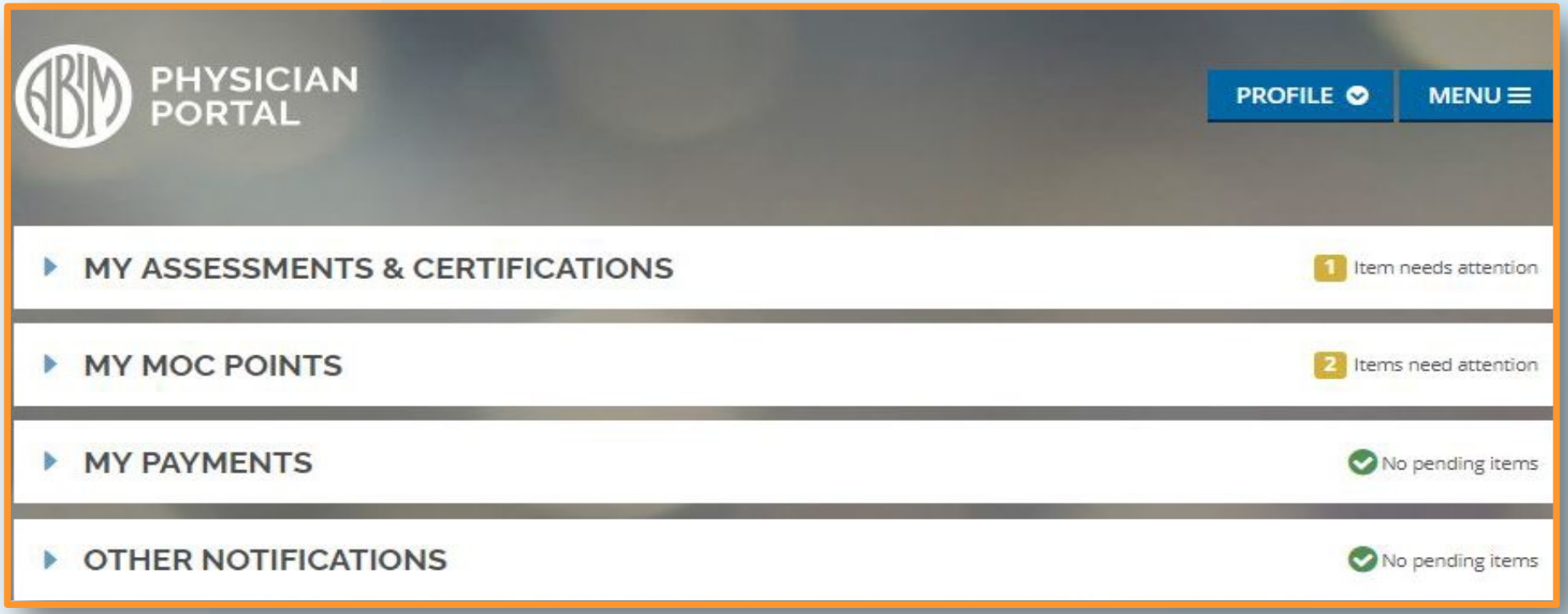
ABIM Portal: Login



ABIM Portal: Profile Page



ABIM Portal: Check Status



Why is this especially important right now?

FIVE YEAR LOOKBACK

and other year end requirements

Types of Certifications

1) Grandfathers
   - Issued prior to 1990 (for the most part)
   - Certified indefinitely, participation status varies
2) Time-limited
   - Issued from 1990-2013
   - Certified for 10 years, participation status varies
3) Must-be-maintained
   - Issued to newly certified starting in 2013
   - Issued for MOC beginning in 2014
   - No end date, **certification contingent on meeting the requirements of the program**, participation status varies

First 5 Year Lookback 12/31/2018

MOC Requirements that **can change a diplomate's certification status** if not completed by 12/31/2018:

- **Assessments**: Pass an MOC exam within 10 years of when you last passed.*
- **Points**: Earn 100 MOC points every five years
- **Attestations**: If you hold a certificate with a procedural or encounter requirement, complete your attestation.
  - Focused Practice in Hospital Medicine: Attest every five years that you continue to meet inpatient encounter thresholds (senior attestation required)
  - Interventional Cardiology: Attest every five years that you continue to meet procedural requirements (senior attestation required)

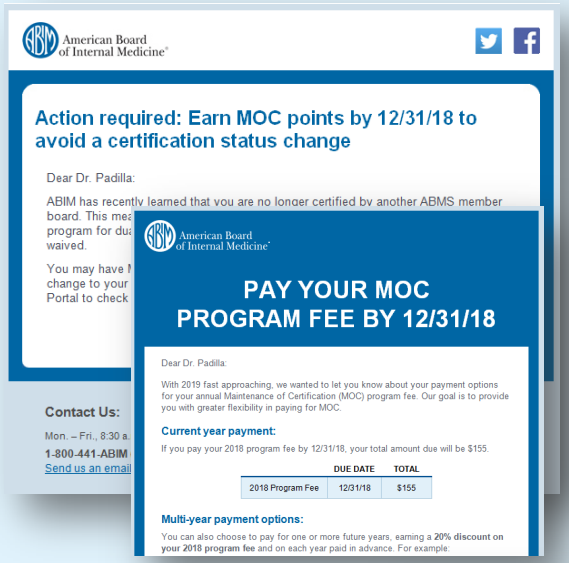
*A diplomate can remain certified if they failed the exam and are in the grace period

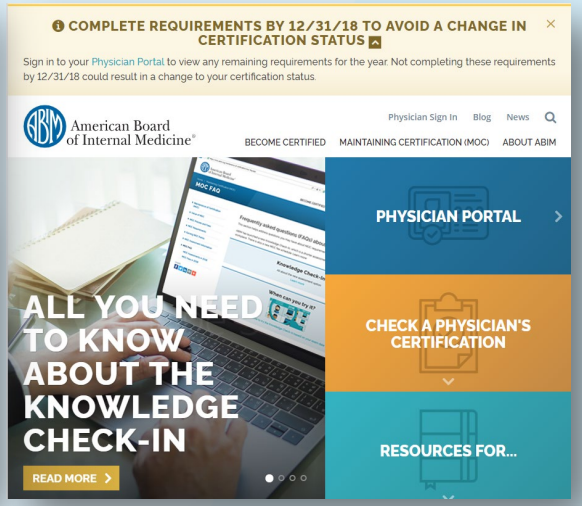
First 5 Year Lookback: Communication Goals

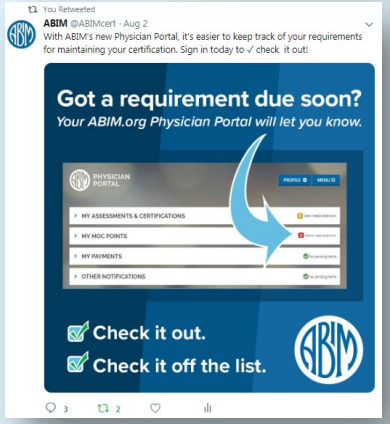
- To minimize the number of diplomates facing a lapse of certification on 12/31/18.
- Utilize all ABIM communication platforms to **drive physicians to sign into their portal** to guarantee that they are aware of their 2018 requirements well before the 12/31/18 deadline.

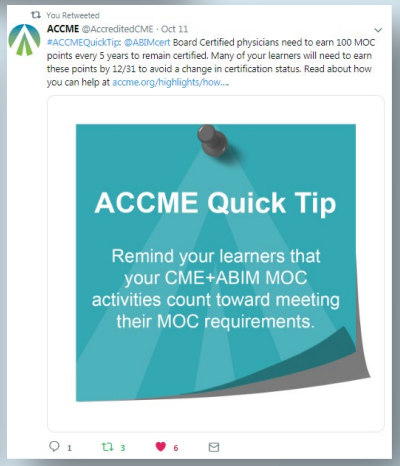
Tactics

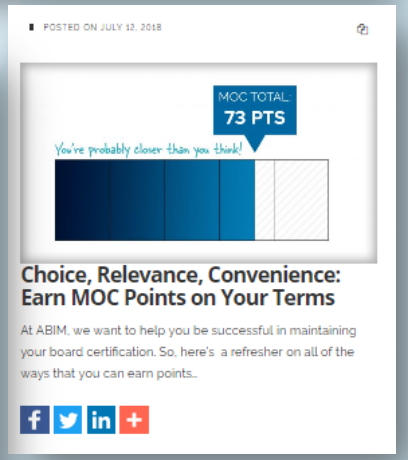
- Email
- Public Site/Portal
- Blog
- Social Media
- Customer Service
- Partners



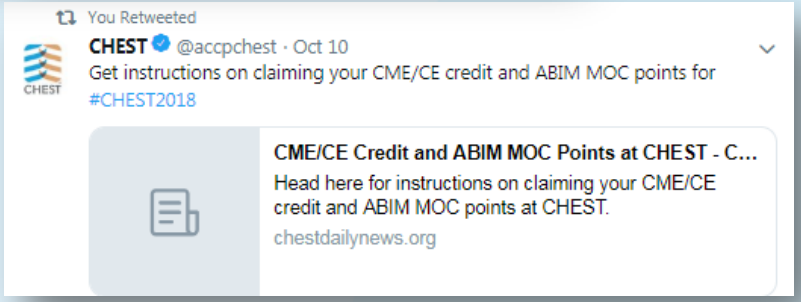






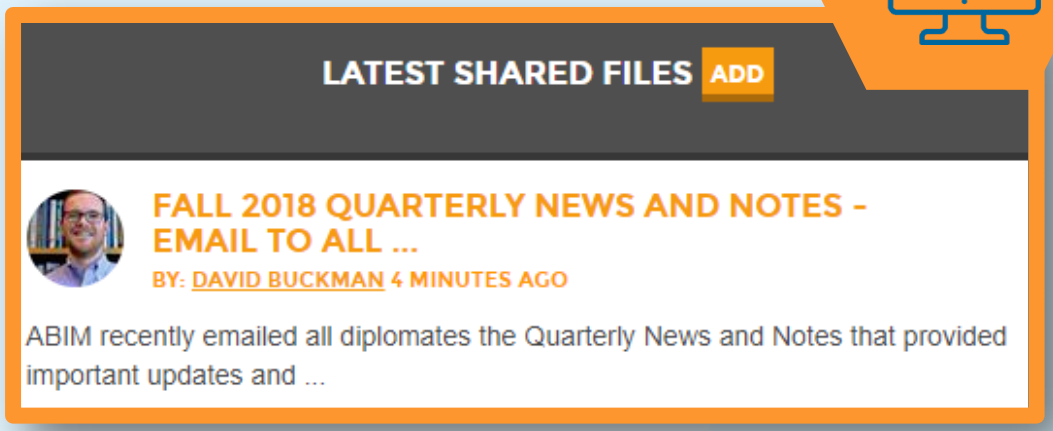


A Community Effort



Efforts to Engage with Societies

- ABIM Engage online community for staff
- Communications staff check-ins
- Co-creation of newsletters, emails, etc.
- ABIM governance recruitment
- Check-in calls with societies ahead of specialty board meetings
- Specialty Board summary reports



Efforts to Engage with Societies: Specialty Board Summary Reports

- Share what was discussed at the meeting in an effort to increase communications and transparency between ABIM governance and societies.
- In the future, our goal is to share more broadly with all diplomates.

American Board of Internal Medicine

April 25, 2018

SUMMARY REPORT

Nephrology Board

A Message from the Chair

It has been a tremendous privilege to serve as Chair of the Nephrology Board and work alongside so many smart and talented people dedicated to improving ABIM's programs. I know how challenging it can be to practice medicine today and that by enhancing the Certification and Maintenance of Certification programs ABIM can better support physicians in their lifelong pursuit of knowledge and help them be the best physicians they can be. I believe that ABIM is working very hard to increase the relevance of Board Certification to nephrologists and look forward to continuing this work with them.

It is an exciting time in Nephrology. This spring ABIM will offer the Knowledge Check-In for the first time in two specialties: Internal Medicine and Nephrology. I look forward to hearing from my

LOOKING FORWARD TO 2019

Knowledge Check-In Rollout

2018	2019	2020*
Internal Medicine	Cardiovascular Disease	Advanced Heart Failure & Transplant Cardiology
Nephrology	Geriatric Medicine	Clinical Cardiac Electrophysiology
	Endocrinology, Diabetes, and Metabolism	Critical Care Medicine
	Gastroenterology	Hospice & Palliative Medicine
	Hematology	Hospital Medicine
	Infectious Disease	Interventional Cardiology
	Pulmonary Disease	Medical Oncology
	Rheumatology	Sleep Medicine
		Transplant Hepatology

** Adult Congenital Heart Disease will be available the first year the MOC assessment is offered in 2023.*

Let's have a conversation….

How can we partner to get the word out to your members?

- What has worked thus far from a communications standpoint? What has not worked?
- What communications channels does your society utilize?
- Any new ideas for us to try?

Let’s have a conversation….

- What program details are you still unclear about as you look to communicate with your members?
- What areas of understanding do your members struggle with the most?
- How else can we help?

Your ABIM Communications Staff Contacts

David Buckman

Program Manager,

Society and Governance Communications

John Held

Director of Communications and Brand Management

Pamela Browner White

Senior Vice President of Communications

American Board of Internal Medicine®

Town Hall Discussion

Richard Battaglia, MD
ABIM Chief Medical Office
(Moderator)

Town Hall Discussion
Panelists

- **Dr. Richard Baron**

  President and CEO of ABIM

- **Dr. Jeff Berns**

  Chair, Nephrology Board; Chair, ABIM Council

- **Dr. Bruce Leff**

  Chair-elect, ABIM Council and Chair, Geriatric Medicine Specialty Board

- **Dr. Asher Tulsky**

  Member, ABIM Council, and Chair, Internal Medicine Specialty Board

American Board of Internal Medicine®

Closing Comments

Dr. Bruce Leff

American Board of Internal Medicine®

Thank you!

Tell Us How We Did….
Please Complete Our Survey