



Infectious Diseases Society of America's Position on Maintenance of Certification Requirements

The Infectious Diseases Society of America (IDSA) strongly supports the objective of lifelong learning for physicians and recognizes that improvement in physician knowledge and practice competence will contribute to improved patient outcomes. The American Board of Internal Medicine (ABIM) Maintenance of Certification (MOC) program is one venue where physician knowledge gaps are assessed and specialty and subspecialty education is available. Professional societies also have a significant mission to update and educate their members, trainees and even nonmember specialists. Therefore it follows that specialty and subspecialty societies should be involved in MOC processes.

IDSA is encouraged that the ABIM is dedicated to improving its recertification and MOC program as outlined in the document "A Vision for Certification in Internal Medicine in 2020." Specifically we applaud the efforts to increase MOC relevance to physician practice, and to redesign the specialty and subspecialty periodic knowledge assessments (examinations). IDSA embraces the concept that lifelong learning is in large part a cognitive process and that MOC should be guided by the principle that knowledge gaps and new material are the most important areas to teach and assess. Societies are in the best position to determine the knowledge gaps and the relevant new material and should be the lead partner in MOC. IDSA recommends the following framework for MOC transformation.

1. Knowledge assessments (examinations):

- a. IDSA agrees with the current ABIM effort to offer a new MOC knowledge assessment alternative to the current 10 year recertification examination. This new option should provide the opportunity for more frequent and relevant assessment of cognitive knowledge gaps and for those who perform well on these assessments to "test out" of the 10 year exam. We also agree with continuing to offer the option of a recertification exam to those who prefer less frequent assessments.
- b. The periodic assessment option should be given not more frequently than every 2 years and could be completed by the physician at home or office. The essential elements of this regular assessment tool should include access to information that physicians need in order to manage patients in real-life scenarios (e.g. an "open-book" approach) and should provide immediate feedback to the test-taker. Ideally there would be an opportunity to remediate errors and knowledge gaps and get access to formative feedback such as rationales and references. Knowledge gap remediation, such as a question-based reassessment of the content areas that had incorrect responses, should be offered by the ABIM. This would allow for further study and integration of knowledge by the physician and count for MOC participation points.

- c. IDSA agrees with the current blueprint process for improving exam relevance to topics that are essential for the physician to know, and to areas where new updated knowledge is needed to be integrated into an existing cognitive skill set.

2. Maintenance of Certification requirements

- a. ABIM, together with specialty and subspecialty societies, should rapidly expand Continuing Medical Education (CME) activities that are eligible for MOC requirement points.
- b. Non-CME physician activities that are directed towards or result in practice improvement and which take place in the physicians' current practice environment should count for general MOC credit (points).
- c. Activities that are directed towards or result in health-care system improvements in quality of care or patient safety should count for general MOC credit (points).
- d. Specialty and subspecialties societies should be the deciding authority on what specific practice and health-care system activities should count for general MOC credit (points), and the relative amount of credit they should receive. For infectious diseases, MOC point eligible health-care system activities that ID physicians often engage include, but are not limited to, hospital epidemiology, antimicrobial stewardship, pharmacy and therapeutics participation, patient safety committees and oversight, chief medical officer responsibilities, health care provider immunization and occupational health, emerging infection responses, and public health activities.
- e. Health-care provider and resident and fellow level graduate medical education activities, including program directorship, didactic instruction, key faculty assignments, and teaching service attending should count for general MOC credit (points). Such credit should be standardized across the medical subspecialties.
- f. Specialty and subspecialty knowledge modules, as provided by professional societies or ABIM, should have their point credit increased to a level above that of hour-based CME to reflect the increased level of self-directed knowledge imparted by these activities.
- g. Group learning activities at national, regional, and local professional society meetings for MOC credit (points) should be encouraged.

3. Practice Assessment Requirements and Technical Skills

- a. ABIM MOC/recertification activities should be focused on assessing and improving cognitive skills. The assessment of technical skills is better addressed by local peer-review, CMS and third party payer quality and value assessments, credentialing processes and state medical boards.
- b. There should be no separate practice assessment, patient safety or "patient voice" requirement for MOC. Further assessment by the ABIM is not necessary and is redundant and overly burdensome. The assessment of these aspects of patient care quality are currently (and better) addressed by local peer-review, CMS and third party payer quality and value assessments, practice patient satisfaction reports, credentialing processes, and state medical boards.

4. Communication and society involvement in proposed MOC transformation processes and activities

- a. Specialty and subspecialty societies must be considered partners and serve as co-creators of the new MOC process. In addition, IDSA feels that it would benefit our members, and all internal medicine specialty and subspecialty physicians, if decisions on MOC be communicated and implemented only after the entire program or product is near finalized rather than in a staggered constantly shifting approach.
- b. Societies should be involved in a proactive rather than a reactive manner.

References:

1. ABIM. Assessment 2020 Task Force recommendations. Available at ABIM 2020 report. <http://transforming.abim.org/assessment-2020-report/>. Accessed July 30, 2016.
2. ABIM. A Vision for Certification in Internal Medicine in 2020. Available at <http://transforming.abim.org/wp-content/uploads/2016/04/assessment-2020-final-report.pdf>. Accessed July 30, 2016.
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