June 22, 2021

Richard E. Hawkins, MD, FACP, President and Chief Executive Officer
Susan M. Ramin, MD, Chair, Standards Task Force
Greg Ogrinc, MD, MS, Senior Vice President, Certification Standards and Programs
Tom Granatir, Senior Vice President, Policy and External Relations

American Board of Medical Specialties
353 N Clark Street, Suite 1400
Chicago, IL 60654-3454

Re: American College of Physicians Response to ABMS Draft Standards for Continuing Certification – Call for Comments

Dear Doctors Hawkins, Ramin, Ogrinc and Mr. Granitir:

On behalf of the American College of Physicians (ACP), we appreciate the opportunity to comment on the American Board of Medical Specialties (ABMS) draft for new Standards for Continuing Certification, for implementation by Member Boards. Thank you for your efforts toward transparency in your response to the Vision Commission recommendations. We appreciate ABMS actions already taken to recognize specialty society leadership within medical and surgical disciplines through inclusion of specialty society representation and testimony within the Vision Commission, during drafting of new Standards, and through feedback to the Draft Standards.

The ACP is a national organization of internists, the largest medical-specialty organization, and second-largest physician group in the United States. Many of our 163,000 members are ABMS Member Board certified physicians, primarily through the American Board of Internal Medicine (ABIM).

ACP has continually advocated for improvements in Board certification policies and procedures in order to improve value of the voluntary certificate for diplomates, reduce administrative burdens experienced by diplomates, and minimize financial burdens of certification. We have been pleased with recent ABIM procedural changes related to our advocacy, including the movement toward a lower-stakes and more convenient longitudinal knowledge assessment option, and the moratorium on MOC requirements through 2021 in recognition of internists' essential roles in leadership of care during the SARS-CoV-2 pandemic.

ACP recognizes the medical profession's responsibility to ensure quality medical care and supports the concept of lifelong learning and the need for ongoing physician accountability. ACP's Professional Accountability Principles outline the important attributes and standards for any organization that is involved in assuring physician accountability. Because a wide variety of attributes contribute to a physician's competence and quality of care, ACP believes that participation in programs for physician accountability such as continuing certification (a.k.a. maintenance of certification (MOC)) should not be

a sole, overriding, principal, or absolute prerequisite for licensure and credentialing including acceptance into health plan networks, reimbursement, hospital medical staff privileges, medical liability coverage, and/or state licensing bodies, and other purposes.

General Comments

1. Special role for specialty society feedback: ACP applauds the use of an independent group to collect comments and perform initial analysis toward revision of the Draft Standards. However, the Call for Comments response form required submission of names, email addresses, and Board certification status in order for individuals to provide their comments. Alternative methods exist to ensure that duplicate responses are not submitted. When this submission barrier is compounded by the truncated Call for Comments timeline, the complexity of the Standards subject matter, and the ongoing pandemic-related work burdens and rise in professional burnout, individual submission of physician comments will likely under-represent the actual degree of physician concerns. **Recommendation**: we strongly urge the ABMS Board of Directors to ensure that the voices of ACP and other specialty societies are appropriately prioritized while formulating final Standards, to reflect many years of communications and advocacy on behalf of our physician members.

2. Recognition of specialty society leadership roles: Specialty societies continue to lead our disciplines, carrying forward our long history of setting standards for professionalism, professional education, health system advocacy, clinical guidelines, performance measures, professional satisfaction drivers, public health priorities, and more. In particular, societies have long histories of collaborating with other agencies in order to achieve progress in the complex fields of improvement sciences and quality assessment. Such work includes but is not limited to our essential engagement with governmental leaders (e.g., National Academy of Sciences, Centers for Disease Control, legislators), quality and evidence groups (e.g., U.S. Preventive Services Task Force, Advisory Committee on Immunization Practices), foundations, private organizations, subject matter experts, and academic health centers. **Recommendation**: ACP welcomes ABMS Member Board interest in assisting with national efforts to support quality of care, professionalism, and education across disciplines, but cautions the ABMS BOD to recognize the significant complexity and expense of such work, the expertise and leadership of specialty societies in these fields, the lack of evidence connecting improvement science processes to a valid assessment of individual physicians as necessary for the scope of Member Boards, and the financial stewardship concerns of using diplomate fees to fund de novo quality and education agendas. To better reflect the special roles played by specialty societies in advancing each discipline, we also strongly encourage ABMS to work with ACP and the Council of Medical Specialty Societies (CMSS) to refine language used throughout the document in reference to societies, and to limit references to collaboration with "other organizations". In particular, it is essential that Boards be held to collaboration with Societies rather than with for-profit or private entities who do not present peer-recognized fiduciary responsibility in the disciplines.

3. Need to address cost, financial stewardship, and financial conflicts of interest: Of the nine guiding principles articulated by the Vision Commission (VC) for its recommendations, the following was one: continuing certification programs should provide "value to diplomates to ensure that the efforts and costs needed to maintain certification are commensurate with

the benefits." Furthermore, the VC Recommendation on Compliance with Standards stated that all ABMS Boards must comply with "financial stewardship." In describing this standard, the VC stated that "The Commission believes sound financial stewardship is a fundamental responsibility of the ABMS Boards and essential in maintaining the trust and goodwill of diplomates. The ABMS Boards need to be efficient in the conduct of their operations and fully transparent with their diplomates about financial matters." ACP appreciates ABMS inclusion of financial management standards with the ABMS Organizational Standards, but asks that actions consistent with the ABMS Organizational Standards be reflected in Member Board Standards. **Recommendation**: ACP advises inclusion of a new Standard on financial stewardship using the language from the VC. Boards must limit their collection of fees to the reasonable costs necessary for individual diplomate certification decisions and discontinue using diplomate-collected revenues to fund activities outside the scope of this primary mandate. In addition, ACP avows that conflicts of interest, such as Member Board financial interests in or arrangements with data registries, performance measures, or for-profit education businesses must be made transparent and fully resolved during the development and implementation of certification Standards.

4. Need to inform organizations that continuing certification should not be the only criterion used in credentialing and privileging decisions: The VC Recommendation on Use of the Credential states that ABMS must inform hospitals, health systems, payers, and other health care organizations that continuing certification should not be the only criterion used in credentialing and privileging decisions, and must encourage these organizations to not deny credentialing or privileging to a physician solely on the basis of certification status. ACP appreciates ABMS efforts toward clarity, including the June, 2019 ABMS release of a special communication to hospital and health system leaders regarding appropriate use of board certification in privileging and credentialing decisions. However, that 2019 special communication did not fully meet ongoing needs for publicly visible clarity regarding the purpose of certification, and the policy is not clearly and consistently reflected by Member Boards. We recommend a more visible approach to disseminating the ABMS policy on appropriate use of board certification in privileging and credentialing decisions, and suggest addressing this within Standard 1 as below.

Comments on Draft Standards 1-17:

1. Program Goals - ACP agrees with the requirement for defined goals, addressing how their program supports diplomates. However, the statement "and is designed to promote improvement in health care provided by participating diplomates" implies a causal relationship between continuing certification and improvement in health care, where no causal relationship has been demonstrated. **Recommendation**: change wording to "… and is designed to *assist diplomates in their continual professional efforts to improve their knowledge, skills, and provided health care*." Furthermore, to address the VC recommendation on Use of the Credential, add the following to the commentary: "*The clearly posted goals must include a statement to inform hospitals, health systems, payers, and other health care organizations that continuing certification should not be the only criterion used in credentialing and privileging decisions, and must encourage such*

organizations to not deny credentialing or privileging to a physician solely on the basis of certification status."

2. Requirements for Continuing Certification – ACP appreciates the attention to due process, clearly articulated policies, and the recognition of extenuating circumstances. ACP is concerned by the reference to verification of attestations through an audit process. Physicians practicing in large health centers or facility-based fields are protected from administrative burden when they are credited with participation in programs that are centrally designed and administered. Such administrative support would generally extend to audit settings. Solo practice and small group practice physicians may experience inequitable administrative burden if their individual work is targeted for review. In addition, audits add to cost burden in the system, so should only be performed when likely to be relevant to certification decisions. **Recommendation**: Require systems that ensure that any audits for attestations are limited in scope and do not fall disproportionately upon solo practice physicians and/or small group practices, using adjusted wording in the final Commentary sentence: "Member Boards *may* verify attestations for participation standards *when relevant to resolving an uncertain certification status. Member Boards must have policies and processes in place, with monitoring of metrics, to ensure that audits do not inequitably burden solo and small group practitioners*."

3. Assessment of Certification Status – ACP understands the desire for a uniform interval for certification status, particularly for equity across disciplines. However, a 5-year interval is expected to increase costs for those diplomates currently engaged in a 10-year certificate cycle, and cost increases are contrary to Vision Commission stated principles. **Recommendation**: change determination based on any fee-based knowledge assessment to no longer than every 10 years, with interval determinations no longer than every five years based on defined participation standards, including evidence of ongoing engagement with continuing education.

4. Transparent Display of Certification History – ACP agrees with the purpose and language as stated. **Recommendation**: We strongly encourage ABMS to work with the Council of Medical Specialties to review proposed uniform status categories prior to implementation of any status label or process changes, for feedback on category terms prior to public display.

5. Opportunities to Address Performance or Participation Deficits – ACP appreciates the transparent support for policies and processes that require fair and sufficient warning. However, the terms "early notice" and "fair and sufficient warning" require clarification. Diplomates at risk require first notice, then time for data collection, time to generate a response plan, and finally time to implement that plan. **Recommendation**: insert a usual minimum time for such notice: "Fair and sufficient warning must be communicated that a certificate might be at risk*, with the usual expectation of at least 2 years notice prior to the anticipated date of certification loss*."

6. Regaining Certification – ACP agrees with defining processes for regaining certification. However, the commentary notes that such processes would be allowed "unless the certificate has been revoked for a breach in professionalism," then goes on to allow potential regain for specific lapses, some of which may fall under professionalism. Furthermore, the Standard does not require processes to be implemented consistently and equitably across all Boards. **Recommendation**: adjust the Standard to expect equity: "Member Boards must *work together to* define a process *that can be equitably and consistently applied across disciplines* for regaining certification…" Within the commentary, adjust the discussion of professionalism: "unless the certificate has been revoked for an *irremediable* breach in professionalism."

7. Program Evaluation – ACP applauds ABMS for recognizing and taking action on the need for Member Boards to continually evaluate and improve their programs, and for including feedback from diplomates. However, the Standard as written focuses solely on assessment of processes, does not address the need for outcomes research, and does not fully address the VC recommendation that "ABMS and the ABMS Boards must facilitate and encourage independent research … about the value of continuing certification." Greater detail needs to be included to clarify that Boards must demonstrate best practices in quality improvement and implementation science methodology for identification of relevant metrics, collection of available data sets that include optional and de-identified feedback from diplomates but do not rely on individual Diplomate responses or data input, benchmarking for quality of Board processes and outcomes, and public reporting of metrics and value benchmarks. The VC also noted the need to better understand the association of continuing certification with outcomes, and the need for research on the impact of continuing certification on diplomate engagement, on stress and burden, and on the physician workforce. **Recommendations**: revise Standard to state "*Member Boards must collaborate to facilitate and encourage independent research about the value of continuing certification, the impact of certification on physicians as individuals, and the impact of certification on the physician work force.* Member Boards must *also* continually evaluate …" Within the commentary, we advise including the VC language by inserting the statement: "*ABMS Boards should collaborate with independent academic health centers with expertise in health system research to understand what components of continuing certification and forms of assessment are most effective in helping diplomates keep current in their specialty, and to study the impact of continuing certification on diplomate stress, on diplomate financial and administrative burden, and on the physician workforce*." Also, the commentary should include: "B*oards must demonstrate best practices in quality improvement and implementation science methodology for identification of relevant metrics, collection of available data sets that include optional and de-identified feedback from diplomates but do not rely on individual Diplomate responses or data input, benchmarking for quality of Board processes and outcomes, and public reporting of metrics and value benchmarks.*"

8. Holders of Multiple Certificates – ACP appreciates the efforts toward transparency and minimization of burden, but also encourages ABMS to specify the need to mitigate financial burden for these diplomates. It is essential that Boards recognize their status as a barrier to

cohesion and communication within disciplines, when subspecialists become professionally separated from their specialist peers through forfeiture of core certificates. Additionally, physicians with essential skills such as geriatrics and pain management are discouraged from maximizing their expertise in disciplines of need, such as palliative care, when certification requirements magnify their costs and administrative burden. **Recommendation**: adjust the Standard to state "… minimizing duplication of effort *and costs* for diplomates who hold multiple certificates."

9. Diplomates Holding Non-time-limited Certificates – ACP appreciates the willingness to provide a path to engagement for these certificate holders.

10. Review of Professional Standing – ACP agrees with ABMS that Member Boards should directly perform independent verification of licensure, and that only material restrictions of licensure reflecting a threat to patient safety should be reviewed for possible Board action. However, ACP is concerned by process implications of wording within the Standard and within the Commentary.

    a. The Standard as written displaces administrative burden from ABMS Member Boards onto individual diplomates, by requiring diplomates to report "any actions taken against them" and "events that affect professional standing," rather than seeking more timely reporting of truly material actions through licensing bodies and the various listed sources of data on physician standings. The expectation of reporting "any actions" also places undue burden and stress on physicians, particularly if the actions themselves represent unprofessional administrative behaviors (e.g. retaliation by an entity toward a physician who reports sexual harassment or Joint Commission violations). **Recommendation**: change the Standard wording: "Member Boards ~~must also require diplomates to report any actions taken against them and events that affect professional standing within a defined period (e.g., within 60 days)~~ *should also seek information from other objective sources to make judgements about a diplomate's conduct.*"

    b. The reference to material restrictions is vague in describing restrictions regarding actions "…that may undermine public trust in the profession." The syntax of that sentence is confusing, and there is insufficient clarity regarding "public trust" separable from "patient safety". Clarity is imperative, as wide subjective variations exist in determinations of what the public "trusts", and physicians should not be held accountable to subjective standards that specialty societies do not consider to be material. For example, ACP believes the patient-physician relationship should be protected from laws that prevent physicians from initiating a discussion about guns or other public health concerns and opposes restriction of licensure or administrative actions based on such legislation. ACP has extensive experience in both setting and implementing professionalism standards through our policies and practices related to Ethics, Professionalism, and Human Rights. This is one reason the VC recommended that Boards "… develop new, reliable and consistent approaches to evaluate professionalism and professional standing in collaboration with specialty societies …". **Recommendation**: add to the Standard wording: "*Member Boards must confer with*

specialty societies in identifying reliable and consistent approaches to evaluate professionalism and professional standing."

11. Responding to Issues Related to Professional Standing – ACP appreciates the expectations for clear and transparent policies, and the attention to due process. However, the statement regarding physicians in treatment programs must be revised to be consistent with professional standards. **Recommendation**: refine the commentary regarding support for physicians successfully participating in physician health programs to note that "Member Boards *must not revoke* a certificate when he/she has been successfully participating in physician health programs or other treatment program recognized by the state medical board*, unless separable unprofessional behaviors or material restrictions are noted*.

12. Program Content and Relevance – ACP applauds the recognition of the need for a balance between core discipline content and practice-specific content. However, the Standard does not reflect specialty society expertise in identifying relevant practice-specific and core content areas. **Recommendation**: revise the commentary: "Member Boards *must collaborate with specialty societies to identify appropriate options for* customization of program assessment content – ideally based on evidence actual practice in the field – to enhance clinical relevance …"

13. Assessments of Knowledge, Judgment, and Skills – ACP endorses the described goals for formative assessment programs that provide learning value to diplomates with actionable feedback. In reference to the offering of an option for a point-in-time secure assessment, we caution that there is a lack of evidence for the proposed doubling of assessments from every 10 years to every 5 years, and doubling of secure assessments would impose burden without evidence of value. **Recommendation**: change the commentary to: "… may be required to take the secure assessment at least once every *ten* years."

14. Use of Assessment Results in Certification Decisions – ACP recognizes the ABMS Member Boards responsibility for making defensible, summative decisions, and appreciates the commentary noting that security authentication procedures should not place unnecessary burdens on participating diplomates.

15. Diplomate Feedback from Assessments – ACP agrees with the need for individualized feedback to support learning. As leaders of education within our disciplines, specialty societies support diplomates as they acknowledge and respond to Board feedback, and we appreciate the recognition of this leadership within the commentary. However, we believe that specialty societies can be more helpful in meeting the goals by expanding the collaboration related to such feedback. **Recommendation**: revise the commentary: "Member Boards are encouraged to *work with specialty societies in identifying these resources. Member Boards should also work with specialty societies to establish mechanisms allowing diplomates to approve automatic sharing of individual Board performance data with personalized learning plans that are developed and implemented by specialty societies*."

16. Sharing Aggregated Data to Address Specialty-based Gaps – ACP agrees that aggregated Member Board data may provide useful information to assess national trends in learning needs. However, the Standard and commentary do not recognize the educational leadership provided by specialty societies in each discipline. Low quality, for-profit, and conflicted education businesses should not be recipients of data that has been generated through diplomate fees and volunteer professional services. Also, Boards must recognize that specialty societies have expertise in identifying content experts and prioritizing gaps, such that specialty societies lead in recognition of changing trends in the specialty, and best options for closing gaps through dissemination of new knowledge. Furthermore, sharing of such data must be continual and timely in order to develop and disseminate content and systems to achieve the stated goals. **Recommendations**: revise the Standard: "… shared with diplomates, medical specialty organizations, and other *essential* stakeholders *in a continual and timely manner*…." Within the commentary, provide a statement that "*Data sets should only be shared with essential stakeholders such as specialty societies who require the information for nonprofit service to the profession.*" Revise the commentary: "Member Boards should collaborate with *specialty societies in a continual and timely manner* to address major public health needs and frequently occurring deficits, *engaging specialty societies in bidirectional communication necessary for further identification and prioritization of gaps.*"

17. Lifelong Professional Development – ACP agrees with the importance of continuing professional development (CPD), and applauds the commentary stating that CPD activities must be of high quality and free of commercial bias. ACP urges a more prominent recognition of the need to minimize administrative burden, particularly to discourage disproportionate burden that may be experienced by diplomates working in independent practices or in disadvantaged settings. Such burdens may be imposed through mandates for specific CPD activity requirements. **Recommendation**: add a final sentence within the Standard: "… and align with program goals. *Reporting of educational activities must not impose significant administrative and/or financial burden on diplomats.*"

Comments on Draft Standards 18-20:
ACP recognizes the medical profession's responsibility to ensure quality medical care, and ACP is a leader in setting evidence-based quality standards through writing of rigorous clinical guidelines, review and identification of validated performance measures, advocacy for public health priorities, publication of peer-reviewed clinical guidance, education regarding high value care principles, collaboration with others on education to reduce diagnostic error, dissemination of expert-led hands on training in clinical skills, and much more. ACP is also a leader in highly effective quality improvement and improvement science education, having designed and disseminated peer-to-peer education in quality improvement methods, and having developed and implemented quality improvement coaching services for clinical teams that currently support numerous clinical practices in achieving their goals. Other specialty societies also have long histories of leading, collaborating and innovating to achieve progress in the complex fields of improvement sciences and quality assessment.

Throughout our long engagement with the national quality agenda, we have continually deepened our understanding of the complexity, team-based factors, and subjective nature of clinical quality

improvement and assessment. We caution the ABMS to recognize that Standards 18-20 as written do not reflect that improvement science expertise is held outside the scope of Member Boards, and that psychometrically validated methods are lacking to link individual physician Board certification decisions with engagement in a Board-derived quality agenda. Importantly, the statement that the Board's "quality agenda should include an overall strategy for improving care and a set of priority improvement targets" oversimplifies what would be a scope of work well beyond the capacity of Boards to implement with current diplomate-derived resources, even before addressing the mandates to reduce diplomate administrative and financial burdens.

We urge ABMS to return to the VC recommendations to build both an evidence base and a framework for supporting individual diplomates in their efforts to advance health and healthcare. The Commission recognized the significant challenges of developing an infrastructure to support learning activities that produce data-driven advances in clinical practice, the need to recognize work already done by diplomates to advance practice, the requirement to satisfy a value proposition with evidence of benefit and avoidance of burden, and the need to develop and implement pilot projects for new ideas and approaches that support individual diplomates in their contribution to team care quality.

18. Quality Agenda –ACP urges ABMS to revise the focus of this Standard to more specifically address VC recommendations in their Advancing Practice recommendation: "ABMS and the ABMS Boards should collaborate with specialty societies … to develop the infrastructure to support learning activities that produce data-driven advances in clinical practice." As further noted in the VC commentary "… the fundamental approach for the advancing practice recommendation is the identification of knowledge/practice gaps and the engagement in learning activities that improve clinical competency." Furthermore, the VC recognized the aspirational nature of such a recommendation given the need to first reduce and avoid diplomate burden through creation of the necessary infrastructure to support recognition of diplomate engagement in ongoing quality of care initiatives. **Recommendations**: Replace the Standard with endorsement of the VC recommendations: "*ABMS Boards should support the national quality agenda by collaborating with specialty societies and other experts in improvement science in order to develop the infrastructure to identify and support existing learning activities that produce data-driven advances in clinical practice.*" Replace the commentary with: "*While evidence is lacking to require individual diplomates to engage in specific quality improvement activities, ABMS Member Boards are expected to support the national quality agenda through collaborative engagement with the discipline at large. Such engagement should lead to development of a framework that can assist diplomates in identifying and optionally selecting learning activities that support them and their clinical teams in working toward improvements in care. The developed framework should support foundational education in fields such as improvement science, high-value care implementation, patient safety, and reduction of healthcare disparities.*"

19. Diplomate Engagement in Improving Health and Health Care – Consistent with the above necessary first development of infrastructure and demonstration of a value proposition, ACP avows that engagement with identified activities must be considered optional for the purposes of individual physician certification. It is particularly imperative that ABMS Boards not mandate engagement with activities that require diplomates to support financial interests with which Boards hold conflicts of interest (e.g. proprietary registries). ABMS

Boards should invite participation in pilot programs to inform an evidence-based approach to supporting clinical quality improvement through learning activity standards. **Recommendations**: change the Standard: "…programs *should invite* participation in relevant activities that *may* improve health and health care." Revise the commentary to reflect the promotion of pilot programs, collection of data to address the value proposition, and recognition of voluntary diplomate engagement to support the profession.

20. Approaches for Improving Health and Health Care - ACP applauds the call for ABMS Boards to recognize a wide range of activities appropriate for improving health and health care, but urges that participation remain voluntary and through pilot programs until and unless the above concerns and VC recommendations are first addressed. After development of validated processes that credit diplomates for their ongoing professional development and work to improve clinical care, ACP endorses recognition methods such as professional attestation that minimize burden in documenting such work. **Recommendations**: Adjust the commentary to explicitly state that engagement with all wide door activities should be invited as participation in pilot programs, with recognition of engagement offered but not required for individual diplomates. State that pilot programs must include not only assessment of learning value and clinical outcomes, but also of administrative and financial burdens.

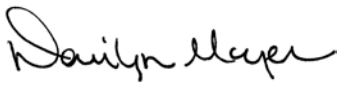
Summary and Next Steps

ACP sincerely appreciates the opportunity to provide detailed feedback on the Draft Standards, as well as the transparency and collaboration modeled by the ABMS throughout this process. Since the initial convening of the Vision Commission and throughout the subsequent response stages, ABMS has been an open and thoughtful partner in revising ABMS Board certification policies to improve value for diplomates and the public, and to generate a more fair and equitable approach to continuing certification across disciplines.

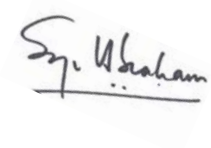
ACP stands ready to continue the collaborative discussion you have so effectively led for the good of our profession. We are happy to meet with ABMS and CMSS leadership to discuss our recommendations in greater detail. Please contact us for further discussion and clarification as needed.

Sincerely,

Thomas G. Cooney, MD, MACP
Chair, Board of Regents



Darilyn V. Moyer, MD, FACP, FRCP, FIDSA
Executive Vice President and Chief Executive Officer



George M. Abraham, MD, MPH, FACP, FIDSA
President

Davoren Chick, MD, FACP
Senior Vice President, Medical Education