AMERICAN ACADEMY OF FAMILY PHYSICIANS

January 14, 2019

Christopher Colenda, MD, MPH, Co-Chair
William J. Scanlon, PhD, Co-Chair
Continuing Board Certification: Vision for the Future Commission
c/o Kathleen C. Ruff, MBA
American Board of Medical Specialties
353 North Clark Street
Suite 1400
Chicago, IL 60654

Re: Continuing Board Certification: Vision for the Future Commission Draft Report for Public Comment

Dear Dr. Colenda and Mr. Scanlon:

The American Academy of Family Physicians (AAFP) appreciates the opportunity to review and provide comments on the Continuing Board Certification: Vision for the Future Commission's draft recommendations. The AAFP is in the unique position of being not only a medical specialty society representing 131,400 family physicians and medical students across the country but is also both a provider and accreditor of continuing medical education (CME). As such, it is using the sum of these three important roles to inform its feedback.

Introduction

Overall, the AAFP appreciates the Commission's recognition of the shortfalls of maintenance of certification as historically administered and the Commission's refocusing of the process on incorporating lessons learned, best practices in adult learning theory, and physician feedback, which is woven clearly throughout the recommendations. The introductory section correctly acknowledges the current shortfalls and articulates a clear purpose of and direction for improvement. The stark fact that only 12% of physicians valued the program (p.9) points to the need to take a strong, definitive stand in addressing the inconsistencies, lack of perceived value, and burden that are endemic in the current process. However, throughout the document, the Commission has often chosen softer language, choosing to "encourage" the ABMS to make a change rather than using more assertive, direct language such as "must". The recommendations should be rephrased in a direct, assertive manner to reflect the crisis point in which maintenance of certification has found itself and the critical need for recommended improvements.

We are extremely enthusiastic about the Commission's explicit direction to the boards to collaborate with specialty societies, which is emphasized throughout the document. We ask the Commission to direct the ABMS to also build accountability for this collaboration into the

process and ensure it is embedded in the structure of continuing certification. The Commission has envisioned the “ideal example” of this collaboration (p.24), which so clearly echoes our comments and the comments and feedback from other stakeholders, that this model should be included explicitly in the text of Recommendation 7.

We applaud the Commission’s direction to the ABMS to ensure hospitals, health systems, payers, and other health-care organizations do not use continuous certification as the sole criteria by which they make decisions; however, we feel this language could be further strengthened so that the voluntary nature of participation is absolutely clear, and we have included suggested wording in the response to Recommendation 8.

REVIEW OF INDIVIDUAL RECOMMENDATIONS

RECOMMENDATION 1

Continuing certification should constitute an integrated program with standards for professionalism, assessment, lifelong learning, and practice improvement.

We fully support this recommendation and see great value in integrating the parts of certification. This recommendation encourages innovation and can open the door for specialty societies and other collaborators to create educationally rich activities that also meet many certification requirements.

RECOMMENDATION 2

Continuing certification should incorporate assessments that support diplomate learning and retention, identify knowledge and skill gaps, and help diplomates learn advances in the field.

a. **ABMS Boards should use longitudinal and other innovative assessment methods that collectively contribute to the determination of continuing certification status.**
b. **Continuing certification should use multi-source data to assess knowledge, judgment and medical decision-making skills, as well as other professional competencies required to sustain and enhance optimal patient care.**
c. **As new advances in medicine and patient care emerge in clinical practice, the ABMS Boards should be encouraged to consider what core knowledge, judgment and skills are needed to be a diplomate in their core specialty or subspecialty and create assessments that are preferentially focused on the content of the diplomate's principal area of practice in that specialty.**
d. **ABMS Boards should be encouraged to develop and test innovative approaches to diplomate assessment to help ensure that diplomates have integrated these advances into their clinical practice.**
e. **ABMS Boards must provide timely and relevant feedback as part of any assessment.**
f. **Continuing certification status should not be withdrawn solely due to substandard performance on a single, infrequent, point-in-time assessment (e.g. every seven- to ten-year examination).**

The Commission is rightly focused on innovation and providing options for assessment. Assessments *should* be both formative and summative, and this is also another area replete with opportunity for boards and specialty societies to work together to identify gaps for physicians and provide opportunities to fill those gaps. We encourage the Commission to use more directive language regarding the need for boards to have exam alternatives, including article-based assessment programs.

In addition, the Commission should specifically recommend that boards offer a variety of options for ***all of the*** elements (parts) of certification, including options that address more than one element simultaneously, so that each physician can more efficiently demonstrate knowledge, competence, and performance in ways that allow for varying levels of concentrated time commitment and learning preferences. Further, we would like to see the Commission ask the ABMS to strongly enforce Subsection F. Having a physician's entire career and livelihood hang on the single score of an exam is an outdated travesty and must not be permitted moving forward.

RECOMMENDATION 3

Professionalism is an important competency for which specialty-developed performance standards for certification must be implemented.

a. **ABMS Boards should develop new and reliable approaches to assessing professionalism and professional standing.**
b. **ABMS Boards should have common standards for how licensure actions for professionalism impact continuing certification.**

We support the Commission's commitment to finding new ways to assess professionalism. While we are supportive of the deeper focus on professionalism, multi-source feedback is mentioned as a possible option and, as we understand this concept, the AAFP considers that to be outside the scope of a certifying board. Successful implementation of multi-source feedback in countries that have done so has shown that it requires trust in the assessor, potentially a significant amount of expense, and a network of well-trained coaches. Thus, this approach would be logistically difficult to implement on the part of a specialty board among a diffuse group of physicians. Additionally, it has the potential to add to burden and lead to checkbox behavior if not implemented well. We recommend that unless these concerns can be clearly addressed, mention of multi-source feedback be removed from the supporting comments.

Consistency is important, and we enthusiastically support Subsection B of the recommendation indicating boards must have common standards for and a consistent application of how licensure actions are addressed and how they impact continued certification status. This is important as we know of situations where a state medical board takes the same action against physicians of different specialties but subsequent action of the appropriate ABMS Board(s) is very different regarding certification status. We would like the Commission to be more direct regarding the need for standardization and application of actions regarding a diplomate's certification status; stating for example, "ABMS Boards must" versus "ABMS Boards should."

In addition to common standards, clarification is needed regarding how "professionalism" is defined for board certification purposes, as well as the role ABMS Boards should have in promoting (in addition to assessing) professionalism. Historically, professional specialty

societies have sought to enhance physician education, quality, and practice support. ABMS Boards have focused on defining the criteria of physician certification, including testing and assessment. However, the evolution of the maintenance of certification process has led to overlap with professional society functions, resulting in confusion by diplomates and duplication of organizational activities. This is fundamentally unfair to diplomates/specialty society members as they seek to comply with both certification and membership requirements. As ABMS Boards clarify the role and criteria for certification, we urge the adoption of specific language regarding the scope of activities by certification entities.

RECOMMENDATION 4

Standards for learning and practice improvement must expect diplomate participation and meaningful engagement in both lifelong learning and practice improvement. ABMS Boards should seek to integrate readily available information from a diplomate's actual clinical practice into any assessment of practice improvement.

The Commission states that CME is observed to be of variable quality and we accept this as a challenge requiring additional focus by accreditors, specialty societies, and all providers of CME. The Commission also encourages boards to provide aggregated diplomate performance data to specialty societies and other organizations to better inform educational needs assessment processes. We fully support this sharing of data and believe that it adds further value to the “ideal example” previously mentioned. However, there are limitations to the utility of aggregated data, as detailed in our response to Recommendation 7, and we believe it is imperative that the boards share this data at both the aggregated and ***individual*** level.

The AAFP was the first of three national CME accreditors for physicians in the United States, followed by the American Medical Association (AMA) and later the Accreditation Council for Continuing Medical Education (ACCME), as well as the American Osteopathic Association (AOA). In this role, we set the standards of continuing education for family physicians and are uniquely positioned to support physicians in their lifelong learning and help them fulfill their certification needs. The findings section on p.18 mentions only the ACCME, failing to recognize the broader community of CME accreditors and their important roles in physicians’ lifelong learning. This oversight must be corrected by the Commission in its final report to acknowledge the role of all current CME accreditors.

RECOMMENDATION 5

ABMS Boards have the responsibility and obligation to change a diplomate's certification status when certification standards are not met.

We support this recommendation on behalf of public transparency, provided there are strong supports built into the continuing certification process that allow physicians to identify areas of deficiency and remediate them in ways that provide ongoing feedback, and that they have multiple options for meeting certification requirements.

We would caution the Commission to think through how the creation of other certification categories, referenced in the findings section (p.20), would be implemented and messaged, since it is clear from the findings section that there is already confusion about certification.

These categories have the potential to introduce further complexity at no benefit to the physician; for example, would insurers, employers, and hospitals recognize multiple categories when making decisions, or simply choose to still recognize a single category? The introduction of new remediation pathways, ongoing feedback to physicians about gaps in knowledge, and boards' enhanced communication with physicians may render these alternative certification categories unnecessary.

RECOMMENDATION 6

ABMS Boards must have clearly defined remediation pathways to enable diplomates to meet assessment, learning and practice improvement standards in advance of any loss of certification.

We are strongly supportive of this recommendation. The emphasis on remediation and explicit pathways back to certification for physicians who are struggling is less paternal, ensures physician retention, and perhaps most importantly improves overall quality of care. We want to make the Commission aware that the Coalition on Physician Enhancement (which counts FSMB among its members) is already working with licensing boards regarding remediation, and we strongly encourage the ABMS and its specialty boards to reach out to this organization to collaborate and draw on these best practices. The ABMS must work to ensure consistency among their member boards related to expectations for remediation options offered to diplomates.

RECOMMENDATION 7

ABMS Boards should collaborate with professional and CME/CPD organizations to create a continuing certification system that serves the public while supporting diplomates in their commitments to be better physicians.

a. **ABMS Boards should share aggregated results and trends in knowledge gaps with other specialty organizations to assist in the promulgation of medical advances to result in safe, higher quality patient care.**
b. **ABMS Boards, specialty societies, CME/CPD providers, and other organizations should work together on a uniform ABMS data strategy to create seamless transfers of information to ease diplomate burden in reporting what they have done, ensure patient privacy, minimize costs, and enable meaningful engagement (e.g. diplomate feedback, gaps in knowledge, registries, etc.).**
c. **ABMS Boards should have structured, at least annual, meetings with major specialty/subspecialty organizations to receive input and feedback about initial certification and continuing certification decisions and programs.**
d. **The ABMS Boards through the ABMS should engage and communicate, at least annually, with state medical societies and state medical boards to receive input and feedback about initial certification and continuing certification decisions and programs.**

We are supportive of this recommendation with the focus on collaboration with specialty societies and sharing of data. However, while it is true that aggregated data will help organizations understand how to address general or specialty-wide gaps, the Commission also acknowledges in Recommendation 4 (p.18) that physicians are not well-equipped to identify

their own gaps and select appropriate activities based on those gaps. Thus, aggregated data is not in itself a sufficient solution to this problem. Recognizing this deficit, the AAFP accreditation system is in the process of developing a new activity type whereby physicians receive credit for creating personalized learning plans based on their practice gaps based on externally validated sources. Given the crucial importance of the roles of both the boards and specialty societies in furthering the specialty, as described in the "ideal example" the Commission offers on p.24, the Commission should include direction to boards and specialty societies to identify ways to share both aggregated AND ***individual*** physician data that allow specialty societies to create and direct physicians to activities appropriate to address ***individual*** gaps in knowledge. In combination with the voluntary sharing of performance data, this could be similar to the Australian model where a physician would have the option to designate a CME provider organization as their CPD home, encouraging a trusting, life-long relationship between the CPD home and the physician.

We urge amending recommendation 7.a. to read **"ABMS Boards must share aggregated results and trends in knowledge gaps with other specialty organizations to assist in the promulgation of medical advances to result in safe, higher quality patient care. In addition to aggregated data, the ABMS Boards must also share data at the individual diplomate level with other specialty organizations in order to assist with personalized learning plan development."**

RECOMMENDATION 8

The certificate has value, meaning and purpose in the health care environment.

- **a. Hospitals, health systems, payers, and other health care organizations can independently decide what factors are used in credentialing and privileging decisions.**
- **b. ABMS must inform these organizations that continuing certification should not be the only criterion used in these decisions and these organizations should use a wide portfolio of criteria in these decisions.**
- **c. ABMS must encourage hospitals, health systems, payers, and other health care organizations to not deny credentialing or privileging to a physician solely on the basis of certification status.**

This is the Commission's most important recommendation, and the Commission must strengthen the position statements to reflect this stronger stance. We applaud the shift of perspective the Commission has proposed in this recommendation. While certification is often touted as voluntary, it has become functionally mandatory, with physicians frequently finding that not participating or failing to meet requirements in this "voluntary" process causes them to in effect lose their livelihood.

We recommend amending recommendation 8.b to read, **"ABMS must inform <u>and educate</u> these organizations that continuing certification should not be the only criterion used in these decisions and these organizations should use a wide portfolio of criteria in these decisions."**

We recommend amending recommendation 8.c to read, **"ABMS must actively encourage hospitals, health systems, payers, and other health care organizations to not deny credentialing or privileging to a physician solely on the basis of certification status."**

In the fourth paragraph of the ABMS Position Statement on the Delineation of Clinical Privileges, we recommend it be amended to: **ABMS supports consideration of a physician's education, training, practice experience, performance and other criteria, including specialty and subspecialty certification, *as important and equal criteria* in granting and delineating the physician's clinical privileges.**

Further, we suggest the following amendment to the ABMS Statement on the Use of Certification in the fourth paragraph: **However, licensing boards should also be free to use specialty board certification and continuing certification as *one of many* indicators of current competence *including documented training, experience, and demonstrated competence*.**

RECOMMENDATION 9

ABMS and the ABMS Boards should collaborate with other organizations to facilitate and encourage independent research that determines:

a. **Whether and to what degree continuing certification contributes to diplomates providing safe, high quality, patient-centered care; and**
b. **Which forms of assessment and professional development activities are most effective in helping diplomates maintain and enhance their clinical skills and remain current in their specialties. Which forms of assessment and professional development activities are most effective in helping diplomates maintain and enhance their clinical skills and remain current in their specialties.**

We fully support the focus on research and collaboration in this recommendation, although this is another area where the language should be more directive: ABMS and the ABMS Board "must" instead of "should."

RECOMMENDATION 10

ABMS Boards must collectively engage in a regular continuous quality improvement process and improve the effectiveness and efficiency of continuing certification programs.

We fully support this recommendation; however, the text underneath the recommendation surfaces the very important concern about finances, which does not appear in the text of the recommendation itself. In our view, the Commission needs to include this important direction regarding reasonableness of fees in the recommendation itself.

We recommend that Recommendation 10 be amended to read, **"ABMS Boards must collectively engage in a regular continuous quality improvement process and improve the effectiveness and efficiency of continuing certification programs. Boards should also assess the efficiency of internal operations as well as their financing. Fees charged to diplomates should be the minimum necessary to finance board operations and to have**

sufficient reserves to invest in programmatic initiatives that advance the quality and applicability of certification programs."

We think regularly seeking diplomate feedback is critically important and we encourage the ABMS to explicitly require that boards provide opportunities for diplomates to provide verbatim comments in the surveys as an additional source of input.

RECOMMENDATION 11

ABMS Boards must comply with all ABMS certification and organizational standards.

a. ABMS Boards must include diverse diplomate representation for leadership positions and governance membership and require that a supermajority (more than 67%) of voting Board members be clinically active. ABMS Boards should also include at least one public member.

While we agree with this recommendation regarding governance, the findings section of this recommendation specifically and appropriately calls out diplomate concerns about finances yet the wording of the recommendation itself avoids this critical subject entirely. We strongly agree with the Commission's statement on page 28 that "fees charged to diplomates should be the minimum necessary to finance board operations and to have sufficient reserves to invest in programmatic initiatives that advance the quality and applicability of certification programs." With this important statement and understanding, we offer the following additional comments that we hope the Commission will agree with and include in its final recommendations:

- The Commission should clearly state that all ABMS Boards must have yearly external audits of each board ***and*** their foundations, if applicable. These audits must be made available to diplomates and the public.
- The Commission should include in its final recommendation a firm and clear statement that diplomate fees should not be used by ABMS Boards to support activities and programs which are unrelated to the certification program and its quality.
- The Commission should question the need for ABMS Boards to have foundations ***if funded*** in any way by fees obtained from diplomates. If such foundations have been funded by excess certification fees and transferred to the foundation from the board, then such foundation monies should be returned to diplomates in some way, either directly or through certification fee reduction for a period of time.

In summary, we call on the Commission to greatly strengthen this recommendation and explicitly set the above expectations regarding the finances of the member boards. Annual financial audits with full transparency and the appropriate use of "minimal" diplomate fees only for certification activities is important for building diplomate trust regarding appropriate use of their fees.

RECOMMENDATION 12

Continuing certification should be structured to expect diplomate participation on an annual basis.

We are concerned about the requirement for diplomates to engage with their board(s) a minimum of once per year. This seems to be counterintuitive given the prevalence of burnout

and concerns about administrative burden among physicians. Certification should not add to these problems, and the Commission clearly states this philosophy elsewhere in the recommendations. The Commission must broaden this recommendation to ensure that certification does not inadvertently become more burdensome and unintentionally encourage the creation of frustrating checkbox activities. For example, the ABFM has utilized a three-year cycle for some time now and this has served as a practical framework for diplomate engagement allowing for flexibility while encouraging frequent engagement.

RECOMMENDATION 13

ABMS Boards must regularly communicate with their diplomates about the standards for the specialty and to foster feedback about the program.

We support this recommendation but suggest that the recommendation be strengthened to include direction to the ABMS that boards must develop standards for the specialty in collaboration with their specialty societies.

We recommend that Recommendation 13 be amended to read, **"ABMS Boards must actively collaborate with specialty organizations to develop the standards for the specialty. ABMS Boards must regularly communicate with their diplomates about the standards for the specialty and to foster feedback about the program."**

RECOMMENDATION 14

ABMS Boards should have consistent certification processes for the following elements:

a. **A uniform cycle length before a decision about certification status is determined;**
b. **Grace periods (either before or after the certification end date);**
c. **Remediation pathways;**
d. **Re-entry pathways to regain certification;**
e. **Single set of definitions for how certification status is portrayed and communicated to users of the credential including the public (e.g. certified, participating in continuing certification, probation, revocation, not certified, etc.); and**
f. **Appeals processes.**

We strongly support this recommendation, although this is an instance where a firm directive ("must" versus "should") would send a stronger, clearer message about the challenges with variation among boards. It is important that all ABMS Boards demonstrate consistency in their certification processes.

RECOMMENDATION 15

ABMS Boards should facilitate reciprocal longitudinal pathways that enable multi-specialty diplomates to remain current in multiple disciplines across ABMS Boards without duplication of effort or excessive requirements.

We wholeheartedly support the focus on decreasing duplication and burden for physicians.

In addition to our comments and suggestions regarding the recommendations above, the AAFP also believes the Commission should suggest important edits to improve two of the ABMS policy positions referenced and attached in the Commission's draft report. We strongly request that the following amendments to these ABMS policies be made:

ABMS Position Statement on the Delineation of Clinical Privileges

PURPOSE
The clear delineation of clinical privileges of medical staff members in health care organizations is intended to improve the quality of care by identifying professional capabilities of physicians and other practitioners, thus providing additional assurance that individual practitioners are competent to fulfill the delivery of care for which they are responsible.

POSITION STATEMENT
Medical specialty certification and subspecialty certification by a Member Board of the American Board of Medical Specialties **(ABMS)** is a voluntary process in which a physician first must meet nationally-established education, training and external assessment milestones to gain medical specialty certification, and then commit to a structured, rigorous program of lifelong learning in order to maintain certification. Medical specialty certification and subspecialty certification provides public assurance of the Board Certified medical specialist's commitment to the development and maintenance of expertise in the specialty.

Granting and delineating the scope of clinical privileges are institutional responsibilities, vested in the medical staff and the governing body of the healthcare organization. Delineation of clinical privileges seeks to assure that individual physicians are qualified to provide the care for which they are responsible by identifying the physician's education, training, and practice experience. In granting and delineating the scope of clinical privileges, the health organization medical staff and governing body consider each physician's training, experience, demonstrated performance, and other criteria relevant to the organization's clinical, operational and professional expectations.

ABMS supports consideration of a physician's education, training, practice experience, performance and other criteria, including specialty and subspecialty certification, **as important and equal criteria** in granting and delineating the physician's clinical privileges. ABMS also believes that neither specialty certification nor subspecialty certification should be the sole determinant in granting and delineating the scope of a physician's clinical privileges.

ABMS STATEMENT ON THE USE OF CERTIFICATION

ABMS Member Board Certification signifies that a physician or medical specialist has demonstrated the knowledge, skill, clinical judgment and professionalism that are essential for the safe and effective practice of his or her medical or surgical specialty.

Continuing certification by an ABMS Member Board signifies that its physicians and medical specialists can objectively demonstrate that they are continuing to meet the standards in their specialties throughout their careers and are committed to improving patient care.

For these reasons, ABMS Member Board Certification is trusted by patients and physicians and widely used by medical groups, hospitals, health systems, health plans and employers as an indicator of physician quality.

ABMS and its Member Boards believe that physicians should be eligible for a medical license without specialty board certification or continuing certification. However, licensing boards should also be free to use specialty board certification and continuing certification as **one of many** indicators of current competence **including documented training, experience and demonstrated competence**.

Information about ABMS Member Board Certification and continuing certification should be available, along with other relevant information or other current validation of training, knowledge, skills, and professionalism, without legal constraint, for consideration by medical groups, hospitals, health systems, health plans and employers in privileging and credentialing activities and decisions.

CONCLUSION

Overall, the AAFP recognizes that a significant number of the concerns and considerations expressed through our testimony and written comments have been addressed by the Commission in their draft recommendations and we appreciate this chance to offer our input for areas of opportunity for improvement. The AAFP looks forward to the Commission's final recommendations and to enthusiastically working with the ABMS and the ABFM to identify ways to collaborate on implementing the recommendations and moving forward from the certification concerns of the current state. Thank you for your thoughtful, productive, and constructive work to this point.

Sincerely,

Michael Munger MD

Michael Munger, MD, FAAFP
AAFP Board Chair