

The Next Generation of Board Certification: IMPROVING HEALTH AND HEALTH CARE SYMPOSIUM SUMMARY DOCUMENT

An ABMS Symposium

December 11, 2020



American Board
of Medical Specialties

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On December 11, 2020, the American Board of Medical Specialties (ABMS) convened nationally renowned experts and thought leaders for a virtual Symposium entitled *The Next Generation of Board Certification: Improving Health and Health Care (IHHC)* to discuss the role of improvement in continuing certification. Among the participants were ABMS Board of Directors, Member Board leaders, staff and Board governance representatives, ABMS Certification Committee members, Continuing Board Certification: Vision for the Future Commission Task Force members, representatives from ABMS Associate Members, Medical Specialty Society leaders, and representatives from the ABMS Portfolio Program Sponsor community. More than 86 unique organizations, including 21 ABMS Member Boards, were represented by the 208 Symposium attendees.

The overall goal of the Symposium was to establish a learning community that advances diplomate engagement with meaningful improvement opportunities through certification programs. Specifically, it sought to identify methods and practices to engage diplomates in improvement work throughout their careers, identify successful approaches to addressing barriers to implementing IHHC initiatives through continuing certification programs, and establish a collaborative quality agenda framework to guide improvement within each specialty.

The Symposium consisted of three sessions, each focusing on a different element needed to reach the overall goal: diplomate engagement, collaboration with specialty societies, and setting an agenda for each specialty. Sessions were composed of keynote presenters, facilitated reactor panels, small group discussions, and at-large question and answer sessions.

The purpose of this document is to provide key take-aways from the discussions held by the presenters, panelists, and participants and identify how ABMS can support efforts to establish a learning community that advances diplomate engagement in IHHC activities through certification programs.

SESSION I

STRATEGIES TO ENGAGE DIPLOMATES IN QUALITY WORK

Plenary speaker/moderator:

Paul B. Batalden, MD, Emeritus Professor (*Active*) at The Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth; Senior Fellow at the Institute for Healthcare Improvement; Guest Professor of Quality Improvement and Leadership at Jönköping Academy for the Improvement of Health and Welfare, Jönköping University; and Co-leader of the International Coproduction of Health Network

Panelists:

Ann Lefebvre

Executive Director for the South Carolina Area Health Education Consortium

Elizabeth A. McGlynn, PhD

Vice President for Kaiser Permanente Research, Executive Director of the Kaiser Permanente Center for Effectiveness and Safety Research, and Interim Senior Associate Dean for Research and Scholarship at the Kaiser Permanente School of Medicine

Joel Tieder, MD, MPH

Associate Professor of Pediatrics at Seattle Children's Hospital and University of Washington; Director of Seattle Children's Multi-Specialty Maintenance of Certification Program and Pediatric Hospital Medicine Fellowship Program; Pediatric Hospitalist; and a recognized national leader in quality improvement (QI) education and research

Jennifer B. McKenney, MD, FAACP

A practicing family physician in a small, rural community; Vice Chief of Staff at Fredonia Regional Hospital, Wilson County Health Officer, and President-Elect of the Kansas Academy of Family Physicians

Barriers to Diplomate Engagement in IHHC Work

- Diplomates sometimes do not perceive IHHC efforts, such as *Improvement in Medical Practice* (IMP) activities, as aligning with their daily work or efforts to deliver high-quality care. These can be viewed as items to be checked off a list to meet continuing certification (CC) requirements.
- Many physicians lack IHHC training. Residency programs have only recently started integrating IHHC as a standard into the Accreditation Council for Graduate Medical Education (ACGME) accredited programs.
- Physicians choose to become members of their professional societies but feel compelled to become board certified to obtain a job.
- Personal agency and choice seem to be foundational to diplomate engagement.
- Although diplomates may agree with the concept of CC, some question the incorporation of improvement into Board CC programs.

How ABMS/Member Boards Can Help Engage Diplomates in IHHC Work

Focus on what IHHC efforts diplomates are engaged in by:

- Tapping into diplomates' organic, intrinsic motivations to improve care and learning how they use processes, resources, systems, feedback, etc., to design IHHC activities around their passion and processes already in place.
- Obtaining feedback from diplomates to determine how engaged they are in IHHC activities and what bandwidth they have to support a wide-door approach to IHHC that captures quality work diplomates are doing in their respective practice settings. This can be done via a needs assessment and through personal engagement with diplomates.
- Articulating an idealized future with shared values and aspirations for IHHC efforts.
- Aligning Member Boards' IHHC activities with national IHHC efforts as well as what practicing diplomates are being asked to do at the local and regional levels.
- Seamlessly integrating IHHC activities into daily practice.

How ABMS/Member Boards Can Help Engage Diplomates in IHHC Work

Member Boards should change their approach to IHHC by:

- Grounding IHHC in empowerment. IHHC provides a body of knowledge and tools to help diplomates control their health care environment and address care gaps. IHHC is about improving, which should resonate with diplomates and be associated with positive feelings.
- Positioning IHHC as a partnership with diplomates and other stakeholders who support their engagement in improvement work.
- Emphasizing what diplomates are doing well and how they can build on that. Traditionally, telling someone to engage in IHHC implies that improvement is needed, which may have negative connotations.
- Finding ways to incentivize diplomates' participation in IHHC through partnership, rather than enforcement.
- Simplifying IHHC requirements for diplomates. For example, giving diplomates IHHC credit for IHHC work that is done routinely.
- Being flexible in identifying meaningful, less burdensome IHHC activities.
- Working with AAMC to introduce IHHC into the curriculum and ACGME to further develop or improve a IHHC curricula in GME training across more specialties.
- Minimizing the resistance to incorporate IHHC in smaller health care systems by assisting them in understanding how their current practices are intrinsically linked to IHHC.
- Identifying how small-scale improvement efforts can provide satisfying results.

Focus IHHC on patient care by:

- Engaging patients in IHHC efforts in a meaningful way, such as using patient-reported outcome measures (PROMs).
- Linking IHHC initiatives to impact patient outcomes. (e.g., preventing hospitalizations, patient-reported experience measures, PROs, reducing costs, etc.)
- Identifying a few specific high-priority areas that would require collaboration

Encourage IHHC efforts across Member Boards by:

- Promoting IHHC best practices across Member Boards and other stakeholders (e.g., Specialty Societies) to alleviate diplomate burden and increase value.
- Identifying several specific high-priority areas that would require collaboration across specialties to facilitate local level improvement efforts.

Address systems issues that could be impeding diplomate engagement in IHHC by:

- Engaging with diplomates to better understand their challenges and concerns regarding IHHC initiatives as well as what barriers exist at a system or practice level.
- Recognize that all systems are complex and often respond in unpredictable ways. This challenges the simple cause and effect assumptions and impels us to consider how the interactions and relationships of different components simultaneously affect and are shaped by the system in order to effectively problem solve and improve.
- Advocating for systems changes that will allow diplomates to refocus on patient care and effective team care.

How ABMS/Member Boards Can Help Engage Diplomates in IHHC Work

Provide IHHC training in improving care by:

- Offering coaching and/or mentoring for diplomates to help them understand and engage in IHHC work. Coaches can be physicians who have a background in medical education and IHHC and are skilled at identifying learning needs through observation and providing real-time feedback.
- Identifying mentors and facilitators across the specialties. They may not need to be specialty specific. Pediatrics is far ahead other specialties in its use of support of institutional leaders.
- Offering grants to support IHHC at hospitals/health systems in rural areas.
- Providing guidance and templates as well as using simple terminology to increase the value of IHHC instruction. Emphasize how IHHC can be integrated into practice.
- Using different vehicles (e.g., podcasts, emails, letters, and phone calls) to collaborate effectively based on diplomate preference.
- Increasing collaboration with training programs and stakeholders (e.g., quality departments, risk management etc.) to establish an inherent IHHC culture within institutions for trainees and practicing diplomates.

Provide support for practice improvement by:

- Building an IHHC community that diplomates can engage with to share and develop skills. Physicians learn best using real-time, practice-based education. For example, explaining how to use IHHC charts while doing an IHHC project.
- Providing additional support for smaller practices that lack the resources that larger groups may have to engage in IHHC.
- Engaging community and rural hospitals. For example, have stakeholder representatives from larger hospitals meet with leaders from smaller hospitals. In addition to sharing IHHC knowledge, they can partner to address IHHC initiatives at the local level.
- Providing diplomates feedback on their proposals for IHHC projects. The American Board of Pediatrics currently provides this feedback to its diplomates. The ABMS Portfolio Program, which works with 18 Member Boards, may be able to help facilitate this process.
- Providing opportunities within the Boards' CC programs to engage with diplomates within all practice settings (e.g., urban, rural, academic, and private practice).
- Providing an appropriate amount of information to diplomates; be mindful not to overwhelm with details or number of communications.

SESSION 2

MOVING TO THE FUTURE: ADVANCING QUALITY THROUGH CONTINUING CERTIFICATION PROGRAMS - PERCEIVED CHALLENGES AND POTENTIAL SOLUTIONS

Moderator:

Tom Granatir, Senior Vice President of Policy and External Relations at ABMS

Member Board/Specialty Society Dyad Members:

David B. Hoyt, MD, FACS

Executive Director of the American College of Surgeons (ACS)

Mary Post, MBA, CAE

Chief Executive Officer of the American Academy of Neurology (AAN)

Damon Marquis

Chief Learning Officer for the American Academy of Dermatology (AAD)

Jo Buyske, MD

President and Chief Executive Officer of the American Board of Surgery (ABS)

Larry R. Faulkner, MD

President and Chief Executive Officer of the American Board of Psychiatry and Neurology (ABPN)

Randall K. Roenigk, MD

Assistant Executive Director of the American Board of Dermatology (ABD)

How ABMS Member Boards Collaborate with Specialty Societies to Advance IHHC Work

- ABS uses many quality initiatives that have been developed by ACS. Among them are continuing medical education (CME) activities and the Surgeon Specific Registry. To date, the two organizations have not collaborated to develop any IHHC or research tools. A collaborative approach to IHHC may foster additional opportunities for partnership between ABS and ACS.
- ABPN and AAN are strong strategic partners. The two collaborate to develop lifelong learning CME, self-assessment, and patient safety resources for diplomates to meet continuing certification requirements. ABPN diplomates can meet continuing certification requirements by participating in the AAN's Axon Registry®. ABPN provided a grant to offer the AAN Annual Meeting on Demand during the COVID-19 pandemic, allowing diplomates complimentary access to it. When ABPN requested nominations for its Part III Pilot Project committee, six out of 11 nominations came from AAN. The two organizations are exploring ways to conduct joint research regarding education, and diversity, equity, and inclusion. This type of research requires better data sharing strategies and offers additional opportunities for future collaborations.
- ABD and AAD joined forces to reduce the administrative burden associated with documenting continuing certification activities. By creating an interface between the AAD's transcript service and the ABD's continuing certification table, a diplomate's activity from their AAD transcript automatically populates the relevant continuing certification requirements on their ABD continuing certification table, including self-assessment, CME, and IMP. AAD launched a Question of the Week program for diplomates, offering both CME and self-assessment credit. At its inception, ABD provided the initial content set for this portal, but item writing responsibilities were later assumed by AAD. Diplomates appreciate the ease of access, immediate performance feedback, and the automatic recording of their participation on their ABD continuing certification table. Additionally, AAD developed DataDerm, a registry certified by the Centers for Medicare & Medicaid Services. Participating diplomates automatically receive continuing certification IMP credit. Furthermore, articles from the AAD's *Journal of the American Academy of Dermatology* are prominently featured in the ABD's 'article-based question' component of its CertLink longitudinal assessment platform.

How ABMS Member Boards Collaborate with Specialty Societies to Advance IHHC Work

Identify how to work together by:

- Convening a high-level meeting between the Boards and Society dyads to chart a five-year plan for how Boards and Societies will collaborate to engage diplomates in IHHC work.
- Scheduling routine meetings between leadership and staff from Boards and Societies to communicate on a regular basis.
- Including Board and Society physician leaders in monthly meetings to identify synergies and develop key relationships within the physician community.
- Identifying leaders in both Boards and Societies who have roles and credibility in both groups and can effectively bridge the gap between the two.
- Resetting a common vision between Boards and Specialty Societies. They have a common interest in supporting high-quality specialty care.
- Developing an overarching shared vision for ongoing quality in the medical profession to improve health and health care with all stakeholders. Once there is a shared vision, work on goals, objectives, and strategies to achieve the vision.
- Working together to create regular and clear communication to foster meaningful engagement by diplomates.

Share information that would benefit both groups by:

- Identifying and sharing best practices for IHHC requirements and activities. For example, share types of activities well received by diplomates and most effective communication strategies. Other Boards and Societies can use or modify successful IHHC activities to be most relevant to their diplomates and members.
- Compiling and sharing reports that demonstrate where learning opportunities exist for diplomates/members. Use that information to guide diplomates to appropriate CME to fill those educational gaps.
- Sharing of aggregated data regarding diplomate practice issues, performance on assessments, and learning preferences.
- Providing more opportunities for Boards/Societies to be involved in the earliest stages of developing IHHC activities.
- Increasing the number of public members on the Board of Directors of both Boards and Societies to advance the communication and shared goals of improving quality of care.

Coordinate efforts by:

- Developing consistent messaging from the Boards and Societies to diplomates.
- Reinforcing to diplomates that the Boards and Societies work collaboratively to set goals, agree to measures, and improve practices.
- Developing simple low-burden entry points for diplomates to engage in IHHC initiatives for both Boards and Societies.
- Forming an online IHHC curriculum/resource center and/or co-hosting an annual meeting to reach out to diplomates/members. Position this meeting as facilitating practice improvement, not IHHC, per se.
- Engaging diplomates/members to identify key, common issues that are meaningful to them and the patients they serve and are amenable to IHHC projects that are designed to be integrated into practice.
- Exploring the use of registries and electronic health records (EHRs) in IHHC efforts.

SESSION 3

DRAWING UP THE PLAYBOOK: BUILDING THE COLLABORATIVE QUALITY AGENDA FRAMEWORK

Presenter:

Carolyn M. Clancy, MD, MACP, Assistant Under Secretary for Health for Discovery, Education and Affiliate Networks at the Veterans Health Administration (VHA)

Moderator:

Carolyn L. Kinney, MD, Executive Director of the American Board of Physical Medicine and Rehabilitation

First Reactor Panelists:

Warren P. Newton, MD, MPH
President and Chief Executive
Officer of the American Board of
Family Medicine (ABFM) and the
ABFM Foundation

Keith J. Mann, MD, Med
Vice President of Continuing
Certification at the American Board
of Pediatrics (ABP)

Daniel J. Cole, MD
Executive Director for Professional
Affairs at the American Board of
Anesthesiology (ABA)

Earl J. Reisdorff, MD
Executive Director of the American
Board of Emergency Medicine (ABEM)

How ABMS/Member Boards Can Build a Collaborative *Quality Agenda Framework*

- Identify quality and safety gaps that exist within each specialty.
- Focus on the scientific infrastructure that supports IHHC and build on the diplomates' unique training and intrinsic concern for patients to drive improvement.
- Set priorities – Look at causes of morbidity and mortality as well as patients' concerns (e.g., determine what the post-pandemic new normal will look like and which positive changes from COVID-19, such as telemedicine, should be kept). It's important to balance process and outcome concerns, and not to lose sight of learning and improvement.
- Develop or prioritize the measures that matter: Engage stakeholders – Think broadly to include patients, employer coalitions, payers, and practicing diplomates.
 - Learn what concerns patients, the most important stakeholder.
 - Consider using PROMs and improving online support and engagement for patients.
 - Work with health care purchasers to support a common roadmap.
 - Employer coalitions are a conduit to patients. Payers can address payment mechanisms. Engage with other providers because health care is a team sport.
 - Work with information technology vendors on such issues as “outlawing” manual data collection.
- Obtain buy-in from diplomates – Incentivize high-quality care through professionalism, national and regional IHHC initiatives, consumerism, and regulation.
- Partner with large health care organizations – Encourage and support diplomates to continually refresh their skills and knowledge. A clear and tangible connection between pride in one's work and the tools for assessing quality can be a potent, non-financial driver of high-performing organizations.
- Learn from existing efforts such as the Simulation Learning, Education and Research Network (SimLEARN), the VHA's national simulation-based training curricula. It provides national policies, procedures, and standards for conduct of simulation-based training across a network of VHA medical facilities in support of quality care. This innovative technology enhances diagnostic, procedural, and communication skills to support quality care and the best possible outcomes. SimLEARN offers training at all career stages.

How Four Member Boards Are Building a Collaborative *Quality Agenda* Framework

ABEM

- Using the approach that “the adult defines the content,” ABEM conducted a national summit, 26 focus groups, and surveyed 13,000 diplomates about how to modify its CC process. Diplomates responded that they wanted an annual activity, knowledge reinforcement, knowledge acquisition, and formative assessment.
- In response, ABEM is transforming the specialty through “accelerated knowledge translation.” The knowledge that gets translated is based on a survey of 500 volunteers; an expert panel of major journal editors, textbook editors, etc.; journal combing; and ideas funneled to MyEMCert editors.
- ABEM physician staff review every major medical journal of importance to the specialty to select topics. Articles undergo multiple review for topic selection. National Academy of Medicine criteria and evidence-based medicine guidelines used include disease burden, controversy, cost, new evidence, potential impact, sufficient evidence, public or private interest, variation in care, and equity.
- To span the gap, ABEM created synopses of major topics (500 words) with open access. High-impact changes are featured in three-minute Osmosis videos.
- ABEM is gauging its success by conducting validated questionnaires, determining diplomate participation in the Clinical Emergency Data Registry, a Qualified Clinical Data Registry, for which they are eligible for IMP credit; request for proposals for research; and outcomes data. Given the difficulty in accessing the latter, process data with a tight link to outcomes are deemed acceptable.

ABA

- ABA is improving patient care, beginning with its formative assessment designed to improve diplomate core knowledge.
- ABA is accelerating knowledge dissemination through MOCA Minute®. ABA has incorporated questions about the opiate epidemic; Zika virus; brain health; maternal care; COVID-19; improvement science; diversity, equity, and inclusion; and health care disparities.
- ABA is co-hosting webinars about best practices during the COVID-19 pandemic with the Anesthesia Patient Safety Foundation.
- ABA has established a “wide door” policy for IHHC/IMP activities. To date, ABA has approximately 15,000 individual improvement activities and roughly 2,500 system improvement activities. Systems also need to focus on improvement; it’s not just for diplomates.
- While it is essential for diplomates to maintain knowledge excellence, innovations from the Member Boards and Specialty Societies also are necessary to enable patients to have confidence and trust in the health care system.

ABP

- ABP has used its position to convene leaders and organizations, fund important projects, and set the direction for improving child health.
- ABP has created a national multi-center collaborative model for improving health care. The learning networks community currently has more than 533 teams at 289 sites in 43 states and D.C. as well as in five countries.
- ABP has created flexibility for pediatricians to obtain IMP credit through multi-institution or large-scale IHHC projects, workplace-based IHHC projects, the National Committee for Quality Assurance’s patient-centered medical home, institutional

How Four Member Boards Are Building a Collaborative *Quality Agenda* Framework

IHHC and safety leadership; and online IHHC modules. The latter option has declined 63 percent after ABP shifted its focus to workplace-based improvement across the spectrum of pediatrics.

- To increase relevance and value, ABP has created virtual IHHC modules to walk pediatricians through IHHC projects, launched a social media campaign to participate in IHHC projects focused on behavioral and mental health issues, launched an IHHC template for COVID-19 improvements, and helped diplomates collect data on health equity for IHHC projects.
- Surveys show that 75 percent of ABP diplomates agree or strongly agree that the IMP/IHHC activities they completed were relevant to their practice; 66 percent reported that these activities facilitated improvements to patient care.

ABFM

- ABFM's Performance Improvement (PI) 1.0 strategy was a response to the *Crossing the Quality Chasm* report issued by the Institute of Medicine in 2001. Built around an assessment of the size of the specialty and the need for education in QI, ABFM put in place requirements for PI for all diplomates and developed online modules and partnered with the American Academy of Family Physicians (AAFP) for QI education. In addition, the Board developed and required knowledge self-assessment modules for the diseases identified in the IOM report as the most important for improving health at that time. In subsequent years, ABFM has worked with ACGME to bring QI into residencies, developed mechanisms for large group practices and residencies to participate more easily and started the PRIME registry, a Qualified Clinical Data Registry, that enables easier EHR data extraction and facilitates the development of quality measures that better capture the core of primary care. In recent years, ABFM has begun a systematic refreshing of offerings to provide improvement opportunities for a wider variety of practices and to reduce burden.
- These interventions have had good outcomes. Annually, about 30,000 ABFM diplomates complete PI modules. In the most recent year, 98 percent of respondents indicated these new activities were relevant to their practice; 95 percent rated them favorable overall, and 85 percent reported that they facilitated improvements in practice.
- There remain significant challenges, however, for family physicians to improve health and health care. QI has evolved to an industrial process, reducing diplomate engagement, EHRs continue to add burden and provide data grudgingly, and many health systems and payers have focused on narrow clinical measures and not the broad array of outcomes envisioned in *Crossing the Quality Chasm*. In addition, family physicians increasingly have been concerned that the available measures do not capture the core value of family medicine.
- Accordingly, ABFM has worked to develop a new strategy for PI in consultation with AAFP. PI 2.0 prioritizes development and widespread implementation of “measures that matter”—measures that capture the core functions of primary care that drive population health: continuity, comprehensiveness, PROMs, and value of care. ABFM is submitting these measures to the Centers for Medicare & Medicaid Services for approval with implementation by payers and systems to follow. Additionally, the ABFM will consider adding selected disease-based measures and addressing other dimensions of care.
- A second component of the strategy is enhancing education about QI/PI. In 2014, ABFM required a QI project in Family Medicine Residency Programs. ABFM made residency the first stage of certification, including a QI project. To date, about 25,000 diplomates have had a QI experience in residency. ABFM's new strategy will include robust quality education, working with AAFP and other partners, diplomates.
- The final component of ABFM's proposed strategy is to support diplomates' intrinsic motivation by enhancing relevance and responsiveness and reducing burden of its CC process, and simplifying the process, including more self-guided activities. ABFM very rapidly implemented PI modules for practice transformation caused by COVID-19 and health equity. Learning from other Member Boards, ABFM is proposing further development of improvement networks and a health care system transformation collaborative.

How Four Member Boards Are Building a Collaborative *Quality Agenda* Framework

- Engaging the whole specialty to participate in the plan will be a critical next step. AAFP representatives attended this Symposium and helped develop the proposed plan. ABFM has reached out to all other clinical and academic organizations in family medicine and plans to convene a summit with these organizations as well as other stakeholders, such as patients and the public, individuals representing rural and other communities, and payers.

Second Reactor Panelists:

Helen Burstin, MD, MPH, MACP

Chief Executive Officer of the Council of Medical Specialty Societies

Tara Montgomery

Founder of Civic Health Partners, an independent consulting practice working with purpose-driven health organizations to improve their public engagement strategies and ethics policies and an Adjunct Lecturer in Health Communication at Tufts University Medical School

Barbara Wachsman, MPH

Public Member on the ABMS Board of Directors and Senior Advisor to two private equity firms specializing in health care financing

How ABMS/Member Boards Can Work with Societies and Patients to Build a Collaborative *Quality Agenda* Framework

- Frame quality efforts to address physicians' intrinsic motivation – professionalism.
- Build quality efforts that are linked to physicians' gap areas and provide feedback rapidly, enabling physicians to reflect on their learning. These efforts should not be burdensome.
- Work with Societies that have the data needed to drive learning and engagement.
- Measure the effectiveness of these quality efforts.
- Focus quality efforts on the health care team, not just physicians.
- Develop a strategy to work with Societies to promote quality together.
- Share these platforms with patients and purchasers.
- Understand that patients do not come in one type and all have unique experiences; expand the definition of PROMs to reflect that.
- Partner with patient advocacy groups to engage patients in quality efforts.
- Work with purchasers, who are the gatekeeper of hospitals, and determine which providers are in and out of networks. However, buyers are not prepared to make decisions regarding quality measures. They would rather see Member Boards and physicians make those calls.
- Understand that large employers, in particular, have data warehouses and are already using these data to evaluate physicians.
- Work with employers, which are conduits to patients. Employers are very interested in PROMs, which should be broadened to include mental health.
- Work with information technology vendors to facilitate access to data.
- Build a culture of learning to position transparency about learning, not punishing.



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