

## Next Steps on Comprehensive Care Internal Medicine

The American Board of Internal Medicine (ABIM) received many responses (more than 280) to the request for public comment on ABIM's vision for Comprehensive Care Internal Medicine as well as letters from a number of professional organizations. The responders included generalist and specialist physicians, educators, patients, purchasers, insurance executives and officers of professional organizations.

Across virtually all the comments there was agreement that the comprehensive care competencies outlined in the report— particularly the abilities to manage teams, information, resources and population-level data – are vitally important in an increasingly complex and fragmented delivery system.

A number of commentators, including physicians, patients and purchasers, expressed strong support for the proposal, telling us:

- general internists who demonstrate these competencies should be recognized for what they do.
- new models of primary care relying on these competencies will be critical to meeting the needs of an aging population.
- this model would likely result in better patient care and be better for the delivery system.
- ABIM's moving forward in this area would have a positive impact on changing educational expectations for internists and increasing focus on skills that many felt are neglected.

Physicians and medical organizations also expressed concern about the proposal and told us they believed:

- this would increase fragmentation in internal medicine and/or in primary care.
- internists – both general and subspecialty – are already doing all the things listed in the Report and that all internists have or should have the competencies listed.
- the real problem facing general internal medicine is the reimbursement system and adding new expectations for those already undercompensated would be both unhelpful and unwise, as it might make even fewer trainees want to do this.
- others are working in this area and ABIM should not act alone.
- ABIM should be confident it can assess the competencies described in the report before it commits to issue a credential based on them.

At the ABIM Board of Directors meeting on February 7, 2008, the Board discussed the feedback it had received (which was distributed unedited to all Directors) and decided to take the following actions:

1. *Develop the tools necessary to rigorously and robustly assess the competencies articulated in the Report, with particular focus on teams, patient advocacy, information management, communication, systems management, change management and resource accountability.*
2. *Develop partnerships with the explicit goal of establishing the above tools in the domains of practice and education.*

ABIM is committed to finding ways to assess these competencies through Maintenance of Certification, but the Board tabled a decision on how to acknowledge them.

We expect the experience we gain by developing these tools, working with other partners, and continuing dialog with other internal medicine organizations, colleagues and other stakeholders will inform a future decision as to how best to acknowledge physicians who demonstrate those competencies – possibly by creating a separate voluntary certification pathway in Maintenance of Certification, a freestanding module within MOC, or by gradually diffusing these competencies throughout MOC, or some combination thereof.

## **Competencies Needed for the Practice of Comprehensive Care Internal Medicine & Status of ABIM Assessment Tools**

A series of Round Table discussions with patients with chronic illness, representatives from major internal medicine organizations, Directors and staff from ABIM, and four key stakeholder groups: the Health Care Team, Subspecialists-Generalists, Health Plans, and Purchasers helped us develop the list of and definitions for the competencies needed in the practice of Comprehensive Care Internal Medicine. What follows is a discussion of those competencies and an analysis of the ABIM assessment tools currently available.

### **Competencies**

Competencies needed in the practice of Comprehensive Care Internal Medicine address the need for personal, longitudinal and coordinated care – including prevention and wellness care – for a defined population of patients with undifferentiated, acute and/or chronic problems. A physician who practice Comprehensive Care Internal Medicine must be:

- An expert diagnostician and clinician
- A patient advocate
- An effective communicator
- A team leader and an effective teammate
- A systems manager
- An effective user of health information technology and health data
- An effective change agent
- A practitioner accountable for efficient, accessible care

### **Definition and Status of ABIM Tools**

#### ***a. Expert diagnostician and clinician***

The Comprehensive Care Internist needs to have broad knowledge across multiple disciplines of Internal Medicine and other specialties and must be skilled in putting that knowledge at the service of patients. At the same time, the Comprehensive Care Internist must be conversant with standard management of common chronic illnesses (e.g., diabetes, cardiovascular disease, cancer, asthma, etc.), as well as possess the ability to formulate diagnoses and management plans appropriate to patients with complex and sometimes interlocking problems. As in the whole of Internal Medicine, diagnostic reasoning is central, but unlike subspecialized practice, knowledge across organ systems and specialties is essential. Care of patients with undifferentiated problems is one of the hallmarks of this form of practice. The ability to “tolerate uncertainty rather than eradicate it” is another distinguishing feature of one who embraces this form of practice. We do not imagine the Comprehensive Care Internist will possess “deep knowledge” in all areas of Internal Medicine, especially as practice occurs at a “technology enabled” interface where a physician can use computers to access a variety of sources of current knowledge. But we expect the Comprehensive Care Internist to plan and organize for the fact that he or she will often be confronting clinical problems for which his or her own available knowledge is insufficient. Comprehensive Care Internists will need to have deep enough system and specialty knowledge to be able to facilitate and coordinate care across many clinical domains.

#### ***Status of ABIM Assessment Tools***

In many ways, ABIM's existing tools are adequate to the task of assessment of clinical and diagnostic skills: Maintenance of Certification products in self-assessment and the secure examination provide validated tools to support and assess broad knowledge competence. There is a need to develop tools that assess the physician's ability to find and apply information at the point of care when such information will benefit the patient.

### ***b. A patient advocate***

In a fragmented delivery system with increasingly complex choices and responsibilities, patients find themselves in need of someone who will be their advocate. Many at the Round Tables referred to this as "system navigational support," encompassing advice on what to get and help in getting it. Examples offered at the Round Tables included advocacy with payers for coverage of appropriate services, with specialists for timely access, and with community organizations to engage appropriate services. This is a role that general internal medicine practitioners have been increasingly called upon to play, and many see it as requiring an unsustainable amount of time and energy which pulls them away from what some think of as their core responsibility. Given that this service is not explicitly recognized or supported by the current reimbursement system, physicians in practice do not typically have the resources to take this on personally, nor are they able to create a more systematic team capacity to meet this need. But it was something most participants in the Round Tables felt was an important component in the practice of Comprehensive Care Internal Medicine even as they acknowledged this was not something the physician should personally be doing. Rather, it is the responsibility of the Comprehensive Care Internist to ensure that patients' advocacy needs are met, whether by another member of the health care team or through external resources.

#### *Status of ABIM Assessment Tools*

ABIM has no tools to assess the skills or structures required to be an effective advocate and would need to further define the professional expectations of the physician even before it could begin to develop useful assessment tools.

### ***c. An effective communicator***

Communication is a core skill of any physician, but is critical for the Comprehensive Care Internist. The Comprehensive Care Internist should be a translator, explaining in accessible terms what other specialists might have communicated more technically. The Round Tables also articulated the expectation of being a "tiebreaker" for patients when they received conflicting advice, or helping patients realize their values as they chose among treatment alternatives that might have a clear "medical" answer which might be in conflict with the patient's personal goals. The traditional expectation of excellent, effective patient-doctor communication is clearly core to the Comprehensive Care Internist. In addition, it was expected that the Comprehensive Care Internist communicate effectively with other specialists and members of the health care team, taking responsibility for framing questions appropriately and assuring provision of selected clinical information to other clinicians.

#### *Status of ABIM Assessment Tools*

Though the ABIM has always aspired to assess communication skills, many of the participants in the Round Tables thought existing ABIM evaluation tools were not robust enough to assess the level of competence that we expect here, both with respect to patient-doctor communication and to peer/system

communication. Adoption of new tools, some of which may already have been developed by others, is likely to be necessary.

#### ***d. A team leader and an effective teammate***

Comprehensive Care Internal Medicine is, of necessity, a team activity. Successful practice will require mobilization of human resources beyond the individual physician. The Round Tables spent a lot of time discussing the need for physicians to be prepared to function as a member of a team, either in the role of leader or participant. Many reflected on the training environment, noting that physicians are trained to make decisions quickly and independently, and to be personally responsible for getting things done. Several noted that it is praiseworthy in training to solve problems by increased personal work, and this was recognized to be dysfunctional in working with teams. These learned behaviors make it difficult to delegate effectively and to respect others' roles in the decision making process. Clearly this is changing rapidly in many training settings, both because of work-hour restrictions (which obligate team approaches) and because of Residency Review Committee experiments. Many in practice, however, were trained under an older model and may be particularly lacking in team-building and team-sustaining skills. For those now in practice, current financing of ambulatory care does not generate sufficient revenue to support a broad team. As a consequence, highly paid doctors are doing tasks that less trained, less expensive employees could and should be doing. Several Round Table participants, particularly among the purchaser/employer community, expressed frustration about being asked to pay for a model with that kind of built-in inefficiency. Many participants noted that there are core skills of team function, including responsible delegation, development of clear job descriptions to support team members' activities, and the ability to convene and run productive team meetings, to name a few.

#### ***Status of ABIM Assessment Tools***

Team skills can be and are assessed in other organizational contexts (such as 360° performance reviews in business). It is likely ABIM will need to develop new capacities to assess "team leadership" competence of physicians, evaluating key competencies such as delegation and respect for other team members. The Agency for Healthcare Research and Quality Framework for Team Competencies may provide a helpful guide.

#### ***e. A systems manager***

All the Round Tables acknowledged the critical role of the organization of systems of care in reliably meeting the needs of all patients, including those with multiple chronic illnesses. Systems development is part of Team Leadership: setting up and implementing systems is requisite to mobilizing other team members and leading an effective team. The groups identified a key skill that a Comprehensive Care Internist needs to possess: the ability to recognize unanticipated or undesirable outcomes as sentinel events which may require a designed solution as opposed to a "patch" (often involving the physician himself simply solving the problem for that particular patient). Competence in Root Cause Analysis, in ongoing performance monitoring and in the integration of people and process were all felt to be essential skills for the Comprehensive Care Internist to possess. In many training environments, responsibility for "systems development" is vested in the hospital and/or a group practice administration and is not seen as a core skill for physicians. But learning to interact effectively and, as appropriate, adopt or lead system change needs to be seen as a core physician skill.

#### ***Status of ABIM Assessment Tools***

These skills are taught and evaluated by business schools, as well as schools of hospital administration or engineering departments, and many participants felt ABIM could “borrow” tools from these other disciplines to assess competencies in the area of Systems Management. ABIM’s existing tools in this area need further development.

#### ***f. An effective user of health information technology and health data***

Successful use of health information technology will clearly be necessary for the competent practice of Comprehensive Care Internal Medicine. None of the participants in the Round Tables felt that the physician needed a deep knowledge of computer science; rather, the groups felt that physicians needed to appreciate the difference between structured and unstructured data, to develop and use the reporting and work organizing capacity of information technology in their practice, and to keep records in a way that made the best use of the information technology available to them. Physicians practicing Comprehensive Care Internal Medicine will routinely generate and test hypotheses about their care, and effective use of information technology to address those queries will require a different approach to documentation, one that anticipates the way in which structured data will underlie this process. They will also employ information technology to activate the team and empower team members to function at the top of their license. Everyone understood that simply “having” technology in the office would not assure its successful use, and that physicians would need to continually re-assess office practice and staff/physician tasks based on evolving capacities created by the technology. The focus was not on “knowing computers” but rather on “effectively using computers to organize and use digital information,” which clearly requires some technical skill. While many participants noted that physicians may not control their “technology environment,” effective use presupposed the possibility of constructive interaction with it.

#### ***Status of ABIM Assessment Tools***

This area seemed to lend itself well to content-based testing and to demonstration of practice capacities as evidence of effective use of technology. Once the knowledge content itself was specified, ABIM could develop assessment tools using its existing assessment framework (including assessments of self-study, knowledge demonstrated on a secure exam and demonstration of performance in practice).

#### ***g. An effective change agent***

A repeated theme in all of the Round Tables was that current practice organizational models will not be sufficient to deliver excellent care, and that models will evolve with new technology and changing patient and delivery system expectations. The capacity to adopt and manage change is thus a core skill of the Comprehensive Care Internist. Almost all physicians who embrace this practice will need to lead or participate in dramatic changes in the design and organization of their practices, and they will need to do this fully engaging and participating in practice teams. Change management is itself a formal skill that can be learned and assessed.

#### ***Status of ABIM Assessment Tools***

Participants felt Change Management was both a testable knowledge issue (core concepts of change management) and a practice implementation issue (the demonstration of effective change within a practice), both of which could be assessed by ABIM, though new tools will be required. Further delineation and specification of the content of relevant expertise in change management will need additional work by ABIM.

#### ***h. Accountable for efficient, accessible care***

A shared expectation of the Comprehensive Care Internist is that the physician's practice be efficient and not wasteful. Accountability for both resource utilization and the quality of care delivered is a core expectation of the Comprehensive Care Internist and one of the clearest ways he or she will demonstrate value to the patient and to the delivery system. Achieving this goal will require success in all the other competencies listed above, as only a well-functioning, high-performing practice team that can measure and improve its results will deliver this kind of value. A willingness to be accountable coupled with a commitment to reporting, analyzing and improving performance is central to the Comprehensive Care Internist.

#### *Status of ABIM Assessment Tools*

ABIM has made great strides in measurement in this area and is already committed to achieving psychometric rigor in physician performance measurement. Further work by others in the fields of quality, efficiency and effectiveness measures will also provide tools for ABIM assessment.