Annual Report 2014 - 2015

ABR CERTIFICATION

Partners in Evolution



"Alone we can do so little; together we can do so much." - Helen Keller



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ABR Vision	The ABR will be the recognized continuously improving the procertification of our diplomates.		

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he ABR Executive Director

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A MESSAGE FROM THE ABR PRESIDENT

Evolution of ABR Certification: **Process and Partnership**

nnual reports can be prosaic reading, even for those who have a thirst for details. By tradition, they offer articles with tidbits of efforts expended and missions accomplished. This year is no exception as a number of significant ABR accomplishments of inter- Milton J. Guiberteau, MD est to our diplomates are



described in this report. However, often missing are explanations of the motivations, practical assumptions, and processes that underlie these efforts. In this time of frequent change in our professional landscape, it seems reasonable that I provide you, our stakeholders, with more than a presidential summary of information already available on the pages that follow.

In a number of significant ways, the past year has been a pivotal one. As documented in this report, the year included (1) completion of transitioning the diagnostic radiology (DR) oral certification exam to a fully computer-based process; (2) the final steps in converting ABR Maintenance of Certification (MOC) to a Continuous Certification process; (3) the culmination of a near decadelong process to establish a new medical specialty of interventional radiology/diagnostic radiology (IR/DR) through the formal implementation of a fourth ABR discipline; and (4) a major restructuring of ABR governance to better meet the challenges of the future. To say that these significant achievements, along with numerous more mundane issues, have consumed much of the Board's time, attention, and resources over the past few years is an understatement. However, with missions accomplished come new opportunities.

With full implementation and maturation of the ABR's MOC program, 2014-15 has represented a welcome occasion to re-evaluate MOC components regarding practicality of requirements and facility of process. This included a healthy dose of Board introspection in re-assessing two fundamental and sometimes conflicting aspects of our

self-regulatory mission: ensuring that programs successfully meet the ABR's foundational goals to protect patients and the public while also providing program components that are sufficiently reasonable, understandable, and easily achievable by practicing diplomates. The Board considers setting an appropriate balance between adequate requirements and diplomate support to be central to its mission. This task is not as simple as it may seem. However, 80 years of evolution in societal expectations, self-regulatory philosophy, and ABR experience have given rise to better options for advancing such an equilibrium.

In the not-too-distant past, medical self-regulation bodies were regarded as ivory tower academes spouting requirements in isolation from a real world of growing external mandates and remote from the everyday challenges and stresses of practicing radiologists. However, with respect to today's ABR, nothing could be further from the truth. Our Board of Trustees is populated by 24 practicing radiology professionals from all corners of our community with a collective practice experience approaching half a millennium. Many are heads of their practices and leaders in local, regional, and national radiology organizations. All are subject to the same MOC requirements and processes (including random audits) as other diplomates and are not shy in expressing their personal concerns and those of their colleagues regarding perceived flaws in our programs. All are well connected to the realities of practice and the ever-expanding obligations placed on practitioners from every quarter, including the universal calls for professional accountability and transparency. As such, ABR trustees understand the importance of our Board's own transparency to diplomates by disclosing the decision-making processes and sources of input we rely upon to establish and evolve ABR programs.

Three of the most important sources of guidance are input from the radiological community through fellow radiology organizations, collaboration with the broader medical community through other specialty boards, and focused feedback from our diplomates. Obtaining this input means we must continue to develop and build on our working partnerships with these resources by using the strengths that each brings to the table to advance mutual goals for our profession.

Professional Organizations. It is a simple truth that professions cannot survive without strong professional organizations. ABR leaders meet regularly with the leaders of many national specialty and subspecialty radiology professional societies to share thoughts on mutual areas of interest within the ABR's programs. As partners in serving our profession, their disparate viewpoints provide windows on the expectations placed on radiologists from many perspectives, both inside and outside the radiology community. In turn, this influences the requirements and standards developed by the ABR to help radiologists meet those expectations. Further, professional societies' creation of products and projects in support of ABR programs has allowed participants easy access to tools for meeting ABR requirements while fostering their satisfaction with the process itself.

Certification and Accreditation Organizations.

To align with the broader medical community beyond our own specialty, the ABR participates in an exchange of ideas with our partners in the ABMS board community, as well as accreditation organizations such as the Accreditation Council for Graduate Medical Education (ACGME). Certainly, in the past year, we have learned a lot from our fellow certification boards' successes and missteps in their own programs, offering us processes to emulate as well as to avoid. Fortunately, the ABR's MOC program has proved to be a virtual role model for adapting requirements to the concerns of practicing diplomates. In addition, the ABR continues to stress the critical need for ABMS to persist in seeking data for external validation of MOC programs' impact on improving the quality and safety of patient care.

Our Diplomates. The introduction of MOC and Continuous Certification fundamentally changed the ABR-diplomate interaction from a one-time encounter with the Board to a professional lifelong relationship. Thus, diplomate input into this partnership has become a valuable ongoing requirement for development and assessment of our programs. As the collective membership of our specialty, we place our trust in the ABR to perform the vital function of certification in a manner that is as robust, yet as nonintrusive, as possible. We obtain feedback from our diplomates through focused online surveys, diplomate advisory committees, and direct interactions

during ABR update sessions and at ABR kiosks at multiple national meetings throughout the year. These efforts have already borne fruit as evidenced by the recent improvements in ABR MOC Part 4 (Practice Quality Improvement), based on diplomate feedback. This change, which offers credit for quality activities already performed by diplomates in the course of their practices, has been very well received. And, as always, there is more to be done.

Already begun is a focused evaluation of MOC Part 3 through consideration of options for possible replacement of the current 10-year "recertification" examination. Because MOC is now a continuous process, it makes sense that a mechanism for ongoing assessment of knowledge and judgement be sought. This also has the potential to eliminate the time, travel, cost, and anxiety of the current exam-center testing model, as well as to link the discovery of any diplomate knowledge gaps with remediation through CME required for MOC Part 2.

The Bottom Line. Board certification represents a radiologist's personal commitment to provide a high standard of quality patient care and is an acknowledged benchmark of public trust. The ABR's challenge in providing Continuous Certification is to achieve the delicate balance of creating rigorous and meaningful programs that are also relevant and appropriate for performance by busy practicing radiology professionals. This means avoiding the pitfalls of either overdiluting our requirements or overreaching them by setting the bar too high.

While the Board must guard its privilege to operate without interference with its mission to protect the public, it also must be open to the perceptions and feedback of our relevant communities and those who delegate to us the awesome responsibilities of self-regulation. These interactions ensure that our Board is operating within acceptable limits in reaching the program balance it hopes to achieve. Employing these methods, the past year has enabled us to successfully reevaluate and improve problematic portions of our MOC program. I am convinced that through using the same methods, the coming year will provide additional opportunities for positive change.

A MESSAGE FROM THE ABR EXECUTIVE DIRECTOR

Discovering ABR Teamwork

S ince I began my position as ABR executive director in July 2014, I have been amazed and excited to discover something new almost every day. Usually, these discoveries are small yet very meaningful: the staff member who doesn't drink coffee but comes in



Valerie P. Jackson, MD

early and makes it for everyone else so several pots will be ready when they arrive; the support our employees offer others who are out sick by sending cards and flowers and donating paid time off from their own accounts to help those who don't have enough to cover a major illness; the adoption of a stray cat, now known as the ABR mascot "Ollie," by feeding her, giving her a kitty condo, and even providing veterinary care; the ABR team that recently participated on a Saturday morning in the local Community Food Bank walk and raised more than \$1,200; and the genuine and touching sorrow expressed at the sudden death of a staff member, with the resulting effort to plant a tree accompanied by a stone placard in front of the building as a memorial.

These personal examples of teamwork and a caring attitude are evident every day in our staff's dedication and hard work, bringing together each of their individual talents to accomplish our goals on behalf of ABR candidates and diplomates. This team also includes our four dedicated associate executive directors, who are part-time yet often put in many extra hours contributing to the work of the ABR.

But it doesn't stop there. I know firsthand how much hard work is accomplished by the volunteer members of our ABR Boards of Governors and Trustees. This 28-member team is composed of practicing radiology professionals from around the country who, among many other tasks, donate countless hours working with exam committees, formulating and writing policies, developing strategic plans, assisting staff members with their projects, attending and presenting at society meetings, and sometimes making tough decisions on behalf of the ABR. Above all, they are dedicated to ensuring that ABR board certification is the most valuable credential possible, while at the same time listening and responding to the concerns of ABR candidates and diplomates.

Casting the net even wider, I cannot say enough to thank the many professional radiology societies, as well as our ABR volunteer committee members! As of October 2015,



ABR mascot Ollie, relaxing in her new "condo"

this group included 449 item-writing volunteers and 766 potential oral examiners. Without their help, the work of our governors, trustees, and staff would not be possible. They come from a variety of practice environments across the country and serve as committee chairs and members, oral examiners, self-

assessment module (SAM) reviewers, and image asset contributors. Like our staff, they put in long hours and work hard but greatly enjoy the benefits of teamwork, including interaction with their colleagues; the exchange of ideas; the opportunity to create, assemble, and administer fair board examinations; and the satisfaction of giving back to their profession. And like our governors and trustees, they all participate in Maintenance of Certification, even if they are



lifetime certificate holders, to exhibit the value they see and the trust they place in the ABR MOC program.

Perhaps the most important members of the ABR team, however, are you—our candidates and diplomates. As of December 31, 2014, the ABR had issued 64,840 certificates since its inception in 1934, with 17,899 of those issued in the past 10 years alone.

Perhaps the most important members of our ABR team, however, are you—our candidates and diplomates.

We consider you the most crucial members of our team, and we appreciate your feedback, whether it's a congratulations for a job well done, a suggestion for improvement, or even a downright criticism. As mentioned in the MOC Update (see page 8), the feedback given by our ABR MOC Advisory Committees, as well as the many responses from diplomates to an April

2015 MOC survey, was very helpful to us in determining the important changes recently made to our MOC program. As the most essential part of our team, your opinions are truly appreciated.

During their breaks, some of our ABR staff members enjoy working on jigsaw puzzles, which we have set up on a table in our lunchroom. A recent puzzle was titled "Impossibles: The Borderless Puzzle with 5 Extra Pieces." Usually, it takes a while for staff members to complete these puzzles since they only work on them for a few minutes at a time, and this one was particularly challenging. But finally, it was done, and I walked in one day to discover this handwritten note on top of the finished puzzle: "Impossible? I don't think so!"

To me, this sums up the positive attitude I've seen displayed by all members of our ABR team—staff, trustees, governors, volunteers, candidates, and diplomates alike. With a team like ours, nothing is impossible, and I'm so proud and honored to be a part of it all!

CERTIFICATION STATISTICS

All Certificates Issued by Decade (1930-2014)										
Year Founded:	1934- 1939	1940- 1949	1950- 1959	1960- 1969	1970- 1979	1980- 1989	1990- 1999	2000- 2009	2010- 2014	TOTAL
1934	1,413	1,844	3,303	4,175	9,318	10,083	12,391	12,994	9,319*	64,840

*Numbers decreased due to transition from the oral exam to the Certifying Exam in diagnostic radiology (see table below).

Specialty Certificates Issued 2005-2014											
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	TOTAL
Diagnostic Radiology	1,094	1,133	1,162	1,207	1,233	1,239	1,257	1,328	1,329	123*	11,105
Medical Physics	135	141	136	200	204	204	315	263	264	279	2,141
(Therapeutic)**	(109)	(121)	(116)	(181)	(169)	(181)	(263)	(232)	(211)	(217)	(1,800)
(Diagnostic)**	(20)	(16)	(16)	(14)	(28)	(22)	(41)	(29)	(45)	(54)	(285)
(Nuclear)**	(6)	(4)	(4)	(5)	(7)	(1)	(11)	(2)	(8)	(8)	(56)
Radiation Oncology	107	136	135	123	166	139	148	155	170	164	1,443
Total	1,336	1,410	1,433	1,530	1,603	1,582	1,720	1,746	1,763	566*	14,689

*Due to the transition from the diagnostic radiology (DR) oral exam to the DR Certifying Exam, only those who took and passed a DR oral exam were certified in 2014. The first DR Certifying Exam was administered in October 2015.

**Specific specialty of medical physics

Subspecialty Certificates Issued 2005-2014											
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	TOTAL
Neuroradiology	81	134	139	148	158	167	185	197	189	159	1,557
Nuclear Radiology	7	4	2	3	2	5	7	7	13	11	61
Pediatric Radiology	28	24	31	34	41	40	53	59	60	57	427
Vascular & Interventional Radiology	77	74	88	81	103	98	117	133	150	177	1,098
Hospice & Palliative Medicine*	NA	NA	NA	9	0	11	0	42	0	5	67
Total	193	236	260	275	304	321	362	438	412	409	3,210

*Subspecialty approved in 2006; examinations offered every other year, beginning in 2008. Certificate administered by the American Board of Internal Medicine.

Number of Diplomates Participating in Maintenance of Certification						
	Diagnostic Radiology	Radiation Oncology	Medical Physics	TOTAL		
Enrolled in MOC*	19,631 (1,872)	2,983 (253)	2,452 (71)	25,066 (2,196)		

*As of November 11, 2015. Number of lifetime certificate holders in parentheses.

EXAMINATION STATISTICS

Diag	nostic Radiology Core Exam Pass Rates	Medical Physics Part 1 Exam Pass Rates (first-time takers enrolled in CAMPEP program)			
Year	Residents taking exam for first time	Year	General	Clinical	
2013	87%				
2014	011/	2010	87%	87%	
2014	91%	2011	0.00/	0.0%	
2015	87%	2011	88%	90%	
		2012	92%	86%	
		2013	86%	77%	
Radiation Oncology Initial Exam Pass Rates (residents taking exam for first time)		2014	70%	75%	

Radiation Oncology Initial Exam Pass Rates (residents taking exam for first time)							
Year	Clinical	Physics	Biology				
2010	96%	90%	91%				
2011	94%	96%	97%				
2012	95%	80%	88%				
2013	93%	91%	96%				
2014	92%	81%	87%				

Radiation Oncology Oral Exam Pass Rates						
Year	Residents taking exam for first time					
2010	85%					
2011	82%					
2012	82%					
2013	89%					
2014	93%					



Medical Phy	ysics Part 2 I	Exam Pass Rates
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Voar	Fir <mark>st-time</mark>	First-time Takers			
Tear	Takers	Enrolled in CAMPEP Program			
2010	83%	100%			
2011	81%	90%			
2012	86%	83%			
2013	74%	78%			
2014	68%	75%			

Medical Physics Oral Exam Pass Rates						
Year	Residents taking exam for first time					
2010	59%					
2011	61%					
2012	60%					
2013	59%					
2014	65%					

Medical Physics 2014 Oral Exam Results (First-time Takers)						
	CAMPEP Graduate	CAMPEP Residency	CAMPEP Graduate & Residency			
Total	39	31	29			
Pass	77%	81%	79%			
Condition	18%	0% <mark></mark>	7%			
Fail	5%	19%	14%			

MAINTENANCE OF CERTIFICATION REPORT

by Vincent P. Mathews, MD, ABR Board of Governors

n early September 2015, the ABR announced two major improvements to its Maintenance of Certification (MOC)



program. The first, regarding requirements for Part 4 (Practice Quality Improvement), became effective immediately. The second, known as "Simplified Attestation," will become available on myABR on January 4, 2016. In addition, the ABR announced that it is exploring alternatives to the current Part 3 requirement of a secure, proctored MOC examination every 10 years.

Almost a decade has passed since the full implementation of all four parts of the ABR's MOC program. While the program has generally been well received by ABR diplomates, it had become increasingly apparent to the ABR trustees, all of whom are practicing radiology professionals who also participate in MOC, that portions of the program needed improvement to make MOC's requirements more relevant to practice. Changes were also needed to reduce the dedicated cost and time required of participants. This was especially true given the ever-increasing external demands imposed by institutions and healthcare systems, as well as by the government, regulators, and payors.

Thus, during the previous year, the Board had undertaken a review of MOC program requirements to address areas of concern identified by its diplomates. In addition to ABR trustee committee initiatives, this reassessment was further informed by input from ABR diplomate MOC Advisory Committees and by responses from diplomates to an April 2015 ABR MOC survey. This feedback was very helpful in focusing and prioritizing MOC program modifications to accommodate areas most in need of improvement.

Changes in MOC Part 4 Requirements

As a first step, the ABR announced the following appropriate improvements to Part 4, which took effect immediately:

Expanded Options for Satisfying Part 4 Requirements

The Board determined that in addition to the traditional PQI project methodology, radiology professionals may demonstrate commitment to quality and safety in patient care in numerous other ways. The new expanded options focus on giving Part 4 credit for activities that diplomates are already performing as part of their practices or voluntary professional efforts. The Board considers such engagement, especially in activities that increase visibility in and commitment to quality improvement both within and external to radiology departments, as fulfilling the intent of MOC Part 4 requirements.

These 16 activities are listed in detail on the ABR website at <u>www.theabr.org/moc-part4-</u> <u>activities</u>. This information also includes the required diplomate documentation of participation for each activity, which should be retained in case of an audit. The Board expects to expand these participatory quality improvement opportunities over time as new activities become staples of radiological practice.

As long as participation in such activities is meaningful and ongoing, it is permissible for a PQI project or activity to be used repeatedly to meet PQI requirements. This new policy regarding criteria for MOC Part 4 is in place for diplomates to use for fulfilling requirements for the March 2016 three-year look-back.

Expanded Options for PQI Project Methodology

The ABR continues to emphasize the importance of PQI projects as quality improvement tools. However, restrictions regarding methodology have been considerably relaxed. The new MOC Part 4 (PQI) policy greatly increases flexibility regarding choice of improvement methodology for PQI projects. Previously, PQI projects were required to use a prescribed Plan-Do-Study-Act (PDSA) process with inherently defined phases. In addition to the PDSA process, diplomates who choose to do a PQI project now may use any standard quality improvement methodology, such as Six Sigma, Lean, the Institute for Healthcare Improvement's (IHI's) Model for Improvement, and other methods. The ABR Part 4 policy has been expanded to accommodate these different approaches in recognition of the interval advancements in quality improvement science over the past decade.

The new expanded options focus on giving Part 4 credit for activities that diplomates are already performing...

Simplified Attestation on myABR

A second area of diplomate concern centered on time-consuming MOC data entry and detailed documentation on the myABR website portal. This has been addressed through "Simple Binary Attestation of Meeting MOC Requirements," which will become available on myABR as of January 4, 2016.

In the current state, diplomates are required to log in to myABR each year and attest to the data necessary to meet participation requirements for each of the four parts of MOC. This sometimes involves uploading documents such as medical licenses or entering PQI project information. It also requires validating CME activity from the CME Gateway, as well as entering CME credits from organizations not contributing data to the CME Gateway. With simplified attestation, diplomates will need only to attest to the fact that each of the requirements for Parts 1 through 4 of MOC has been met. Entering detailed data will not be required each year; however, diplomates will need to retain this information in case of an audit, so they can document that they have indeed met the requirements of MOC.

If a diplomate is audited, he or she will be asked to provide the following documentation:

- For Part 1, a valid state medical license
- For Part 2, records of completing 75 AMA Category 1 Continuing Medical Education credits, 25 of which are self-assessment CME, in the last three years
- For Part 3, no attestation will be required. The diplomate will be informed of his or her current MOC exam status for each certificate held and when the next exam will need to be passed.
- For Part 4, records of completing an appropriate PQI project or activity in the last three years

We hope this new process will reduce the burden of MOC documentation for ABR diplomates. This will also free up staff and development resources to permit the ABR to further improve not only MOC, but other areas of its diplomates' experience with the ABR as well.

<u>Future Focus for MOC Program Improve-</u> <u>ment: Part 3 (Knowledge Assessment)</u>

The above improvements represent just the beginning of the Board's ongoing commitment to continuously improve diplomate satisfaction with and sense of accomplishment through ABR MOC participation. In this respect, the ABR is exploring alternatives to the current Part 3 requirement of a secure, proctored MOC examination every 10 years. We will be working closely with ABMS and its member boards, radiology professional societies, and experts in the field to identify innovative knowledgeassessment tools that take advantage of new technological and communication norms. Our goal is to provide less intrusive, more relevant, and more cost-effective knowledge base sampling than past traditional methods. As progress is made in this area, the ABR will continue to reach out to its diplomates for input and feedback.

CHANGES IN BOARD GOVERNANCE

DIAGNOSTIC RADIOLOGY REPORT

by Milton J. Guiberteau, MD, ABR President

fter 80 years of a single governance **L**structure at the ABR, the Board perceived a need for modification to meet growing demands and obligations and to better serve our candi-



dates and diplomates. Consequently, the ABR trustees undertook a rigorous two-year evaluation of our governance system. The process included external expert assessment, internal analysis by the Board of Trustees of possible options proposed by a multidisciplinary task force, and the guidance of a governance facilitator. The Board undertook this process with the understanding that any changes would build upon the time-tested representation of clinical practice areas; would be compatible with our internal structure of multiple radiological disciplines (diagnostic radiology, radiation oncology, medical physics, and interventional radiology); and would improve the Board's ability to respond to the needs of our stakeholders, as well as to those of the organization itself, in a thoughtful and timely manner.

After careful scrutiny of the options, a governance structure, which the Board believes will accomplish these goals and favorably impact our operations to achieve our mission in a more effective and responsive manner, was adopted in its final form at our October 2015 meeting. Consequently, the many duties relevant to the ABR's mission of certification, previously managed by a large 24-member board, have been divided between two smaller organizational components.

The **Board of Trustees** will retain its familiar structure of members with discipline and subspecialty expertise, reflecting major areas of current clinical practice. It will assume responsibility for the ABR's largest core obligation of creating both initial certification and Maintenance of Certifica-

tion (MOC) examinations and determining examination goals, content, scoring, and candidate feedback. A Board of Trustees with such dedicated purpose will allow for a more coherent and concentrated examination effort necessitated by a significant increase in the number and frequency of examination administrations over the last decade.

A newly created, smaller **Board of Governors**

(7 to 11 members), composed of the ABR officers and members with specific portfolios of responsibility, is charged with the nonexamination duties of the board. These responsibilities include ABR financial affairs, Continuous Certification (MOC) program processes, communications, strategic planning and priority setting, intersociety relations and outreach, and oversight of American Board of Medical Specialty matters. In addition to providing efficiency for the conduct of ABR business affairs, the establishment of a governing board requiring members with skills other than or in addition to academic expertise will allow for a composition reflective of the broader practicing radiology community.



While these changes will be transparent to our diplomates and others in the radiology and broader medical communities, the ABR is confident that this updated structure, reflective of the current operational norm in many professional organizations, will enhance our ability to serve our candidates and diplomates. Establishing an efficient, systematic approach to managing our mission of board certification is crucial during this time of changing and challenging practice environments.

by Kay H. Vydareny, MD Associate Executive **Director for Diagnostic** Radiology and the **Subspecialties**

nce again, this has been a very busy year for the discipline of diagnostic radiology. The transition to the new



examination paradigm is now complete. For the first time, those who gain initial certification in diagnostic radiology in 2015 will have passed the computer-based Core and Certifying examinations. The Maintenance of Certification/Continuous Certification program also has continued to change to make it easier for diplomates to comply with the requirements. More details about these programs can be found below.

We would like to thank the 266 diagnostic radiology volunteers, serving on 31 separate committees, for helping the ABR with these endeavors. Indeed, the ABR could not perform its mission without the help of these volunteers, who spend countless hours writing new examination questions, evaluating questions written by others, and compiling the examinations. We can never thank you enough for what you do!

As noted above, the ABR has attempted to make the **Initial Certification** MOC/CC process easier for its diplomates. This year The Core Examination was administered in Tucson has seen significant progress in this direction. Sixand Chicago in June and November of 2015. The June teen Participatory Quality Improvement Activities, as examination continues to be the larger one since most well as the traditional Practice Quality Improvement of the candidates complete 36 months of training in (PQI) Project, are now accepted as fulfillment of MOC diagnostic radiology in time for that administration. Part 4 activities. Beginning Monday, January 4, 2016, We continue to shorten the scoring timeline, and diplomates will be able to simply attest on myABR to this year, candidates received their scores six weeks participation/completion of Parts 1, 2, and 4 of the after the examination; this is approximately half the MOC process, rather than having to delineate the time needed for those who took the June 2014 exam specifics of each part. In addition, they will no longer to receive their scores. Statistics for first-time takers be required to upload documentation of their MOC (1,188) were similar to those of the previous examinaparticipation. The ABR will continue to audit a portions: 87 percent passed, fewer than 1 percent condition of diplomates each year, so primary documentationed (all in physics), and 12 percent failed. tion should be retained in case an audit is requested.

The ABR continues to have an assortment of study aids available on the website for the Core Examination, including module blueprints and study guides, sample topic content, a Quality and Safety syllabus, and a practice examination. The Quality and Safety

syllabus has been updated and incorporates all topics included on the examination. (Links to the study aids can be found at www.theabr.org/ic-dr-core-exam.)

For those who finished their training in June 2014 and passed the Core Examination, the long-awaited Certifying Examination was administered for the first time in Tucson and Chicago on October 1-2, 2015. A total of 1,099 candidates took the exam—846 in Chicago and 253 in Tucson. This total includes 8 candidates who previously conditioned the oral examination and were transitioned to the Certifying Exam. As expected, the pass rate on this examination was higher than that of the Core Exam; all candidates who finished their residency in June 2014 and passed the Core Exam also passed the Certifying Exam.

The Clinical and Noninterpretive Skills (NIS) modules administered on the Certifying Exam are identical to those found on the MOC exam. Study guides for the clinical modules, as well as a syllabus for the NIS module, are available on the ABR website. A study guide for the Essentials of Diagnostic Radiology module, which is unique to the Certifying Exam, is also available. (Links to all the study aids can be found at www.theabr.org/ic-dr-certifying-exam.)

Maintenance of Certification/Continuous Certification (MOC/CC)

Further details about these and other new initiatives can be found on our website (www.theabr.org/mocpart4-activities), as well as in the MOC Update article included in this report (see page 8).

RADIATION ONCOLOGY REPORT

by Paul E. Wallner, DO; Dennis C. Shrieve, MD, PhD; and Anthony L. Zietman, MD

n important initiative during the past year was directed to improving volunteer clinical category activities and diversification of committee membership. Of eight clinical committees,

six now have members in private practice. This level of diversity should provide candidates and diplomates with a greater level of assurance of fairness and relevance of both the initial certification (IC) and Maintenance of Certification (MOC) examinations.



Paul E. Wallner, DO, I Associate Executive I Director for Radiation O Oncology



required general radiation oncology module. Skin

Pediatric tumors will be removed from the adult

central nervous system module beginning in 2017

and will be included in a new module(s) developed

solely for that topic. A subcommittee under the aegis

of the Central Nervous

System Committee,

to be chaired by Dr.

Iris Gibbs of Stanford

University School of

Medicine, has been

organized to develop the

new pediatric modules.

A significant change in

the new IC and MOC

examinations is the

cancers had been included in the head/neck category

but will also be moved to general radiation oncology.

er, DO, Dennis C. Shrieve, MD, cutive PhD, Trustee, Radiation adiation Oncology

Anthony L. Zietman,
MD, Trustee, Radiation
Oncology

Committee esprit and function have also been significantly improved by implementation of periodic face-to-face meetings rather than reliance on conference calls and webinars. In-person meetings are being scheduled for each committee on a biannual basis, with the meetings devoted to development of both qualifying (written) and certifying (oral) examinations.

The new MOC Part 3 modular examination was administered for the first time in October 2015. The examination consisted of approximately 200 questions, of which 140 were in a required general radiation oncology module. Diplomates had the ability to select two additional modules, each containing 30 questions. These modules were taken from the current eight clinical categories, or diplomates could choose general radiation oncology questions.

As development of the modular examination proceeded, it became apparent that several combinations of clinical material that had served well for the qualifying and certifying examinations were not appropriate for the MOC examination. For future examinations, bone and soft tissue sarcoma questions will be removed from the thoracic (formerly called lung) category and included in the introduction of a group of questions collectively referred to as non-clinical skills. This material includes items related to quality assurance and quality improvement, patient safety, bioethics, and biostatistics. Because this formalized material is new to the Board examinations, trustees and staff have developed a syllabus that will be embedded in the existing web-based IC and MOC study guides. A link to the new syllabus is now available on the ABR website (www.theabr.org/moc-ro-comp3) and contains essentially all material in these topics felt to be necessary for examination preparation. An effort has been made to assure that the material is relevant to the clinical practice of radiation oncology.

In 2010-2011, with the aid of a stakeholder's advisory committee, radiation oncology staff and trustees developed a Focused Practice Recognition in Brachytherapy (FPRB) proposal, which was ultimately approved by the American Board of Medical Specialties. The project included elements of education, clinical care, clinical research, and data collection and received significant unrestricted financial support from Varian Medical Systems, Inc. Despite various organization announcements, publications, and presentations, participation was significantly lower than had been anticipated, and in February 2015, the ABR trustees decided to terminate the program. Participants will continue to actively use the FPRB designation through 2017, the originally planned demonstration project termination date. After that time, if queried, the Board will indicate that the diplomate had attained the recognition but that the program is no longer active.

All eight radiation oncology clinical category volunteer committees were re-organized effective January 1, 2012. At that time, it was anticipated that new appointees would serve terms of up to three years, with possible re-appointment, and that rotations on and off the committees would henceforth be staggered so that all appointments would not terminate concurrently. To maintain stability during the organizational transition, all certifying (oral) examination chairs retained their posts. Several of those chairs have now served for six or more years, and rotation of chairs has begun. The staff and trustees of the Board wish to acknowledge the extraordinary efforts and service of three oral examination chairs rotating from their posts:

 William Regine, MD, University of Maryland, gastrointestinal cancer chair, has been replaced by Michael Haddock, MD, Mayo Clinic/Rochester.



- Robert Amdur, MD, University of Florida, head/ neck/skin cancer chair, has been replaced by Steven Frank, MD, MD Anderson Cancer Center.
- Julia White, MD, Ohio State University, breast cancer chair, has been replaced by Jennifer Bellon, MD, Dana-Farber Cancer Institute.

The RO trustees continue to recognize the importance of the Holman Research Pathway as a way to attract those with a strong research background into radiation oncology, and then to help them initiate careers as independent investigators. The last three years saw a decline in the number of applicants, but this year there was a spike, raising the possibility that these represent year-to-year variations rather than trends in any particular direction.

The radiation oncology trustees will be working with the Society of Chairs of Academic Radiation Oncology Programs (SCAROP) to encourage additional programs to recruit, support, and ultimately add Holman Pathway trainees to their departments.

MEDICAL PHYSICS REPORT

by G. Donald Frey, PhD, Associate Executive **Director for Medical** Physics

he past year has seen several changes to the initial certification (IC) and Maintenance of Certification (MOC)



programs for medical physics. These changes may be of interest to medical physicists, as well as medical physics residents, students, and program directors.

Initial Certification - Part 1

To ensure that certification requirements are being met, the ABR audits a small percentage of Part 1 applications each year. Fortunately, past audits have shown that the vast majority of Part 1 candidates meet ABR certification requirements. To more closely align our requirements with CAMPEP expectations for graduate programs and residencies, the ABR has made a number of changes in the way audited candidates are evaluated.

Beginning in 2016, the two required bioscience courses will be Anatomy and Physiology and Radiobiology. The ABR will also require the following medical physics courses: Radiological Physics and Dosimetry, Radiation Protection and Safety, Fundamentals of Medical Imaging, and Radiation Therapy Physics. Variation in the names of these courses is acceptable as long as they match the CAMPEP-required courses. Credits for the bioscience and medical physics courses must total at least 18 hours.

The number of Part 1 applications for 2015 remained about the same as in 2014, returning to historic values. The large increases in 2012 and 2013 were most likely due to an influx of candidates who chose to enter the system before CAMPEP requirements were fully implemented. The number of candidates certified each year is closely related to the number entering the system.

Finally, the ABR has instituted a rule stating that after passing the Part 1 exam, candidates will have no more than 10 years to become board eligible. Because some candidates pass Part 1 but never continue with the certification process, the new rule will allow dormant files to be closed. This rule has already been implemented, but candidates who now are reaching their 10-year limit will have until 2017 to become board eligible.

The Oral Examination

The Oral Examination in Medical Physics is designed to test the clinical skills of the candidate and assess his or her readiness to practice medical physics independently. A broad range of topics gives each candidate the following opportunities:

- To demonstrate an understanding of common medical physics equipment performance evaluations
- To analyze the results of these evaluations and make appropriate recommendations
- To explain how patient care may be affected by the performance of clinical equipment
- To analyze uncommon situations and explain how the candidate would approach them
- To communicate the results of medical physics evaluations.

The focus of the oral exam is on clinical competence. This distinguishes it from the Part 1 and Part 2 exams, which focus on the fundamental concepts of medical physics and include detailed calculations. The oral exam includes 25 questions in five categories. Each candidate is examined by five examiners, each of whom asks one question in each of the five categories. This ensures that the candidate's score in each category is the average of the scores on five questions evaluated by five different examiners.

The oral examiners are selected from experienced medical physicists who have either MS or PhD degrees. The pool of examiners contains physicists from private practice and from academic departments. Examiners must

be at least five years post initial certification and must have previous experience on an ABR question-writing committee. All new examiners must be enrolled in Maintenance of Certification (MOC), and beginning with the 2016 exam, all examiners, as well as all other ABR volunteers, must be enrolled in MOC.

Each year the examiners receive training on the and Part 4 (Practice Quality Improvement). oral exam and its content, and new examiners have additional training. The examiners are "Simple Binary Attestation of Meeting MOC Requirements" will become available on myABR organized into panels, and the panel chairs have further training on ABR procedures and scoring. as of Monday, January 4, 2016. Finally, the ABR Following the final evaluation of the candidate is exploring alternatives to the current Part 3 by a panel, the scores and decision of the panel are reviewed by the associate executive director (AED) for medical physics and a medical physics trustee to verify that there were no errors in the Update" article on Page 8. process.

To ensure that each question is asked in the same way by each examiner, all examiners who will be asking a particular question meet together to discuss each of the questions. During the course of the exam, the examiners are observed at least twice by either a trustee or the AED for medical physics.

The oral exam categories used in all three physics disciplines were identical for many years. These categories remain very relevant for therapeutic medical physics, but an analysis by the oral exam committees suggested that the congruence between the categories and clinical practice could be improved for diagnostic medical physics and nuclear medical physics. Thus, new categories were developed for those two specialties. The current categories are listed at <u>www.theabr.org/ic-mp-study-guide#oral</u>. A statistical analysis of the revised categories showed a performance similar to that of the traditional categories.

Maintenance of Certification (MOC) Improvements

The ABR has added the category of Participatory Quality Improvement Activities as an additional way to meet the MOC Part 4 requirement.

Participatory Quality Improvement is based on active participation in quality and safety activities in your medical physics practice. A full list of 16 qualifying activities can be found at www.theabr.org/moc-rp-comp4.

The ABR also is working to simplify its attestation requirements for Part 1 (Professionalism), Part 2 (Lifelong Learning and Self-assessment),

requirement of a secure, proctored MOC examination every 10 years. More information about these improvements can be found in the "MOC

The oral examiners are selected from experienced medical physicists who have either MS or PhD degrees.

If you were recently certified, you should be aware of the following:

- Continuing education (CE) and selfassessment continuing education (SA-CE) credit completed during the year of certification can be counted for your first MOC look-back.
- A Practice Quality Improvement (PQI) Project or Participatory Quality Improvement Activity completed during your residency can be counted for MOC.
- You may claim up to 25 CE credits for a year of fellowship in a clinical environment.

As these credits will not automatically appear in myABR, you should keep documentation in case you are ever audited. If you have any questions, please contact the ABR MOC Division by email (moc@theabr.org) or call the ABR Connections Center at (520) 519-2152.

INTERVENTIONAL RADIOLOGY REPORT

by Anne C. Roberts, MD, Associate Executive Director for Interventional Radiology

The new interventional radiology/diagnostic radiology (IR/DR) primary certificate, approved by the American Board of Medical



Specialties in 2012, continues to progress, and the ABR could issue the first initial certificates as soon as 2017. The IR/DR certificate was designed to recognize interventional radiology as a unique medical specialty, addressing the diagnosis and treatment of diseases through expertise in diagnostic imaging, image-guided minimally invasive procedures, and the evaluation and clinical management of patients with conditions amenable to these methods. Those certified in IR/DR will have demonstrated competency to practice in diagnostic radiology, as well as the full scope of interventional radiology.

The Accreditation Council for Graduate Medical Education (ACGME) has approved the program requirements for the Interventional Radiology Residency Program, and applications for program accreditation are now being received by the Radiology Residency Review Committee (RRRC). An onsite visit is required for all applying sites, and for the programs that have already applied to the RRRC, site visits are being scheduled. The first programs may be evaluated at the November 2015 meeting of the RRRC, and if accredited, they should be able to enter trainees as early as the 2016-2017 academic year.

Expected Components and Rules

Individuals interested in IR/DR certification will need to apply specifically for this new residency. Candidates may NOT be actively enrolled for certification in both DR and IR/DR—only one training program leading to certification may be pursued at any given time. However, during the initial years of implementation, some transfers of DR residents into the IR/DR certification pathway are expected and will be accommodated.

Candidates for the IR/DR certificate will be required to successfully complete a residency at an ACGME-accredited IR program to meet the training requirement for certification. The program requirements will provide three potential ways to achieve this training: either a five-year integrated program of diagnostic and

Those certified in IR/DR will have demonstrated competency to practice in diagnostic radiology, as well as the full scope of interventional radiology.

interventional radiology (this will be the first stage for most programs), or a combination of DR residency followed by an independent one- or two-year IR program (this will be implemented later by most programs who decide to offer it). The number of years spent in the independent IR program depends on how much interventional radiology experience the resident obtained in his or her DR program.

The examination structure will consist of the DR Core Examination in the 36th month of residency training, and an IR Certifying Examination with both oral and computer-based components three months after completion of training. Details of the examination structure and specific requirements for each exam are still being determined.

Impact on VIR Subspecialty

The IR/DR certificate is designed to eventually replace the VIR subspecialty certificate. The

transition is expected to be a seven-year process. The ACGME anticipates that the last year of accreditation for one-year VIR fellowships will be 2019-2020. When the ACGME ceases to accredit VIR fellowships and instead accredits only the new IR residencies, the VIR subspecialty certificate will sunset. Those who hold a VIR subspecialty certificate will be issued a replacement IR/DR certificate at no additional cost if they are meeting all MOC requirements. This process will likely begin in 2018.

Suggestions for Candidates Currently in Training

The ABR recommends that these candidates continue their training and seek certification according to the current processes. Those



interested in practicing in IR can seek certification in DR with a subspecialty in VIR, or pursue these two certificates via the Diagnostic and Interventional Radiology Enhanced Clinical Training (DIRECT) pathway. (Please note, however, that DIRECT pathway candidates must finish their residencies and fellowships by 2020, and no new DIRECT pathway candidates may begin training after July 2016.) Those who have begun DR training also may have the opportunity to transfer into an IR residency at their own institution to seek initial certification in IR/DR.

The ABR will continue to provide information regarding the new IR/DR specialty certificate as it becomes available. Please check our website at <u>www.theabr.org</u> for the latest information.

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NEW TRUSTEES 2015

The ABR welcomes the following new trustees, whose terms of service began on November 1, 2015. ABR trustees participate in leadership and decision making to carry out the ABR's mission and set standards for board certification in initial certification and Maintenance of Certification.

Michael G. Herman,

PhD, is a board-certified medical physicist who is involved with practice, education, and research in the Department of Radiation Oncology at the Mayo Clinic in Rochester, Minnesota. He is professor of medical physics and



chair of the Division of Medical Physics. He earned a bachelor's degree in engineering physics at Lehigh University and a doctorate in experimental nuclear physics at the University of Rochester. Dr. Herman has held leadership positions in the American Association of Physicists in Medicine and the American College of Medical Physics. He mentors clinical medical physics fellows and graduate students with current interests in image guidance, particle therapy, and patient outcomes.

Mary S. "Mimi" Newell, MD, holds a lifetime certificate in diagnostic radiology and is an associate professor of radiology and associate director of Emory University's Breast Imaging Division in Atlanta, Georgia.



She graduated from the University of Michigan Medical School in 1984. She currently serves as chair of the Appropriateness Criteria and Parameters Committee for Breast of the American College of Radiology and treasurer of the Georgia Radiological Society, and her areas of clinical interest and special expertise include breast cancer imaging. M. Elizabeth "Liz" Oates, MD, a diplomate in diagnostic radiology and nuclear radiology, received her education at Boston University School of Medicine and completed a radiology residency at LA County Harbor-UCLA Medical



Center, as well as a nuclear radiology fellowship at Tufts-New England Medical Center. As Rosenbaum endowed chair of radiology and professor of radiology and medicine, Dr. Oates serves as the department chair at the University of Kentucky in Lexington. She chairs the American College of Radiology's Commission on Nuclear Medicine and Molecular Imaging and serves on the Board of Chancellors. Dr. Oates also sits on the Diagnostic Radiology Residency Review Committee. Her interests include all aspects of nuclear radiology education and practice.

James B. Spies, MD, MPH, is chair and chief of service at MedStar Georgetown University Hospital's Department of Radiology and professor at Georgetown University School of Medicine in Washington, DC. He was board certified in



diagnostic radiology in 1984 and in vascular and interventional radiology in 1995. Dr. Spies earned a medical degree at Georgetown, served a residency at the UC School of Medicine in San Francisco, and completed a fellowship at the New York University School of Medicine. He is an interventional radiologist whose primary clinical and research interest is in uterine embolization for fibroids. His special interests include uterine artery embolization and gynecologic intervention.





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