

## LESS IS MORE

# Beyond the Examination—Does ABIM Longitudinal Knowledge Assessment Performance Reflect Higher-Value Practice?

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Since 1936, the American Board of Internal Medicine (ABIM) has required certification of US internal medicine physicians with the stated mission of enhancing “the quality of health care by certifying internists and subspecialists who demonstrate the knowledge, skills, and attitudes essential for ex-

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cellent patient care.”<sup>1</sup> After the initial time-limited examination, instituted in 1990, recertification is offered every 10 years or, since 2022, through the Longitudinal Knowledge Assessment (LKA) in which physicians answer 30 questions each quarter over 5 years. Physicians have long raised concerns that recertification imposes substantial financial and time burdens despite uncertain gains.<sup>2</sup> The traditional maintenance of certification process has been estimated to cost internists more than \$20 000 and 250 hours over a 10-year cycle,<sup>2</sup> and a 2016 survey found that only 15% of physicians believed that the traditional process was worth the time and effort.<sup>3</sup> In theory, the examinations may be useful, first, to assess performance and identify knowledge gaps, and second, to improve performance through ongoing engagement with clinical content. There is some evidence of the first goal,<sup>4</sup> for example, in a study finding that physicians with higher LKA scores had slightly lower inpatient mortality.<sup>5</sup> But we know little beyond this.

In this issue of *JAMA Internal Medicine*, Vandergrift et al<sup>6</sup> examine the association between first-year LKA scores among 7089 outpatient general internists initially enrolled in LKA in 2022 or 2023 and the receipt of low-value services in the outpatient setting among fee-for-service Medicare beneficiaries during the internists' first year of LKA participation. Patients attributed to physicians (that is, assigned as their primary care practitioner based on the plurality of outpatient evaluation and management contacts over the current and prior 2 years) with a top quartile LKA score had a 7.9% lower chance of receiving any low-value service, for an absolute difference of -2.5 percentage points, after adjusting for clinical covariates and prac-

tice setting. The two individual measures with the largest absolute difference were total/free triiodothyronine testing in patients with hypothyroidism and prostate-specific antigen testing in men aged 75 years or older. Lending credibility to the interpretation that physician knowledge may help to explain less low-value care use, the association between LKA score and low-value service utilization was driven by services in which the patient's attributed internist was also the ordering or referring physician; when low-value services were ordered by other clinicians, they found no association with the LKA score.

Given the considerable debate around the value of LKA, it is important to understand what these results tell us—and what they do not. The finding of an association between LKA score and low-value care use suggests that LKA scores may indeed reflect some aspects of physician performance. At the same time, LKA score quartile accounted for a tiny share (0.4%) of the overall variance in receipt of low-value services, suggesting that other physician-level (eg, training quality, risk tolerance),<sup>7</sup> patient-level (eg, preferences for testing), or environmental factors (eg, electronic health record order sets)<sup>8</sup> that correlate with LKA performance may play a larger role.<sup>9,10</sup> And as the authors note, this cross-sectional study cannot tell us whether participating in LKA may help to improve future performance.

Future studies should examine whether longitudinal LKA participation can improve care decisions or other aspects of physician performance. While these results do not support using ABIM LKA scores as a proxy for physician quality, for example when setting payment rates or determining eligibility for physician networks, they could be used to identify a minimum knowledge standard for board certification in internal medicine or to guide self-improvement. In the meantime, ABIM test-takers who are chagrined about the time and financial costs involved can take some solace in the potential significance and implications of a high score.

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