ACP Update
Indiana Chapter Meeting
November 2017
Leading the Way in Fostering Excellence & Professionalism in Internal Medicine for 102 years

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ACP Defined

ACP’s Mission & Goals
Mission: To enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine.
Goals:
- To establish and promote the highest clinical standards and ethical ideals
- To be the foremost comprehensive education and information resource for all internists
- To advocate responsible positions on individual health and public policy relating to health care for the benefit of the public, our patients, the medical profession and our members
- To serve the professional needs of the membership, support healthy lives for physicians and advance internal medicine as a career
- To promote and conduct research to enhance the quality of practice, the continuing education of internists and the attractiveness of internal medicine to physicians and the public
- To recognize excellence and distinguished contributions to internal medicine
- To unify the many voices of internal medicine and its subspecialties for the benefit of our patients, our members and our profession

ACP’s focus at a glance
- The science of medicine
  - Annals of Internal Medicine
- The clinical practice of medicine
  - Clinical standards, guidelines
- The education and professional development of physicians
  - ACP, meetings and courses
- The ‘quadruple aim’ of healthcare
  - Better care, better health, physician professional satisfaction, lower per capita costs
- The future of medicine
  - Students, residents, fellows
- Professional satisfaction
  - Payment reform, practice redesign
2017-2018 Priority Initiatives

- Help ACP members experience greater professional satisfaction and fulfillment
- Facilitate the transition to value based payment and new delivery models
- Deliver authoritative, comprehensive, evidence-based information and education in innovative formats at key points of need
- Work towards universal access to affordable, high quality, and high value healthcare
- Increase ACP’s role and critical input as a national leader in optimizing performance measurement
- Expand ACP’s work in reducing the cost of healthcare and increasing the value
- Increase the number and engagement of ACP members
- Continue to advocate for timely reforms to ABIM’s MOC process
- Foster innovation within the College to strengthen ACP’s support for members and its work to increase the quality, value, and effectiveness of healthcare

Who we are

Data from ACP’s 2016 Member Survey has revealed some major trends that paint a portrait of an evolving physician workforce:

- Half of post-training physicians are internal medicine specialists (GIMs), two in ten are hospitalists, and three in ten are subspecialists. Survey respondents under age 40 are more commonly hospitalists and less commonly GIMs or subspecialists.
- One in three works in a small practice with five or fewer physicians, one in four in a medium setting with 6 to 20 physicians and four in ten in a large setting with more than 20 physicians.
- Most physician-owned practices (58%) have five or fewer physicians, while those owned by health care systems (36%) or the government (57%) have more than 20 physicians.
- Six in ten report respondents that they or their practice use digital technology such as email or text to communicate with patients and/or their families, with seven in ten (74%) primary care physicians and eight in ten (81%) physicians in academic medical centers reporting use for this purpose.

Source: 2016 Member Survey Detailed Report (random sample of 2,000 U.S., non-student, ACP members ages 65 and younger between March and June 2016)

2016 Member Survey—ACP members have become more demographically diverse

- Respondents are slightly younger with a greater proportion of women at younger ages.
- The majority of ACP members, particularly the younger ones, report an evolution toward the employed model:
  - 72% are employees; 22% are full/part owners; 5% are independent contractors; 1% are volunteers
  - 57% report ownership of their practice by hospitals (20%); health care systems (23%); or academic medical centers (24%)
  - Ownership by physicians has decreased from 31% in 2013 to 25% in 2016.
- With the employment model comes an increase in physician practice size.
  - 43% of those providing patient care report working in a “large” setting having more than 20 physicians.
  - The proportion working with more than 100 physicians grew from 17% in 2013 to 28% in 2016.

ACP and Health Care Policy

ACP’s prescription for better health care.

1. Expand coverage and access.
   - Improve, don’t repeal, the ACA.
   - Stabilize markets, commit to cost-sharing reduction payments.
   - Create Medicare buy-in option for aged 55-64.
2. Bring greater value for the dollars spent.
   - Lower prescription drug prices.
   - Apply evidence to clinical decision-making, cost-sharing and coverage.
   - Enact reforms to our medical liability system.
   - Promote transparency across health care.
   - Improve Medicare’s new Quality Payment Program.
3. Leverage technology to improve patient care.
   - Reduce barriers to telemedicine/enact Connect Act.
   - Improve functionality of EHRs.
4. Support a well-trained physician workforce with skills and numbers needed.
   - Develop a national workforce policy.
   - Maintain funding for Title VII primary care training.
   - Expand GME slots on prioritized basis.
   - Enact legislation to establish all-payer GME funding.
   - Address impact on workforce of travel ban.
ACP's prescription for better health care.

5. Support medical and health services research and public health.
   - Ensure sufficient funding for NIH, AHRQ, CDC.
   - Maintain commitment to preventing and mitigating adverse health impact of climate change.
   - Support research and enact policies to reduce firearms-related violence.
   - Support policies to address opioid epidemic.
6. Reduce barriers to chronic care management.
7. Reduce administrative burdens.

The Affordable Care Act 2010

For 7 years, this has been how the GOP has viewed "Obamacare." Now they can actually do something about it.

The rise and fall of ACA repeal

- **March 7**: the House version of ACA repeal, the American Health Care Act (AHCA), introduced in the House.
- **March 24**: House Speaker Ryan withdraws the AHCA because of lack of support.
- **May 4**: modified AHCA narrowly passes House, 217-213, with amendment that allows states to waive essential benefits and modified community-rating requirements.

The rise and fall of ACA repeal

- **June 22**: draft of Senate version, the Better Care Reconciliation Act (BCRA), released.
  - Incorporated many of the elements of the AHCA:
  - Medicaid caps/block grants, end of higher federal match for expansion;
  - repeal of individual and employer mandates;
  - state waivers of essential benefits and community rating, $ for high risk pools and market stabilization;
  - repeal of most ACA taxes; tax credit subsidies that would increase premiums and deductibles for older, sicker and poorer patients.
The rise and fall of ACA repeal

**July 17:** Majority Leader Mitch McConnell decides not to go forward with vote on BCRA, after 4 Senate Rs declared opposition. Issues statement that the current effort to immediately repeal and replace the ACA through BCRA “will not be successful.”

Headlines declare the bill is dead.

So what’s the practical impact on your practice and your patients if the ACA was repealed?

- Reduced Medicaid payments.
- Fewer patients on Medicaid, many of whom would be enrolled instead in high deductible plans.
- Millions will just go without coverage.
- Higher out-of-pocket costs for older, sicker and poorer patients.
- Loss of coverage/higher premiums for patients with preexisting conditions
- More uncompensated care.
- Loss of lives.
- Higher deductibles and premiums for poor and sick
- Loss of coverage of essential benefits
- Denial of coverage for preexisting conditions
- Uncertainty on Value with Quality Payment Program and Regulation with EMR requirements

Sanders Plan

- Single Payer Plan
- Year 1 eligibility 55 years
- Year 2 eligibility 45 years
- Year 3-4 eligibility 35 years and under
- Includes dental and vision coverage
- Payment: 7.5% payroll tax, 4 percent individual tax
- Taxes on corporations and wealthy and no premium deduction for corporations
- Cost 16 trillion over 10 years v. Urban Institute 32 trillion over 10 years.
Graham Cassidy Bill

Graham (R-S.C.)-Cassidy (R-La) Bill Provisions

- Repeal Medicaid expansion
- Decrease or eliminate cost sharing/premium subsidies
- Block grants to states and redistribution of funds
- Eliminate individual mandate
- Result: millions more uninsured or underinsured
- Allows states to waive essential benefits, protections for pre-existing (and new!) medical conditions.
- Requires states to develop entirely new health care financing systems by 2020, or lose all dedicated federal dollars.

Graham Cassidy was opposed by:

- Just about every major physician membership organization including ACP, Group of 6 coalition (ACP, AAFP, AOA, AAP, APA, ACOG), and AMA
- Just about every major patient advocacy group.
- Yet there was a very real chance it could have become law.
- We helped stop it, for now, but it may come back.

Kumail Nanjiani (@kumailn)

9/25/17, 5:12 PM

News stories from 300 years in the future:

1. Mars colony self-sustainable
2. Robot understands love
3. Senate to vote on Repeal & Replace the ACA

"the competition will be staggering," Trump said. "Insurance companies will be fighting to get every single person signed up. And you will be, hopefully, negotiating, negotiating, negotiating. And you will get such low prices for such great care."

Executive Order: Cost Sharing Insurance Subsidies for low income individuals scrapped.
34% increase in silver and 18% in bronze plans
Alexander R-Tenn/Murray D-Wash Bill

- Retain CSR for 2 years
- States can set up other insurance options
- $106 million for publicity for ACA
- Catastrophic coverage option (1.1 billion/8yrs)
- $3.8 billion savings to budget/no effect on insured

Hatch (R-UT)/Brady (R-TX) Bill

- Fund CSR payments through 2018
- “Pro-life Protections" (Plans that cover abortions are barred from CSR)
- Delay in enforcing the individual mandate to 2021
- Retroactive exemption from the employer mandate for 2015-2017
- Raise maximum contribution for HSA accounts.

Americans lacking health insurance

![Chart showing percentage of adults underinsured in Q3 2013 and Q3 2017 with percentages of 18% and 12.3% respectively.]

Source: Gallup

What has ACP doing?

- **Letters/Media:**
  - 15 ACP National letters to Congress; 14 coalition letters to Congress
  - 2 TV appearances (one with Bob Doherty; two with Nitin Damle) on MSNBC “The Last Word” and with Kate Snow and Lawrence O’Donnell show
  - Satellite Media T. with Bob Doherty and Nitin Damle (January 9th), reached more than 16.2 million people with CSR airing of the content.
  - Dr. Damle testified on a “hearing” on the AHCA organized by House Democrats, Facebook live video.
  - Press briefing at ACP’s Annual Meeting (Doherty/Damle) (Facebook live video).
  - Press event in conjunction with the Group of Leadership Fly-in in February and again on June 26.
  - Press event in opposition to BCRA, sponsored by senators Stabenow and Hassan featuring the group of six on June 28.  The president of AAP spoke on behalf of the group.
  - A press event in conjunction with the Group of Six leaders and a reporter from the Washington Post to discuss Hill visits and events for that day "Fly-in.
  - The G6 featured by MSNBC’s Katy Tur in a July 12 segment on the Hill.  AAFP’s leader spoke for group.
  - 9 articles in “The Advocate” in opposition to the AHCA/ACA repeal efforts
  - 1 ACP annual joint release/Statements on the AHCA/ACA repeal efforts
  - 6 Blog posts by me on the AHA/ACA repeal-efforts

Advocacy efforts to prevent ACA repeal without comparable replacement

- ACP remains committed to sustaining the gains made by the Affordable Care Act (ACA)
- ACP Online offers information on how the federal health care law affects internists, their practices, and their patients.
- Recent statements
- State-by-state analysis
All in month’s work: 30 days of ACP advocacy: September 6 to October 6, 2017

- Spoke out on Hate Crimes as a Public Health Issue
- September 5 statement on Charlottesville
  [link](https://www.acponline.org/advocacy/ACP-statement-charlottesville-2017.pdf)

- Defended “Dreamers”
- September 5 statement on President Trump’s decision to end DACA
  [link](https://www.acponline.org/advocacy/ACP-statement-trump-daca-2017.pdf)

- Advocated to improve the Medicare Advantage Program
- Proposed policies to improve the Medicare Advantage Program
  [link](https://www.acponline.org/advocacy/ACP‐newsroom/american‐college‐of‐physicians‐says‐medicare‐advantage‐should‐increase‐transparency‐align‐and‐reduce)

- Supported Legislation to Lower Prescription Drug Prices
- September 19 joint letter supporting CREATES Act, “For too long, brand-name pharmaceutical manufacturers have exploited patent laws in order to stifle generic competition and attendant lower prescription drug prices.” [link](https://www.acponline.org/advocacy/ACP-policy/letters/joint_letter_to_congressional_leaders_supporting_creates_act_2017.pdf)

- Advocated for Better Quality Measurement
- Proposed policies to improve the Medicare Advantage Program
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- Advocated for Better Medicare Payments for Internists’ Services
- September 11, Comments on Medicare Physician Fee Schedule
  [link](https://www.acponline.org/advocacy/ACP-policy/letters/comment_letter_to_cms_re_cy_2018_medicare_pfs_proposed_rule_2017.pdf)

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Another top ACP priority: embracing diversity, opposing discrimination in ALL forms

- Position Statement on Gender Pay Gap Within the Field of Medicine, Approved by the ACP Board of Regents, November, 2016. https://www.acponline.org/acp_policy/policies/gender_pay_gap_position_statement_2016.pdf

Another top ACP priority: embracing diversity, opposing discrimination in ALL forms

- Coming soon! Policy papers on women in medicine, women’s health, and social determinants of health care.

But don’t just put out letters.

- We lobby Capitol Hill.
- We lobby federal agencies.
- We issue grass roots action alerts to our Advocates for Internal Medicine (AIMn) network.
- We develop action plans for our chapters.
- We form coalitions with allied organizations and plot out strategy and actions together.
- We take legal action (usually amicus briefs).
- We promote our views through social media.
- All while working on ongoing policy analysis and development.

Updated Position Paper on Legalization of Physician-Assisted Suicide

- ACP reaffirmed its opposition to the legalization of physician-assisted suicide and affirmed a professional responsibility to improve the care of dying patients.
  - ACP cites ethical arguments and clinical, policy, legal, and other concerns for its positions.
  - ACP acknowledges the range of views on, the depth of feelings about, and the complexity of the issue.

Quality Payment Program (QPP) In a Nutshell

Law intended to align physician payment with value

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
  Now known as...
- Quality Payment Program
  - Merit-Based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (APMs)

ACP and Payment Reform
Preparing for a new Payment System: MACRA/QPP

- Congressional Intent of MACRA:
  - Sustainable Growth Rate repeal
  - Improve care for Medicare beneficiaries
  - Consolidates and simplifies Meaningful Use, Value-based Modifier and PQRS
  - Change our physician payment system from one focused on volume to one focused on value

How Will Clinicians Be Scored Under MIPS?

A single MIPS composite performance score will factor in performance in 4 weighted performance categories:

- **Quality**: 60%
- **Advancing Care Information**: 25%
- **Clinical practice improvement activities**: 15%
- **Cost**: 0%

*Based on reporting data in 2017

Timing of QPP Implementation

<table>
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<th>performance year</th>
<th>submit</th>
<th>feedback available</th>
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<tr>
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<td>March 31, 2018</td>
<td>2018</td>
<td>January 1, 2019</td>
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Advanced Alternative Payment Models (APMs)

As defined by MACRA/QPP, advanced APMs must meet the following criteria:

- The APM requires participants to use certified EHR technology.
- The APM bases payment on quality measures comparable to those in the MIPS quality performance category.
- The APM either (1) requires APM Entities to bear more than nominal financial risk for monetary losses; OR (2) is a Medical Home Model, expanded under CMMI authority.

Medical Home Models

- **Medical Home Models**:
  - Have a unique financial risk arrangement for becoming an Advanced APM (2.5% of A & B revenues).
  - Enable participants (who are not excluded from MIPS) to receive the maximum score in the MIPS CPIA category.

*Based on reporting data in 2017
QPP Exemptions and Payment Adjustments

- Less than 90,000 dollars per year in payment or less than 200 patients.
- Exclude 585,560 / Include 572,000 clinicians.
- CMS predicts in 2020 most participating clinicians will positive or neutral adjustment.
- 76% bonus payment totaling 673 billion dollars or 1176 dollars per clinician on average.
- 1-15 clinicians 0.7% increase
- 16-24 clinicians 0.4%, over 100 clinicians 1.4%

ACO/MSSP Results

- One billion dollar spending cut over first 3 years
- 428 ACO with 282 curbing spending for one year
- Of the 282 ACO’s, 33% were able to meet threshold.
- “High Performers” cut spending an average of 673 dollars per beneficiary, others increased by 707 dollars and FFS had a 695 dollar increase
- 2.4 billion overspent and 3.4 billion cut spending=net 1 billion dollars

ACO/MSSP Quality Results

- 82% improved quality on 33 measures
- Depression screening went from 26 percent to 46 percent
- Fall risk screening went from 35% to 59%.
- OIG conclusion:
  - “While policy changes may be warranted, ACOs show promise in reducing spending and improving quality.”

Helping You Transform Your Practice: Prepare for Value-Based Payment

- ACP participating in grant-funded Transforming Clinical Practice Initiative (TCPi) from Centers for Medicare & Medicaid Services (CMS).
- Goal: Help equip clinicians with tools, support to achieve better health, better care and lower costs. The initiative supports the creation of regional, national learning communities to share and widely disseminate best practices.
- ACP is one of 10 national Support and Alignment Networks; helping clinicians and practices transform from volume-based to value-based, patient-centered care by offering:
  - Free Access to ACP Practice Advisor® new modules being developed that specifically help with practice transformation.
  - Referrals to Practice Transformation Networks - peer-based learning networks designed to coach, mentor and assist clinicians in developing core competencies specific to practice transformation.
  - Free CME/MOC Through High Value Care Cases.

ACP Practice Advisor®

- Improve process and structure of care
- Spotlighted practices
- Practice biopsy
- Links to tools based on biopsy results
- CME and MOC

ACP Quality Payment Advisor
Administrative Complexities

‘Patients Before Paperwork’ Initiative

- ACP has developed a comprehensive approach to address the top administrative complexities members face, including tools on ACP’s website such as ACP Practice Advisor.
- New ACP position paper “Putting Patients First by Reducing Administrative Tasks in Healthcare” (“Annals of Internal Medicine, March 2017”)
- Through policy development and collaborations with other groups, feedback to regulatory agencies, and education, ACP seeks to reduce physician burn-out and help restore the joy of practice.
- A 2014 ACP focus group showed the top 3 frustrations as:
  - Electronic Health Record Usability
  - Quality Reporting
  - Dealing with Insurance Companies
- For more information, visit https://www.acponline.org/advocacy/where_we_stand/patients_before_paperwork/

Factors affecting physician satisfaction and fulfillment

- Increased regulatory requirements: performance reporting; meaningful use of EHRs
- Burdensome documentation requirements
- Prior authorization; other approvals
- Electronic health records
- Inefficient practices
- MOC requirements
- Professional isolation (for some)
- Short visits; unrelenting time pressure
Part of the EHR solution: simplify documentation requirements

Reworking Evaluation & Management (E/M) Documentation Guidelines:
- Based on Clinical Documentation in the 21st Century the College has held numerous meetings with the deputy administrators at CMS and other agencies within HHS regarding reducing the administrative burden of the E/M documentation guidelines.
- On June 28 2017 ACP attended a meeting with Secretary Price where the College outlined a proposal to move forward with reform of E/M documentation guidelines.
- This has led to Solicitation of Public Comment on the reform of the E/M documentation guidelines through the 2018 Medicare Physician Fee Schedule NPRM.
- ACP will provide detailed comments and recommendations for simplification and alignment of E/M documentation through the rulemaking process.

Some historical background

- 1936 – ABIM created by a joint action of ACP and AMA
  - Goal: Distinguishing internists who meet peer-reviewed standards from those who do not (or choose not to)
  - Independent organization insulated from pressure of dues-paying members
- 1941 – first subspecialties introduced (Cardiology, GI, Pulmonary)
- 1990 – all new certificates limited to 10 years

The certification examination

- First exam in 1936 – 8 essay questions
- 1946 – essay questions replaced by multiple choice questions
- 1972 – oral examinations discontinued
- 2006 – examinations converted from paper and pencil to computer-based

Types of certificates: evolution over time

- Before 1990: certified for life
  - Exceptions: Critical Care; Geriatrics
- 1990 through 2013: certificates time-limited for 10 years; need to recertify by expiration date
- Starting in 2014
  - No expiration date
  - Need to participate in Maintenance of Certification (MOC) and meet MOC milestones

Major issues with dissatisfaction about ABIM’s MOC program

- Lack of evidence of benefit re quality of care
- Cost: too expensive
- PIMs are time-consuming, tedious busywork
- From diplomates with time-limited certificates: why is there a 2-tier system, i.e. with “grandparents” exempt from the requirements?
- Exam is “one size fits all” and not relevant or customizable to my practice
- High failure rate for the secure examination
Historically, anger intensified in 2014 with changes, specifically ...

- Doubling of self-assessment point requirement
- Addition of patient safety and patient voice requirements
- From “grandfathers/grandmothers”: new website reporting of “meeting MOC requirements: yes or no?” is coercing them to participate in MOC

Secure examination pass rate

- Examination pass rate was dropping over time
- Potential implications of losing certification on credentialing by hospitals or health plans
- ABIM response
  - Pass rate has been just as low in the past
  - Ultimate pass rate is much higher

ACP’s positions re MOC

- ACP supports the principles behind lifelong learning and professional accountability, which includes certification and maintenance of certification
- These responsibilities are best handled by an independent, non-profit certification board (i.e. ABIM)
- However, ACP has felt the process needs to be improved, and has advocated strongly for reform
- The low pass rate needs to be addressed

ACP’s position re MOC and credentialing

"ACP does not support making participation in MOC an absolute prerequisite for state licensure, hospital credentialing, or health plan (insurer) credentialing. Instead, decisions about licensure and credentialing should be based on the physician’s performance in his or her practice setting and a broader set of criteria for assessing competence, professionalism, commitment to continuous professional development, and quality of care provided."

ACP’s feedback to ABIM

- Need for more dramatic changes in the MOC process
  - Secure examination
  - Self-assessment of performance
- Need for more timely changes: slow reform wouldn’t work
- Need for a change in tone of communications
  - Not defensive
  - Acceptance of responsibility: mea culpa
- Need for change in website reporting

New ABIM announcement – 2/3/15

- Tone: “We got it wrong. We’re sorry.”
- Self-assessment of practice: immediate suspension of practice assessment, patient safety, and patient voice requirements for at least 2 years
- New, more relevant exam in Fall 2015 (for IM)
- Enrollment fees at or below 2014 level through 2017
- By end of 2015, more flexibility for self-assessment of knowledge
- Change in website reporting to “participating” rather than “meeting requirements”: within 6 months
Additional events re ABIM and MOC

- Lots of positive responses to ABIM’s announcement, but...
- Lots of negative responses to ABIM’s announcement – too little, too late
- Announcement of an “alternative certifying board” – the National Board of Physicians and Surgeons (NBPAS)
- Attacks on ABIM as an organization – through social media and scathing Newsweek articles

More recent changes from ABIM

- Extended practice assessment suspension through end of 2018
- Changes in October 2015 exam
  - New “blueprint” for exam questions based upon feedback on a diplomate survey
  - Change in method for determining passing cut-point
- December 2016 – announced an alternative with a “lower stakes” option to the q10 year secure exam

Optional alternative to q10 year exam announced in December 2016

- Will start in 2018
- Shorter “knowledge check-ins” q2 years
  - Taken on personal or work computer, or at testing center
  - Will be open book (ABIM provides single resource)
  - Don’t need a passing score on each 2 year assessment; if fail 2 in a row (except for 1st exams in 2018), need to take the 10 year exam
  - Results available immediately; will get more feedback

And still more details...

- Testing time: 2 to 3 hours (including break)
- Exam offered 4 to 6 times per year
- Testing sites: home, office, or testing center
- Video camera recording requirement (video data will be archived and viewed only if there is a question of irregular examination behavior)
- Immediate pass/fail feedback provided; more detailed feedback provided 2 or more weeks after the examination

IM MOC Exam First Time Taker Pass Rates

- Source of data: abim.org

Additional points about alternative

- Initially, available for core IM and nephrology
  - Plan to roll out to other subspecialties in 2020
- Cost and payment options not yet specified
- Ultimately, also planning to have 10 year exam also be open book
- If certificate expires in 2017, still need to take high stakes exam
- If certificate expires in 2018, can do either 10 year exam or q2 year alternative
The new society maintenance pathway...

- Would be an alternative to other MOC pathways offered by ABIM, i.e. the current 10-year secure exam or the 2-year approach announced by ABIM.
- Would be anchored in the principles of continuous learning, and would include guided independent study, self-assessment, and evaluation – all based on ACP’s Medical Knowledge and Self-Assessment Program (MKSAP).

Open Book

- Examination resource is MKSAP syllabus/text
- No “direct links” from question to text where answer may be found
- Participants will access “open book” content via MKSAP search engine or table of contents

Examination Content Preview

Timing and Examination Window

January 2019 - Content Preview

December 2019 - Examination Window

Additional points about proposal

- The society MOC pathway that ACP is exploring would be offered by ACP, but ABIM would continue to be the certifier.
- ACP would attest to ABIM that a member has successfully completed the ACP pathway, which would satisfy ABIM’s requirements for maintaining certification.
- Senior leaders and senior staff from ACP and ABIM are making progress in working through the details of a potential society pathway.

Comprehensive Scope

- All internal medicine topics
- Guided by ABIM blueprint
  - Proportionality of content
  - High-importance items
- Future innovations
  - Hospital-based
  - Ambulatory-based
  - Both hospital- and ambulatory-based

Challenges

- Assuring security of questions
- Identity verification
- Financial model
- Some subspecialties have multiple societies
- Will ABIM accept a society’s model as being sufficiently credible?
ACP Initiatives

Encouraging High Value Care

Resources to help provide the best patient care while reducing health care costs:

- New High Value Care (HVC) Online Cases: Earn free CME credits and MOC patient safety and medical knowledge points through web-based cases and questions
- Curriculum For Educators, Residents and Students: Created by ACP and the Alliance for Academic Internal Medicine (AAIM), features six one-hour interactive modules
- HVC Course For Medical Students: Students evaluate the benefits, harms and costs of tests and treatment options so they can make HVC a reality in clinical practice

Encouraging High Value Care (cont'd)

Resources to help physicians provide the best patient care while reducing health care costs:

- High Value Care Coordination (HVCC) Toolkit: Resources to facilitate more effective and patient-centered communication between primary care and subspecialist doctors.
- Pediatric to Adult Care Transitions Toolkit: Resources to facilitate more effective transition and transfer of young adults from pediatric to adult care.
- Collaboration with Consumer Reports: A series of new High Value Care Resources to help patients understand the importance of seeking appropriate care.

Evidence-Based Clinical Guidance

ACP's Clinical Practice Guidelines, Guidance Statements, Best Practice Advice and High Value Care papers are rigorously developed based on review of the best evidence available. Recent Clinical Policies and Recommendations:

- Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain (February 2017)
- Pharmacological Treatment of Hypertension in Adults Over Age 60 to Higher vs. Lower Targets (January 2017)
- Diagnosis of Acute Gout (November 2016)
- Management of Chronic Insomnia Disorder in Adults (May 2016)
- Nonpharmacological Versus Pharmacological Treatment of Adult Patients with Major Depressive Disorder (February 2016)

Annals of Internal Medicine

Celebrating Its 90th Anniversary

One of the most widely cited medical journals in the world; current, evidence-based science at your fingertips. Recent Annals features include:

- Redesigned annals.org—Annals’ new interface features a responsive design that automatically optimizes for all devices, including desktop, tablet, or smartphone
- “Online first” articles—new content weekly
- Annals for Hospitalists—Includes monthly alerts highlighting Annals’ hospital medicine content, a new Hospital Medicine channel at annals.org, and “Inpatient Notes,” monthly web-only commentary on hospital medicine topics
**Annals Impact Factor: 2001-2016**

2016 Impact Factor: 17.202

**Impact Factors: General Medical and Selected IM Subspecialty Journals**

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**2016 Annals.org Traffic**

- **8,263,578** views in 2016
- Number of monthly visitors varied from a high in March of **783,295** to a low of **564,435** in July
- Annals.org visitors came from the Americas (58%), Europe (18%), Asia (18%), Oceania (3%), & Africa (3%)

**Topics That Demand Media Attention**

**What's on the Horizon for 2017?**

- “Early Career Physicians” blog
- Precision Medicine series with Columbia University
- Explore new hospital medicine feature
- Explore new ways to summarize systematic reviews
- Expand multimedia content
- Increase submissions of high profile articles, particularly targeting Europe
- Continue to grow Annals.org traffic, social media
MKSAP® 17

The gold-standard of physician self-assessment for 50 years; discounted for ACP members

- Use for board preparation, recertification (MOC) preparation and credit, and updating medical knowledge
- Covers general internal medicine and 11 internal medicine subspecialties
- 1,200 multiple-choice questions; answers and critiques included
- Available in both print and digital formats

DynaMed Plus™

Clinical content that is current, concise and easy to search:

- Free access for members (extended through December 2017)
- Includes overviews and recommendations for more than 750 topics, 2,500 searchable images and numerous calculators
- Mobile apps available for Android and iOS
- Sign up at www.acponline.org/clinical-information/clinical-resources-products/dynamed-plus-a-new-benefit-for-acp-members

IM Essentials™

Updated, integrated suite of materials for students

- Developed by ACP and the Clerkship Directors in Internal Medicine
- Helps third-year medical students care for patients, prepare for clinical rounds, study for the end-of-rotation and USMLE Step 2 exams
- IM Essentials Text (Print)
- IM Essentials Questions (Print)
- IM Essentials Online (integrated digital version of both IM Essentials and IM Essentials Text)

Internal Medicine In-Training Examination (IM-ITE)

Web-based program designed for self-assessment and program evaluation

- Developed by ACP in collaboration with Alliance for Academic Internal Medicine
- Gives residents an opportunity for self-assessment
- Allows program directors the chance to evaluate their programs
- Identifies individual resident knowledge gaps to guide learning
Resources for Educators

- Teaching Medicine Series
  - *Theory and Practice of Teaching Medicine*, *Teaching Methods*, *Teaching in the Hospital*, *Teaching in the Clinic*, *Teaching Clinical Reasoning*, *Mentoring in Academic Medicine*, and *Leadership in Medical Education*
- *Annals of Internal Medicine* teaching tools
- *Internal Medicine In-Service Training Examination* for residents
- *ACP Board Prep Curriculum* for residents
- *High Value Care Curriculum* for trainees at all levels
- *IM Essentials* for medical students

ACP’s Wellness Task Force Update

"A calm and modest life brings more happiness than the pursuit of success combined with constant restlessness."

Wellness Task Force Mission

- To help ACP be a leading voice in providing guidance and resources that optimize internist well-being and engagement to better serve our patients and our communities

Wellness Task Force Charge

- To advise ACP staff as they explore how best to develop an infrastructure to support expansion and sustainability of wellness initiatives for physicians and physicians-in-training
- Specific issues on which the Task Force will advise include:
  1) A mission statement for ACP’s approach to promoting physician wellness
  2) Identifying key gaps and prioritizing projects
  3) How to raise awareness
  4) How to engage and deploy ACP’s wellness champions
  5) How to address key systems issues implicated in physician burnout
  6) Partnerships to amplify efforts and broaden reach
  7) Identifying and promoting the most effective tools to enhance physician wellness
  8) A wellness presence and resources on ACPOnline
Task force adopts Stanford’s Model for wellness

Four Working Groups

- Individual wellness strategies
- Systems level wellness strategies
- Partnerships and a culture of wellness
- Measurement and tracking of burnout and wellness

Themes

- ACP needs an infrastructure that addresses individual, practice and organizational wellness gaps across a spectrum
  - ACP’s focus should be specifically on how we can improve internist wellness
  - Standardized training, deployment, and growth of ACP’s wellness champions (through chapters) is underway and will be central to our infrastructure
  - Provide a menu of evidence based tools to measure wellbeing, burnout, administrative burden
  - Provide a list of strategies to improve the culture of wellness for internists and their practices
  - Communications strategy and timeline is essential—our members need to know that ACP is taking this on and providing valuable guidance and resources to help (will sync efforts with Patients Before Paperwork Initiative)

ACP Continues to Grow

Total ACP membership is 152,000 and international membership is 14,215. ACP has 67 domestic chapters/regions and 19 international chapters: Bangladesh, Brazil, Canada (6 chapters), Caribbean, Central America, Chile, Colombia, Gulf, India, Japan, Mexico, Saudi Arabia, Southeast Asian, and Venezuela

Professional Development

- ACP Leadership Academy
- Ethics manual & case studies
- Mentoring and networking
  - at the chapter and national levels
- ACP Associate Poster Competition
- Doctor’s Dilemma
- ACP Member Forums
- Career Connection
  - a comprehensive listing of career opportunities for physicians

Become an ACP Fellow

Election to Fellowship recognizes excellence in the practice of internal medicine and is achieved through professional accomplishments within one, or across multiple pathways:

- Published academician: author of at least 2 published articles in medical journals
- Commitment to continuing education: multiple certifications, recertification or MKSAP for score
- Active involvement in ACP: at least 5 years of membership & participation in ACP activities including national or local committees/councils
- Senior physician: distinguished career in internal medicine

www.acponline.org/FACP
Support the Next Generation of IM

- Encourage a young person to understand the rewards of internal medicine as a career
- Convince a medical student to see the bright future of internal medicine
- Recommend general internal medicine to a resident
- Invite another internist to become an ACP member
- Sponsor a qualified ACP Member for Fellowship (FACP)

Thank you . . .

...for your continued support of ACP and your commitment to internal medicine.

ACP's Rx for a Forward-Looking Agenda to Improve American Health Care

1. Expand coverage and access.
2. Bring greater value for the dollars spent.
3. Reduce the crushing administrative burden on physicians and patients.
4. Leverage technology to improve patient care.
5. Support a well-trained physician workforce.
6. Reduce barriers to chronic care management.
7. Support scientific research and policies to improve public health.

Internal Medicine Meeting 2017: ACP's Annual Scientific Meeting

Internal Medicine Meeting 2018
April 19-21, 2018
New Orleans
Register online at https://im2018.acponline.org/

Center for Patient Partnership in Healthcare (CPPH)

The Center's primary focus is to promote principles of partnership between patients, families, and clinicians to improve care and outcomes. Major initiatives include:

- Partnering with patient and consumer groups to bring the patients' voice to ACP activities
- Development of clinician educational programs and resources focused on patient and family engagement to improve access, care coordination, and medication management
- Identifying opportunities for patients and families to participate in healthcare professional education, such as collaborating as faculty on educational programs
- Development of patient education resources to support patient self-management, enhanced communication, and shared decision-making
- Offering a library of over 100 resources – www.acponline.org/patient_ed

Who loses if insurers can again waiver coverage or charge more for preexisting conditions? Your patients.

ACP’s Rx for a Forward-Looking Agenda to Improve American Health Care

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5. Support a well-trained physician workforce.
6. Reduce barriers to chronic care management.
7. Support scientific research and policies to improve public health.
**What is ACP doing?**

- **Grass roots:**
  - 35 action alerts to our grassroots network across the country, which includes targeted alerts to key House members and senators.
  - A “write to Congress” letter-writing campaign for all of our 50 chapter governors during the March Board of Governors meeting.
  - 7 separate full-scale action campaigns for our 50 chapters that also involved targeted campaigns for 8-10 states with Republican senators who have expressed concerns about the AHCA/BCRA.
  - ACP’s 2017 Leadership Day in May brought 400 members from across the country representing 47 states and DC; a major component of our advocacy for this event was messaging in opposition to the AHCA.
  - Messaging in opposition to the AHCA was printed on mock prescriptions for use by ACP advocates with their lawmakers during Leadership Day.

**Advocates for Internal Medicine Network (AIMn)**

- Grassroots advocacy network designed to help ACP members engage with federal lawmakers on policy issues important to internists.
- AIMn members receive legislative updates and alerts as key policy issues unfold, including sample messages to members of Congress.
- Enroll at https://cqrcengage.com/acplac/
- To learn more, contact Shuan Tomlinson:
  - Tel: 202-261-4547
  - Email: stomlin@acponline.org