ACP Priorities for 2014: How The College is Helping You by Fostering Excellence in Internal Medicine
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 on 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 education and 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
2014-15 Priority Initiatives

ACP identified 10 initiatives as high priorities for FY 2014-15:

- Develop and implement a Maintenance of Certification (MOC) Navigator
- Help ACP members experience more joy in their professional lives
- Expand ACP’s reach internationally
- Increase knowledge and use of High Value Care (HVC)
- Increase the impact of ACP Smart Medicine
- Increase ACP’s visibility in academic centers/institutions
- Support implementation of the Affordable Care Act
- Improve the utility, safety, and quality of Electronic Health
- Facilitate transitions to value based payment and delivery models
- Support effective partnerships among patients, families and care teams
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ABIM Responses to ACP Discussions

- 1 year grace period if you do not pass written exam
- Decrease retake fee from $775 to $400
- Form committee to look at clinically relevant modular exam
- More patient survey flexibility (Part 4)
- Review underlying certification requirements for sub-specialists
- Increase MOC options for clinically inactive physicians
- Clarification of MOC vs MOL requirements
Revision of language on ABIM website re: Lifetime Certification

- Now reads: Certified; Meeting MOC requirements Yes/No
- Will be altered to clarify certification will not be removed and MOC participation is encouraged but voluntary
MOC Navigator

www.acponline.org
High Value Care

- Issue of the decade starting in 2000: quality of care and patient safety
- Issue of the decade starting in 2010: decreasing the cost of care
- Challenge: how to address both simultaneously
Excess Cost Domain Estimates

- Unnecessary Services ($210 B)
- Inefficiently Delivered Services ($130 B)
- Excess Administrative Costs ($190 B)
- Excessive Pricing ($105 B)
- Missed Prevention Opportunities ($55 B)
- Fraud ($75 B)
Conserving resources through rational care does not mean rationing

- Rationing: decisions are made about the allocation of scarce medical resources and who receives them, leading to *underuse* of potentially appropriate care

- Rational care: assuring that care is clinically effective, thus avoiding *overuse* or *misuse* of care that is inappropriate
Overview of Goals for HVC Initiative

- Develop guidance for physicians about appropriate use of care, focusing initially on diagnostic testing
  - Assemble and integrate evidence-based and consensus-based recommendations

- Educate target audiences about areas of overuse and misuse of care
  - Practicing clinicians
  - Trainees (residents and medical students)
  - Patients
High-Value, Cost-Conscious Health Care: Concepts for Clinicians to Evaluate the Benefits, Harms, and Costs of Medical Interventions

Douglas K. Owens, MD, MS; Amir Qaseem, MD, PhD, MHA; Roger Chou, MD; and Paul Shekelle, MD, PhD, for the Clinical Guidelines Committee of the American College of Physicians*

Health care costs in the United States are increasing unsustainably, and further efforts to control costs are inevitable and essential. Efforts to control expenditures should focus on the value, in addition to the costs, of health care interventions. Whether an intervention provides high value depends on assessing whether its health benefits justify its costs. High-cost interventions may provide good value because they are highly beneficial; conversely, low-cost interventions may have little or no value if they provide little benefit.

Thus, the challenge becomes determining how to slow the rate of increase in costs while preserving high-value, high-quality care. A first step is to decrease or eliminate care that provides no benefit and may even be harmful. A second step is to provide medical interventions that provide good value: medical benefits that are commensurate with their costs.

This article discusses 3 key concepts for understanding how to assess the value of health care interventions. First, assessing the benefits, harms, and costs of an intervention is essential to understand whether it provides good value. Second, assessing the cost of an intervention should include not only the cost of the intervention itself but also any downstream costs that occur because the intervention was performed. Third, the incremental cost-effectiveness ratio estimates the additional cost required to obtain additional health benefits and provides a key measure of the value of a health care intervention.

For author affiliations, see end of text.
ACP’s Choice of 5 Overused Items for “Choosing Wisely” Campaign

- Screening exercise ECG in asymptomatic individuals at low risk for coronary heart disease
- Imaging studies in patients with non-specific low back pain
- Brain imaging studies (CT or MRI) for simple syncope and a normal neurological examination
- CT pulmonary angiogram as the first study in patients with low pretest probability of venous thromboembolism, rather than D-dimer
- Preoperative chest radiography in the absence of a clinical suspicion for intrathoracic pathology
HVC and Residency Training Launched in July 2012

- Habits start early in training → need to focus on students, residents, and fellows

- Joint initiative to develop HVC program for residents: AAIM, ABIM Foundation, and ACP

- [http://www.acponline.org/education_recertification/education/curriculum/](http://www.acponline.org/education_recertification/education/curriculum/)
Partnering with Patients

- Annals of Internal Medicine Summaries for Patients
- ACP Foundation’s Health TiPS
- Articles in lay press: “Pointless tests drive medical costs skyward” (op-ed in Philadelphia Inquirer, 6/9/11)
- Collaborations with consumer organizations (e.g., Consumer Reports)
Point-of-Care, Clinical Decision Support Tool—

Quick access to evidence-based recommendations through 500+ disease modules.

Valuable Benefit of ACP Membership
Integrated links to –

• Annals of Internal Medicine
• Clinical Guidelines
• High Value Care Recommendations
• ACP JournalWise
ACP JournalWise

- ACP JournalWise is a personalized, mobile-optimized updating service for clinical articles from more than 130 medical journals that is free to ACP members.

- Updated daily and available on Smartphone, tablet, or desktop, ACP JournalWise screens and provides customized alerts and summaries for articles categorized by specialty area, methods quality, and clinical importance.
Mobile Access

• A mobile web app, ACP Smart Medicine automatically adapts to your device
• Optimized viewing from smartphones and tablets
• Mobile access integrates ACP Smart Medicine into your workflow for more efficient healthcare
• Easily set-up a shortcut using standard device settings
Key Points provides an overview of the management of a given disease.
## Diagnostic Studies for Gout

<table>
<thead>
<tr>
<th>Test</th>
<th>Sensitivity (%)</th>
<th>Specificity (%)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serum uric acid (level &gt;7 mg/dL)</td>
<td>55</td>
<td>93</td>
<td>The higher and more prolonged the elevated uric acid level, the more likely that gout and tophi will develop (29)</td>
</tr>
<tr>
<td>Synovial fluid monosodium urate crystals on polarized microscopy</td>
<td>84.4</td>
<td>100</td>
<td>Sensitivity may be operator dependent (16)</td>
</tr>
<tr>
<td>Monosodium urate crystals in tophi</td>
<td>30</td>
<td>100</td>
<td>Sensitivity may be operator dependent (16)</td>
</tr>
<tr>
<td>ACR diagnostic criteria</td>
<td>80</td>
<td>64</td>
<td>Diagnostic accuracy was measured in a primary care population (23)</td>
</tr>
<tr>
<td>Overlying erythema on exam</td>
<td>89</td>
<td>24</td>
<td>From the EULAR guideline (15)</td>
</tr>
<tr>
<td>Unilateral first MTP joint attack</td>
<td>77</td>
<td>71</td>
<td>From the EULAR guideline (15)</td>
</tr>
<tr>
<td>Symptom onset at night</td>
<td>90</td>
<td>48</td>
<td>From the EULAR guideline (15)</td>
</tr>
</tbody>
</table>
### Differential Diagnosis of Gout

<table>
<thead>
<tr>
<th>Disease</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gout</td>
<td>Acute, rapid onset of painful monarticular arthritis, commonly in the great toe. Monosodium urate crystals typically seen in synovial fluid. More common in men than women; incidence rises with patient age.</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>Symmetrical polyarthritis, preferentially affecting small joints of hands and feet, often with subcutaneous rheumatoid nodules (in 20%). Radiographic changes include soft-tissue swelling, diffuse joint-space narrowing, marginal erosions of small joints, and symmetrical multiple joint involvement. Usually is osteopenic and without signs of repair (osteophytes). Acute rheumatoid arthritis synovitis sometimes mimics gout. Rheumatoid arthritis is more likely when more joints are involved or when there is hand involvement. Rheumatoid arthritis is much more likely than gout to involve the hands.</td>
</tr>
<tr>
<td>Septic arthritis</td>
<td>Fever, arthritis, tenderness. Usually occurs in previously abnormal joints; up to half of patients have rheumatoid arthritis. Radiographs generally show presence of swelling and effusion. Must be diagnosed early to avoid joint destruction.</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>Erythema and swelling of extremity with tenderness and fever. Soft-tissue lymphatic drainage often abnormal. Radiography shows soft-tissue swelling but no joint changes.</td>
</tr>
</tbody>
</table>
Therapy provides more about disease treatment. Recommendations are graded based on the strength of the evidence.
Over 800 figures available for visual reference.
Review disease-specific guidelines alongside ACP’s recommendation

Available tables include:
- Screening for Osteoporosis
- Screening for Prostate Cancer
- Aspirin for Primary Prevention of Coronary Events
- Screening for Diabetes
- Screening for Hepatitis C
- Screening for HIV
- Screening for Breast Cancer
- Nonoccupational Postexposure Prophylaxis (NPEP) for HIV
- Preexposure Prophylaxis (PrEP) for HIV

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**Screening for Osteoporosis**

<table>
<thead>
<tr>
<th>U.S. guidelines holder</th>
<th>Year</th>
<th>Based on systematic review</th>
<th>Recommendation Frequency</th>
<th>Population</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACOG</td>
<td>2012</td>
<td>Yes</td>
<td>DEXA</td>
<td>Interval 5 years in the absence of new risk factors</td>
<td>Women aged ≥65; all postmenopausal women aged ≥65 with a risk factor or based on FRAX*</td>
</tr>
<tr>
<td>USPSTF</td>
<td>2011</td>
<td>Yes</td>
<td>DEXA or hip and L-spine or QUS of calcaneus</td>
<td>Notspecified</td>
<td>Women aged ≥65; women with fracture risk of a 65-year-old white woman</td>
</tr>
<tr>
<td>AACE</td>
<td>2010</td>
<td>Yes</td>
<td>DEXA</td>
<td>Notspecified</td>
<td>Women aged ≥65, younger women with risk factors²</td>
</tr>
<tr>
<td>ACP*</td>
<td>2008</td>
<td>Yes</td>
<td>Periodic risk assessment, DEXA</td>
<td>Notspecified</td>
<td>Men at increased risk who are candidates for drug therapy</td>
</tr>
<tr>
<td>ACPM</td>
<td>2008</td>
<td>Yes</td>
<td>Interval 2 years</td>
<td>Men aged ≥65; men aged ≥70; patients aged &gt;50 with risk factors²</td>
<td>Screen patients aged ≥65 with one major or two minor risk factors²</td>
</tr>
<tr>
<td>NCP</td>
<td>2013</td>
<td>No</td>
<td>DEXA</td>
<td>Every 2 years on average</td>
<td>Women aged ≥65; men aged ≥70; patients aged &gt;50 with fracture or risk factors²</td>
</tr>
</tbody>
</table>

**Non-U.S. guidelines**

| NICE                   | 2012 | Yes                        | DEXA                     | 2 years | Women aged ≥65; men aged ≥75; men and women aged >50 with risk factors² | Use FRAX² or Q fracture² score to assess 10-year risk |
| Canadian Task Force on Preventive Health Care | 2004 | Yes                        | DEXA                     | 2 years | Women aged ≥65; women aged >50 with prior fracture, weight ≤60 kg, or high T-score (≤−2.5) or OAFT² (≥5) | No comment on screening men |

**Gaps in recommendations:**

- Make screening net universally accessible, optimize screening interval often net specified and not well-studied.

**The ACP Smart Medicine approach:**

Screen women aged 65 and older and men aged 75 and older with DEXA at least once, and use FRAX to identify younger patients for screening. Repeat negative screens in 2 years if result will change management.
• Use ACP Smart Medicine to teach:
  • Diagnostic reasoning
  • Guideline-adherent management
  • High-value care
• Quickly access recent guidelines and the best evidence when preparing for teaching sessions
• Use our tables and figures in your presentations
A Key Benefit: ACP Fellowship

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 two 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 and participation in College activities including national or local committees/councils
- Senior Physician with a distinguished career in internal medicine

www.acponline.org/FACP
ACP Membership Continues to Grow

- Effective June 30, 2013, total membership was 137,000, and international membership exceeded 11,000.

- ACP has 58 domestic chapters and 15 international chapters.
International Membership

- **15 International Chapters:**
  - Brazil, Canada (6 chapters), Central America, Chile, Colombia, Japan, Mexico, Saudi Arabia, Southeast Asia, Venezuela

- **In 2013:**
  - ACP Southeast Asia Chapter became active.

- **In 2014:**
  - ACP will hold its first national conference in India, September 5-6, 2014, in New Delhi.
Internal Medicine 2015: ACP’s Annual Scientific Meeting

April 30 – May 2, 2015, Boston, MA

- Over 200 educational, interactive workshops
- Case-based sessions and feedback on challenging patient management problems

Join us as we celebrate ACP’s 100-year anniversary!

www.acponline.org/im2015
Why join ACP?

- Evidence-based Clinical Information and Educational Resources
  *Annals of Internal Medicine*, MKSAP, Clinical Guidelines, ACP Smart Medicine, scientific meetings, *ACP Internist*, *ACP Hospitalist*, and ACP JournalWise

- Board Certification and Maintenance of Certification (MOC) resources
  MKSAP, review courses, resources and opportunities for MOC points

- CME
  Earn CME by attending live meetings, working online, or watching course recordings on your own schedule.

- Influential Advocacy

- Practice Support
  Tools and resources for Quality Improvement and Practice Transformation

- Professional Development
Thank you . . .

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