Demystifying ABIM MOC

Amy K. Holbrook, MD, FACP
Abbott Northwestern General Medicine Associates
No Disclosures
American Board of Internal Medicine

• Created in 1936
• Largest medical specialty board
  • 200,000 physicians, 25% of US physicians
• Certifies all internal medicine specialties and subspecialties
• “Voluntary”

• Subsidiary of American Board of Medical Specialties
History of ABIM

- 1936: One time exam - essay and oral exam
- 1972: Oral examinations discontinued
- 1990: Started giving 10 year certifications
- 1995: MOC modules added
- 2014: Increased cost and significantly increased requirements
  - Changed from 10 year certificate to ‘dependent on MOC participation’
- 2015: ABIM backed off on changes
  - Eliminated QI requirement, patient survey, patient safety modules
- 2018: Testing changed to Open Book
- 2018: Two year “Knowledge Check-In” now alternative option
- 2019: Plan for “Longitudinal Assessment”
Current Requirements

• 100 MOC points every 5 years
• Complete some MOC points every 2 years
• Recertification exam every 10 years
  • *New 2 year option started in 2018

• Personalized portal
Knowledge “Check-In”

- 2 year exam in lieu of 10 year exam
- Only offered in even numbered years*
  - 12 dates in 2020
  - Need to register for a specific date/time slot
- Get 20 MOC points
Knowledge “Check-In” - Logistics

• Need a computer with a camera and microphone
  • Home, office, or testing center
  • No one allowed to be in the room

• ~3 hours
  • Two blocks of 45 questions each (90 min each)

• Immediate feedback on performance
  • Some find out if they passed immediately, or “provisional” pass

• Access to UpToDate
## Knowledge “Check-In” by Specialty

<table>
<thead>
<tr>
<th>2018</th>
<th>2019</th>
<th>2020*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>Cardiovascular Disease</td>
<td>Advanced Heart Failure &amp; Transplant Cardiology</td>
</tr>
<tr>
<td>Nephrology</td>
<td>Geriatric Medicine</td>
<td>Clinical Cardiac</td>
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<td></td>
<td>Endocrinology, Diabetes, and Metabolism</td>
<td>Electrophysiology</td>
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<td></td>
<td>Gastroenterology</td>
<td>Critical Care Medicine</td>
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<td></td>
<td>Hematology</td>
<td>Hospice &amp; Palliative Medicine</td>
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<td></td>
<td>Infectious Disease</td>
<td>Hospital Medicine</td>
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<td></td>
<td>Pulmonary Disease</td>
<td>Interventional Cardiology</td>
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<td></td>
<td>Rheumatology</td>
<td>Medical Oncology</td>
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<td>Sleep Medicine</td>
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<td>Transplant Hepatology</td>
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Knowledge Check-In Experience

• 1200 physicians took it in 2018
  • ~90% were able to complete it without issues
  • Some glaring technical issues

• Do the system check!

• Can choose to take it at a testing center
Traditional Exam

• Still every 10 years
• At a testing center

• Now open book
  • Open book = UpToDate
What if I Fail?

- If you fail the 10 year exam the year you’re due, you have a 1 year grace period to retake it before your lose your certification.

- If you fail the 2 year “Check-In” the year you’re due, you need to take and pass the 10 year exam within a year.

- If you took and passed a “Check-In” exam 2 years early, but fail the year you’re due, you can try again in 2 years.

- If you fail two “Check-Ins” in a row, you need to take and pass the 10 year exam within a year.
Longitudinal Assessment Option

- Announced in August 2019
- “Self paced pathway to acquire and demonstrate knowledge”
- Details/timeline vague
- Immediate feedback
Costs

• Annual MOC Fee
  • $128 year before due
  • $160 in year due
  • $180 after year due

• Traditional Exam Fee
  • $650 for IM
  • $1200 for subspecialty

• Check-In Exam Fee
  • $130 for IM
  • $24 for subspecialty
Cases
Case 1

• Dr. Liv Indadream

• Took initial exam in 1989
• Certified for life - “grandfather”
• Doesn’t need to participate in MOC to maintain certification
Case 2

- Dr. Rahul Follower
- Initial certification in 2012
- Loves MOC points, earns them at ACP every year, has way over 100
- Can choose 10 year test in 2022, or
- 2 year “Check-In” in 2022, or 2020 for a cushion
Case 3

• Dr. Ann Xious

• Initial certification in 2003, recertified in 2013
  • Near nervous breakdown in 2013 with palm scanning

• Reluctantly earns points every 2 year in December

• Will start 2 year “Check-In” in 2022, 2020 if wanted cushion
  • Could also choose 2023 traditional exam
Case 4

• Dr. O. Noim Screwd

• Initial certification in 2000, recertified in 2010
• Was in a state of pleasant denial until 15 min ago
• Never knew what MOC stood for

• Needs to join MOC and earn 80 points before 2020
• In 2020, needs to either take 10 year exam or 2 year “Check-In”
  • Get 20 points for test
• If not, even with taking test in 2020, would lose board certification
License vs Board Certification

- ABIM governs board certification
  - Required by many employers
- Minnesota Medical Board governs state license
  - Required to practice medicine
  - Requires 75 hours of CME every 3 years
- Participation in MOC counts in lieu of CME for medical license
Alternative Pathways

• “Collaborative Maintenance Pathways”
  • American College of Cardiology
  • American Society of Clinical Oncology
National Board of Physicians and Surgeons

- Alternative “grassroots” board certification organization
- Launched in 2015
- ~7500 diplomates
- Multispecialty
- Requirements:
  - Initial certification by ABMS organization
  - 50 hours of CME every 2 years
  - Clinical privileges
Take Home

• 2 year "Check-In" Exam vs Traditional 10 year exam
• Need to earn points every 2 years, 100 points every 5 years
• Lots of variables based on your re-certification timing
  • Check personalized portal
Talking to legislators

Charles Reznikoff, MD, FACP
Charles.reznikoff@hcmed.org
Hennepin Healthcare
Minnesota ACP 2019
Overview

• How are medical providers and legislators different?

• Five anecdotes and lessons learned:
  • Understanding what legislators want
  • Answering legislators’ concerns
  • Remaining trusted in partisan times
  • Giving testimony
  • Spending your political capitol wisely
Legislators—

*Masters of the possible, not the ideal*

- Variety of training backgrounds, often not medical
- Think in terms of communicating with, responding to and motivating constituents
- Anecdote more powerful than data
- If data, must be understandable to average people in soundbite form
- Their actions must be accompanied with appearances and public gestures
- They are experts on the priorities of their constituents
Show respect and be respected

• They are polite and formal
• They respect your title and your expertise
• Show equal respect to them
• Make eye contact, shake hands
• Dress nicely, bring business cards
• Send follow up thank you letters and thank you emails
• Make yourself at their disposal
Five Anecdotes
1. What Legislators want
Rosen visits Hennepin Health...

• In early 2019, Sen Julie Rosen (R) Chair of the Finance Committee visited Hennepin Healthcare
• After giving a policy speech, she stayed to talk to our providers
• A line formed to talk to her; I got in line
• The proceedings were quite tedious
• When I got to the front of the line, I said something to Julie that made her smile and loudly say “yes!”
• My Department Chair asked what I had asked for to get such a prompt and animated response......
What had I asked for?
What had I asked for?

• ...Nothing

• I had **offered** her an opportunity to speak at an event promoting her bill

• Everyone else in the line was asking for funding, without giving anything in return

• I asked her to participate in a project, which happened to give her something in return— an opportunity to promote her legislation.

• I got the only “yes”
1. What Legislators want

• If you only think of legislators as people to approve or fund your plan, you are less likely to communicate with them successfully
• It is not enough to have a good project
• Develop a relationship with them
• Respect and understand that their job is not just funding your projects!
• Contribute meaningfully to their job if you want something meaningful for yours
How docs think

• My project is evidence-based
• My project will help people or save lives
• My project deserves funding
1. What Legislators want

• How have you helped legislators communicate with their constituents?
• Does your project affect other stakeholders of theirs?
• How have you helped them promote this plan to their colleagues in the legislature?
• Does this affect their fundraising?
• Do you understand the trade-offs necessary to fund your project?
2. Resolve legislators’ concerns
Mandated Medical Curriculum?

• Rep Dave Baker (R) was alerted by a member of the public that the University of Minnesota had inadequate curriculum on opioids and addiction
• He wrote the Dean of Education concerned about this
• His letter prompted fears that he may author a legislative curriculum mandate for MN medical schools
• This created alarm at the UofM Medical School
• I was asked to develop/deliver curriculum for the entire (240 person) med school third year in five weeks
Impromptu Addiction Curriculum

- I recruited content experts and organized small group case-based discussions on important topics of pain and addiction
- Rep Baker and multiple University Deans showed up to observe
- The flow, space, content, and materials were all well below my standards as a teacher
- By the end of the session I was frustrated with getting such short notice and certain I had failed
2. Resolve legislators’ concerns

- *Dave Baker was delighted by the sessions*
- He has no background in addiction science or pedagogy; no basis to judge the session’s quality
- He was not inclined to legislate curriculum
- He needed to know that something was being done to resolve his constituents’ concerns
- He needed to be able to deliver this information back to his constituency
- He benefitted from the opportunity to attend
2. Resolve legislators’ concerns

- *Legislators don’t resolve problems the way medical providers do*
- They often do not assess success the same way
- A legislator must respond to constituent concerns by assuring a process is place (or creating one)
- Legislative fixes are challenging, costly, and have unintended consequences
- Their endpoint is a process to resolve the issue
- Success is the ability to effectively communicate that process to constituents
3. Get invited into advocacy opportunities
Dean Phillips town hall

- US Rep Dean Phillips (DFL) 3rd congressional wanted to host a town hall meeting on the topic of the opioid epidemic
  - He invited me; we had never met before; I obliged
  - The event went well:
    - Full room, lots of questions
    - Media present, cameras rolling
  - How did Rep. Phillips know I was not going to say something crazy?
How did I get invited?

• He had vetted me with mutual acquaintances
• He had vetted me on social media
An aside about twitter....

• An addiction colleague whom I respect greatly recently tweeted about recreational marijuana
• She posed a hypothetical argument about unsafe marijuana-impaired doctors and pilots
• She got more than 7000 responses, include obscene and disparaging responses
• She had to shut down her twitter

• (She has gotten into twitter beefs before)
Be deliberate about your social media presence

• If you promote partisan views publicly, how does that change your ability to advise legislators?
• If you are involved in controversy online, you may become too hot to touch
• Expect all legislators you’re working with to know if you are publicly promoting partisan or controversial viewpoints on social media
• In Minnesota and America, the legislative bodies are split, requiring bipartisanship to get anything done
Partisan thinking to avoid....

• If you drape your medical advice in partisan talking points you will be less effective, for example:

  “Medicare for all would allow coverage of these life-saving medications for all of Minnesota”

  “Many Minnesotans are not getting life-saving medications. We need to find ways to make those medications available”
My approach to navigating partisanship

• I collaborate with members of both parties
• No one has ever asked me my political allegiance
• No one has ever asked me my voting district
• I avoid public displays of my voting preference
• I avoid discussing off topic politics
• I avoid letting my advice redound to a political view
• I offer a menu of solutions to the problem
• *Facebook is for liking baby photos*
• *Twitter is for the birds*
3. Get invited into advocacy opportunities

- Addiction Medicine does not obey partisan lines
  I am thankful for the work of both parties

- Partisanship is so strong that it can fool us into thinking one party has all the good ideas

- If you want to be a partisan warrior first and foremost, you fill a different role than I want
4. Give public testimony successfully
Logistics of giving a testimony

• Committee schedules and locations often change
• You need someone to update you to those changes
• You may need to take the day off
• There is some formality to the proceedings
• Have a “pro” to tell you when to sit in front of the microphone and how to address the committee
• The committee understands if you are unfamiliar with the proceedings
Opioid Stewardship bill 2019

• The “Opioid Stewardship Bill” did not pass the house in 2018
• Renewed effort led by MN Rep Liz Olson (DFL) in 2019 as control of the house changed
• The bill required testimony in various committees as it worked its way towards a floor vote
• I was asked to testify in support to the committee
• How does one prepare for testimony?
The first committee hearing:

• Supporting the bill was a series of emotional testimonies: the crowd cheered and cried
• One expert declared doctors had made errors contributing to the opioid epidemic
• One expert proposed more funding for their successful anti-addiction project
• Testimonials told horrific and tragic stories
• *Meanwhile, the other side was well-paid, well-organized industry lobbyists dissecting the bill*
Preparing your words

- Know your time limit
- Know the coalition for and against the bill
- Write every word in advance
- Share your words in advance with the legislator who invited you
- Share your words with your hospital lobbyist
- Practice, timed
- Stick to the script
Do not....

• Speak generally on the topic without a purpose
• Promote your own project unless it’s part of the bill
• Preach to the choir, sound off righteously
• Tell anecdotes unrelated to the bill
• Ramble, or go over time
• Use medical acronyms or jargon
• Express partisan views
• Talk about yourself
Do...

• Make eye contact with everyone on the committee
• Specifically address the legislation being considered
• Frame your argument to which committee it is
• Target the legislators on the fence
• Describe specific instances where the bill will help
• Generate one or two memorable thoughts or anecdotes that illustrate the importance of the bill
• Deliver to legislators language that they can use with their constituents to justify their vote
• Talk about real Minnesotans
Answering questions

• After your testimony you will be asked questions
• Answer simply and honestly; they value your expertise
• They are asking to be educated, but moreover they are looking to “borrow” your language to communicate to their constituents
• Rarely someone will try to bait you into making an on-the-record statement they can use for other legislation, so be specific in your responses
4. Give public testimony successfully

• You are a member of a team
• You are helping with a narrow task
• That task is to win over uncertain legislators to support a specific bill
• It is done with effective political communication
• Plan ahead
• Communicate with your teammates
• Be disciplined
5. Spending political capitol
Jeff Schiff ousted at DHS

• New Human Services Commissioner restructures DHS
• In the process abruptly “restructures” Schiff’s job
• This was legal, and not that abnormal
• Dr. Schiff was lead on many important projects, and his ouster happened without a successor in mind
• I am on and very invested in one of those projects
• Jeff was my friend and seemed highly competent
I was one of eleven members of a state working group to sign an “open letter” expressing concern.

It is strongly worded letter but I agree with its content.

Cosigners included a sheriff, a state senator, and many docs.

This letter was published in the Star Trib and Pioneer press and emailed to legislators.

I signed it from myself, without identifying any institutional affiliation.
Did I spend political capitol?

• I was within Hennepin Healthcare (HH) policy for public speech by not attaching my affiliation
  • Reconsidered their speech policy
• HH needs to be in good standing with DHS
• HH leadership was not happy with me.
• HH’s public policy team believed they could have helped navigate this better if involved
• *I compromised myself in my workplace and I compromised my workplace in eyes of DHS*
Meanwhile...

• Unbeknownst to me, a group member emailed legislators opining off script about Jeff’s ouster
• Those emails were forwarded to many people including the Governor
• Jeff has given on the record interviews criticizing DHS to Star Trib
• Multiple resignations at DHS and ultimately the commissioner stepped down
Oh yea, also this:

• I want to retain my status as a neutral advisor to state legislators
  • Time will tell if I damaged this

• I am up for promotion to Associate Professor at the University
  • So far so good with this

• I applied for the state Opioid Advisory Counsel
  • Approved by the new DHS commissioner
  • I did not get a spot
If I could do it again...

• I might still sign a letter expressing concern
• I would strategize with HH's policy team first
• I would be open to using back channels first
• I would ask that the letter be written differently
• I would ask that we as a group be more careful and defined about who is sent this letter
• I would prioritize protecting all the relationships that are (politically) valuable to me
5. Spending political capitol

- It is good to speak your conscience
- *Creating negative press for a politician is big move*
- Creating bad press for others will affect your ability to communicate with politicians in the future
- It may affect you professionally
- Be sure you understand and control all the dynamics before you do it
- Check with your organization before you proceed
  - Their speech policy
  - Potential back channel, noninflammatory solutions
Summary

• 1. With every legislative ask consider what you are offering in exchange
• 2. Legislators do not resolve issues the way medical providers do
• 3. Be deliberate and cautious about your partisanship and social media presence
• 4. When asked to testify, be a team player
• 5. Know when you are about to spend political capitol; don’t be surprised by the fall out
Other instances...

• Rep Paulsen in the US House Ways and Means
• Authoring the Naloxone amendment
• Sen Franzen and recreational cannabis
• Baker and fallout from the opioid reports
Thank you!
Questions?
Want to be “in the room where it happens”? It starts with standing for something.

Minnesota Chapter, American College of Physicians
October 10, 2019
The room where it happens.

*The scene:*

Alexander Hamilton, Thomas Jefferson and James Madison meet over dinner in NYC, and emerge with an agreement to locate the nation’s capital (to Virginia) and Hamilton’s plan for a central banking system.

*Aaron Burr is not invited.*
The room where it happens

*Burr:]*
Two Virginians and an immigrant walk into a room

*[Burr and Ensemble:]*
Diametrically opposed, foes

*Burr:]*
They emerge with a compromise, having opened doors that were

*[Burr and Ensemble:]*
Previously closed

*[Ensemble:]*
Bros

*Burr:]*
The immigrant emerges with unprecedented financial power
A system he can shape however he wants
The Virginians emerge with the nation's capital

And here's the pièce de résistance:
No one else was in
The room where it happened
The room where it happened
The room where it happened
No one else was in
The room where it happened (The room where it happened)
The room where it happened
The room where it happened (The room where it happened)
No one really knows how the game is played
(Game is played)
The art of the trade
How the sausage gets made (How the sausage gets made)
We just assume that it happens (Assume that it happens)
But no one else is in
The room where it happens (The room where it happens)
But what did Burr stand for?

HAMILTON/JEFFERSON/MADISON/WASHINGTON:

What do you want, Burr?
What do you want, Burr?

*If you stand for nothing
Burr, then what do you fall for?*
What can *Hamilton* teach us about advocacy?

*If you stand for nothing, what do you fall for?*

What does ACP stand for?
What do we stand for?

The following statements are not official ACP policy, as approved by the Board of Regents. They characterize *(in my own words)* what the College stands for, based on approved policies.

1. That advocacy must always put the interests of patients above all else.

2. That *everyone* should have coverage for the care they need, at a cost they, and the country, can afford.
What do we stand for?

3. That physicians have a responsibility to advocate for policies to lower costs without compromising care; to practice high-value, cost-effective care themselves, and be accountable for it.

4. That physicians and patients must be freed of unnecessary administrative tasks that take time away from patient care, contribute to professional burn-out, and impose enormous system- and practice-level costs.
What do we stand for?

5. That technology should support patient care and not detract from it.

6. That a well-trained internist will be shown to be the best value in American medicine.

7. That public policy must support the training, retention, and well-being of internists, and the overall primary care physician workforce, as being essential to good outcomes of care and lower costs.
What do we stand for?

8. That practices and delivery systems must center on what is best for patients and families, and be supportive of internists and other clinicians within those systems.

9. That patients and physicians benefit from having a choice of practice models, from large groups to small independent practices, and those choices should be supported.

10. That internists must be compensated for their services at a level commensurate with their value.
What do we stand for?

11. That the medical profession has a responsibility to advocate for policies to address social determinants of health, the environment, discrimination, tobacco and substance use, public health, inequality, gun violence, immigration and other societal issues affecting the health of patients and the public.

12. That all persons, without regard to where they live or work; their sex or sexual orientation; gender or gender identity; race, ethnicity, faith, or country of origin; must have equitable access to high quality medical care, and must not be discriminated against based on such characteristics.
We stand for patients and physicians, by urging Congress to take action on the following priorities:

- Lower the High Cost of Prescription Drugs
- Address the Epidemic of Firearms-Related Injury and Death
- Expand Coverage and Stabilizing the Insurance Market
- Fund Federal Workforce, Medical and Health Services Research, Public Health Initiatives
- Improve Physician Payment under Medicare
- Reduce Unnecessary Administrative Tasks on Physicians and Patients
- Support Healthy Women and Families
- Support Medical Education and Reduce Student Debt
- Protect patients from surprise bills
We stand for policies to reduce Rx costs.

- Increase transparency and accountability in prescription drug pricing and improve access to lower-cost generic medications by co-sponsoring/supporting:
  - The *Fair Accountability and Innovative Research (FAIR) Drug Pricing Act* (H.R. 2296/S. 1391), which would require drug companies to disclose and provide more information about imminent drug-price increases, including data about research and development costs.
  - The *Reforming Evergreening and Manipulation that Extends Drug Years, REMEDY Act* (S. 1209), to aid in the approval of more generic drug applications by the FDA and therefore improve patient access to those medications.
  - The *Prescription Drug STAR Act* (H.R. 2113), to promote drug pricing transparency by requiring manufacturers to justify and explain price spikes on their drugs as well as reveal the price and quantity of the drug free samples that they give to clinicians.
  - The *Medicare Prescription Drug Price Negotiation Act of 2019* (H.R. 275/S. 62), to allow the federal government to negotiate lower drug prices on behalf of Medicare beneficiaries.
  - The *Creating and Restoring Equal Access to Equivalent Samples (CREATES) Act of 2019*, (H.R. 965/S. 340), to prevent egregious practices by manufacturers that keep generic drugs from coming to the market.
**We stand for policies to reduce injuries and deaths from firearms.**

- ACP advocacy is driving the national debate
- Spawning the #ThisIsOurLane movement.

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What does ACP recommend to curb injuries and deaths from firearms?

- New policy paper updates 2015 policy paper.
- The paper does not threaten the 2nd amendment right to own firearms for personal defense or recreation. Rather, we seek to:
  - To keep guns out of the hands of felons, all convicted domestic violence abusers (whether against a person within their house or outside of it), those with temporary as well as permanent restraining orders, and persons at imminent risk of harm to themselves or others
  - Background checks for all sales.
  - Close domestic violence loopholes.
  - Extreme risk protection laws
  - To require safe storage of guns and ammunition
  - To prohibit sales only of “assault” rifles and large capacity magazines.
  - To study causes and solutions to reduce injuries and deaths.
NRA Response to new ACP Policy Paper sparked *This is Our Lane* movement

- In response to the most recent ACP policy recommendations on reducing firearm-related injuries and deaths published in *Annals*, the NRA tweeted saying physicians should “stay in their lane.”

- Physicians were quick to respond...
Our Response

The @NRA lectures "in their own lane" and not speaking with @ACPInternists polices with Renee Butkus, ..., and the stance of @AnnalsofIM, has this to be. Read & add your own.

The @NRA tells @ACPInternists to remove #GunViolence. We pledge to talk about violence whenever we can. Click the link at us bit.ly/Annals.

Tell @NRA to stay in its own lane and out of the exam room. Take a stand today! Please click bit.ly/2Qr7L0N and make the commitment to talk to your patients about #gunviolence. Evidence shows that your counsel could save a life #ThisisMyLane #ThisIsOurLane.
Public Response

Maggie Fox
@maggiefox

The @NRA tells doctors to stay out of their business. Doctors are very much the @CDCgov release

Esther Choo MD MPH
@choo_ek

We are not self-important: we are to the care of others
We are not anti-gun: we are in our patients
We consult with everyone but doctors. Most upsetting, actually, is our disability from gun violence unparalleled in the world.

NRA @NRA
Someone should tell self-important anti-gun doctors: articles in Annals of Internal Medicine are pushing for gun control. However, the medical community seems to have consulted NO ONE but themselves. nraila.org/articles/20181...

6:03 AM - 8 Nov 2018

235 Retweets 436 Likes

4,068 Retweets 12,646 Likes

Joseph Sakran
@JosephSakran

As a Trauma Surgeon and survivor of #GunViolence I cannot believe the audacity of the @NRA to make such a divisive statement.

We take care of these patients everyday. Where are you when I’m having to tell all those families their loved one has died. @DocsDemand Docs4GunSense

NRA @NRA
Someone should tell self-important anti-gun doctors to stay in their lane. Half of the articles in Annals of Internal Medicine are pushing for gun control. Most upsetting, however, the medical community seems to have consulted NO ONE but themselves. nraila.org/articles/20181...

2:59 PM - 7 Nov 2018 from Baltimore, MD

11,797 Retweets 29,368 Likes

613 Retweets 12K Likes 29K Likes

Tweet your reply
First patient, finger wound to the hand, mother cried in fear. It took us to save him. This is the last one eligible. #ThisIsOurLane

Can’t post a patient. This is what it looks like.
@NRA @Joseph

Now, why in the hell do you think we have something against guns? Now, sort of like the trouble you have with life? #ThisIsOurLane #GunControl

Here’s hoping that the @NRA and @AnnCoulter realize that this is the reality we face. We seek solutions, and we won’t quit because lives depend on it. Help us with #bulletcontrol. Join us. #ThisIsOurLane #TraumaShoes #TraumaSurgery @EAST_TRAUMA @traumadoctors @DocsDemand
ACP’s position paper on reducing firearm-related injuries and deaths published in *Annals* has received extensive coverage in light of the NRA tweet saying physicians should “stay in their lane.” ACP, and the position paper, was mentioned in several top-tier media outlets, including CNN and CBS.

For more than 20 years, the American College of Physicians (ACP) has advocated for the need to address firearm-related injuries and deaths in the United States.

"...a public health crisis that requires the nation's immediate attention."

DOCTORS TAKE ON NRA OVER GUN VIOLENCE

#THISISOURLANE

DOCTORS PUSH BACK ON NRA COMMENTS

©CBSN
Firearms Position Paper Response: Top-Tier Media Coverage

- The New York Times: Doctors Revolt After N.R.A. Tells Them to ‘Stay in Their Lane’ on Gun Policy
- TIME: Doctors Slam NRA’s Directive to 'Stay in Their Lane' After Chicago Hospital Shooting
- NBC News: NRA tweet warns doctors to 'stay in their lane' over gun control
- HUFFPOST: ‘This Is Our Lane’: Doctors Slam NRA After Chicago Hospital Shooting
- AP: It’s a Twitter war: Doctors clash with NRA over gun deaths
- THE WALL STREET JOURNAL: After NRA Rebuke, Many Doctors Speak Louder on Gun Violence
- The Guardian: #ThisIsOurLane: NRA’s criticism spurs doctors to speak out on gun violence

Medical societies are calling for gun-control measures and other solutions to what they see as a public-health crisis.
Reduce injuries and deaths from firearms.

Universal background checks

Funding for research

Intimate Partner Violence

Safe Storage

Access to Mental Health treatment

Extreme Risk Protection Laws

Physician counseling and “Gag Laws”

Firearms with Features designed to increase their rapid and extended killing capacity
We stand for policies to reduce firearms-related injuries and deaths.

- Congress should support the following bills to address the public health consequences of firearms:
  - Cosponsor and pass the Gun Violence Prevention Research Act (H.R. 674/S. 184), to provide $50 million for the CDC and other federal agencies to fund research on the prevention of firearms-related injuries and deaths.
  - Senators should follow the action taken by the House and pass the Violence Against Women (VAWA) Reauthorization Act of 2019 (H.R. 1585), to provide protections for domestic violence victims by restricting access to firearms by those deemed a threat to them.
  - Senators should follow the action taken by the House and pass the Bipartisan Background Checks Act of 2019 (H.R. 8), to expand background checks to all firearms sales in the United States.
  - Cosponsor and pass the Assault Weapons Ban of 2019 (S. 66/H.R. 1296), to ban the sale of certain types of semi-automatic rifles and high capacity magazines.
We are making a difference.

- Several states have enacted, or are close to enacting, extreme risk protection laws, bans on undetectable guns, universal background checks, and closing domestic violence loopholes. ACP developed a [Chapter Tool Kit](#) to help chapters advocate with your own legislators.
A Texas judge ruled that the entire ACA is unconstitutional, because the 115th Congress repealed the individual tax penalty for not having coverage, without repealing the coverage requirement itself.

Instead of defending the ACA, the Trump administration supports the judge’s view that the entire law should be struck down. ACP joined with AMA, other organizations urging reversal on appeal.

If not reversed, the result would be catastrophic:

- No protections for pre-existing conditions.
- No essential benefit requirements.
- Lifetime and annual caps on benefits would return.
- No premium subsidies to make coverage affordable.
- No funding for Medicaid expansion.
- No phasing out of the Medicare Part D doughnut hole.
- Preventive services no longer would be offered by Medicare at zero out-of-pocket cost.
- The Center on Medicare and Medicaid Innovation likely would shut down, threatening APMs
We stand for ensuring all Americans have access to affordable coverage.

- New ACP position paper, *Improving the Patient Protection and Affordable Care Act's Insurance Coverage Provisions: A Position Paper From the American College of Physicians* recommends steps to close coverage gaps, including lifting income cap on premium subsidies, reinsurance, and universal Medicaid expansion, public option in all exchanges.

- Congress should support the *Protecting Pre-existing Conditions and Making Health Care More Affordable Act of 2019* (H.R. 1884), which strengthens and expands tax credits; stops skimpy health plans that do not cover essential benefits and discriminate against people with pre-existing conditions; and provides funding for reinsurance programs.
We stand for reforming physician payments to support value of care by internists.

- Major wins in the proposed Medicare physician rule! If finalized:
  - Reverses CMS proposal to collapse E/M code payments and de-value complex cognitive care
  - Accepts RUC recommendations to improve RVUs and payments for office visit codes (ACP lead the multi-specialty efforts to survey physicians and make the case for higher payments)
  - Reduces documentation of E/M services
  - Improves payments for care management services
In November 2018, CMS released the 2019 Medicare Physician Payment Schedule Final Rule outlining a new E/M payment structure proposal—including blended payment rates for office-based/outpatient E/M visit levels 2 through 4 and separate payment for level 5 office visits.
### Previous CMS Proposal:

<table>
<thead>
<tr>
<th>Complexity Level under CPT</th>
<th>Visit Code Alone*</th>
<th>Visit Code Alone Payment</th>
<th>Visit Code With Either Primary or specialized care add-on code**</th>
<th>Visit Code with New Extended Services Code (Minutes Required to Bill)</th>
<th>Visit with Both Add-on and Extended Services Code Added**</th>
<th>Current Prolonged Code Added (Minutes Required to Bill)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>$76</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 3</td>
<td>$110</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 4</td>
<td>$167</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 5</td>
<td>$211</td>
<td>$211</td>
<td></td>
<td></td>
<td></td>
<td>$344 (at 90 minutes)</td>
</tr>
<tr>
<td>Established Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>$45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 3</td>
<td>$74</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 4</td>
<td>$109</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 5</td>
<td>$148</td>
<td>$148</td>
<td></td>
<td></td>
<td></td>
<td>$281 (at 70 minutes)</td>
</tr>
</tbody>
</table>
ACP was a leader, along with several other specialty societies, in creating a coalition to push to improve payments for the historically undervalued E/M services, by retaining separate payment levels for each of the E/M codes, and revising the code definitions.

ACP’s representative to the RUC, Dr. Bill Fox (also, chair-elect, Board of Governors) presented the coalition’s recommendations, which were accepted by the RUC, and now CMS!
Dr. Fox makes a case to the RUC for the value of complex cognitive care!

Dr. Fox at RVS Update Committee, April 26, 2019 (2nd from right)
CMS’s Proposed Changes E/M

CMS proposes to assign separate payment rather than a blended rate, to each of the office/outpatient E/M visit codes (except CPT code 99201, which will be deleted).

Payment for a new prolonged visit add-on CPT code (CPT code 99XXX).
# Proposed E/M wRVU Changes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
<th>Current Work RVU</th>
<th>New Work RVU</th>
<th>Work RVU Increase</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>New Pt, straightforward medical decision making, 15-29 min day of visit</td>
<td>0.93</td>
<td>0.93</td>
<td>0%</td>
<td>22 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>New Pt, low level medical decision making, 30-44 min day of visit</td>
<td>1.42</td>
<td>1.60</td>
<td>13%</td>
<td>40 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>New Pt, moderate level medical decision making, 45-59 min day of visit</td>
<td>2.43</td>
<td>2.60</td>
<td>7%</td>
<td>60 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>New Pt, high level medical decision making, 60-74 min day of visit</td>
<td>3.17</td>
<td>3.50</td>
<td>10%</td>
<td>85 minutes</td>
</tr>
<tr>
<td>99211</td>
<td>Est Pt, Supervision</td>
<td>0.18</td>
<td>0.18</td>
<td>0%</td>
<td>7 minutes</td>
</tr>
<tr>
<td>99212</td>
<td>Est Pt, straightforward medical decision making, 10-19 min day of visit</td>
<td>0.48</td>
<td>0.70</td>
<td>46%</td>
<td>18 minutes</td>
</tr>
<tr>
<td>99213</td>
<td>Est Pt, low level medical decision making, 20-29 min day of visit</td>
<td>0.97</td>
<td>1.30</td>
<td>34%</td>
<td>30 minutes</td>
</tr>
<tr>
<td>99214</td>
<td>Est Pt, moderate level medical decision making, 30-39 min day of visit</td>
<td>1.50</td>
<td>1.92</td>
<td>28%</td>
<td>49 minutes</td>
</tr>
<tr>
<td>99215</td>
<td>Est Pt, high level medical decision making, 40-54 min day of visit</td>
<td>2.11</td>
<td>2.80</td>
<td>32.8%</td>
<td>70 minutes</td>
</tr>
<tr>
<td>99XXX</td>
<td>Prolonged visit new/est pt, add'l 15 min</td>
<td></td>
<td>0.61</td>
<td>New</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>
Documentation Changes

- History and Exam would no longer be used for code selection; but are performed and documented as medically appropriate.

- **Medical Decision Making (MDM) or Total Time on the Date of the Encounter may be used for code selection**
  - (without regard to whether counseling and coordination of care dominate the service).
Summary of Changes cont.

- MDM is based on the **number and complexity of problems addressed**, the amount and/or complexity of **data** to be reviewed and analyzed and the **risk** of complications and/or morbidity or mortality of patient management.

- THERE IS NO REQUIRED MINIMUM TIME (for 99202-99215) as long as your MDM supports the required documentation for the level of service selected.

- Time is an **option** for code selection.
Care Management Services

- **Transitional Care Management**
  - CMS is proposing to increase the work RVUs for these services.
  - Also considering for separate reimbursement for services that are currently considered overlapping.

- **Complex Chronic Care Management (CCCM)**
  - The agency propose to adopt two G codes for complex chronic care management services in place of the two existing CPT codes.
  - Revising what must be included in the comprehensive care plan.

- **Principle Care Management**
  - CMS proposes to create two new payable codes for Principle Care Management (PCM) services, which would entail providing care management services to patients with a single serious, high-risk condition.
ACP stands for reducing administrative burdens.

ACP Patients Before Paperwork Initiative

What is Patients before Paperwork?
ACP's Patients Before Paperwork initiative's goal is to reinvigorate the patient-physician relationship by reducing administrative complexities and eliminating unessential tasks that detract from patient care and contribute to physician burnout.

Policy Development
ACP policies provide a cohesive framework for identifying and evaluating administrative tasks, and offer detailed recommendations to analyze administrative tasks to determine whether they need to be challenged, revised, or eliminated entirely.

Tools You Can Use
Resources and tools help physicians put ACP's policies into practice. They include resources that assess practice efficiencies and resources on physician well-being and professional satisfaction.

Collaborating with Stakeholders
ACP engages with key regulatory agencies and stakeholders to help streamline regulations imposed by insurers, federal regulators, and other external entities to reduce administrative burdens for physicians.

Advocating for Internists
ACP has long identified reducing administrative complexities or burdens as a priority. ACP works to advocate for changes in our health care system that simplify excessive administrative burdens that put a strain on physicians and patient care.

For more information, visit, www.acponline.org/pb4p

https://www.acponline.org/advocacy/where-we-stand/patients-before-paperwork
Patients Before Paperwork:

✓ Reduce E/M documentation requirements
✓ Eliminate/standardize preauthorization
✓ Reduce burden of reporting under Medicare Quality Payment Program
✓ Fewer, better, more meaningful, relevant and actionable performance measures
We stand for protecting patients from surprise bills.

- **Hold Patients Harmless:** ACP strongly supports legislative efforts to provide protections for patients from unexpected out-of-network health care costs, when additional services are provided by out-of-network clinicians without the patient’s prior knowledge.

- **Examine Network Adequacy:** Health plans have an affirmative obligation to pay fairly and appropriately for services provided in- and out-of-network, and regulators should ensure network adequacy in all fields, including emergency care. Evidence exists that narrow networks contribute to surprise out-of-network costs.

- **Include A Dispute Resolution Process:** ACP supports creating process that would allow an independent arbitrator to establish an appropriate and fair payment level between the insurers’ in-network rate and the clinician’s charge.
You need to stand for something to be in the room where it happens. *But that’s not enough.*

You also have to know “how the sausage is made”
Believing in something is essential. But you also have to know “how the sausage is made”

Burr:
No one really knows how the game is played (Game is played)
The art of the trade
How the sausage gets made (How the sausage gets made)
We just assume that it happens
But no one else is in the room where it happens
ACP knows “how the sausage is made”

- Coalition-building (Group of 6): ACP, AAFP, AAP, APA, AOA, ACOG: represents over 560,000 physician and medical student members!
- Lobbying: congressional and regulatory branches
- Judicial branch: lawsuits and amicus briefs
- Grass roots (AIMn and Leadership Day)
- Earned and social media
- And of course, evidence-based policy positions

*We do it all. We do it well.*
We’re in the room where it happens

- The White House, HHS, and Congress regularly consult with us on a wide range of issues, from opioids, to Medicare payment policies, to immigration, to GME and workforce, to regulatory relief, to coverage, to public health, to gun violence—the list goes on and on.

- Even when we disagree, we are invited because ACP is viewed as a respected, credible, and evidence-based organization that stands for policies to improve the lives of patients, and daily work of our physicians.
We’re in the room where it happens

Tweet from CMS admin. Seema Verma, pictured with Dr. Lopez and ACP Staff Shari Erickson and Brooke Rockwern

ACP-president McLean, Group of 6, on Capitol Hill, 9/16/19

Dr. Moyer and G of 6 with Admiral Brett Giroir, assistant secretary of Health at HHS
We’re in the room where it happens

Dr. Fox at the RUC

LD attendees with Rep. Ami Bera, D-CA

ACP’s Shari Erickson discusses Medicare payment policy with CMS administrator Seema Verma

LD day attendees with Senator Bill Cassidy, R-LA
Yet can’t we do more?

- What if we were to craft a comprehensive statement of what changes should be made to American health care, supported by evidence, to better serve the needs of patients and the physicians who care for them?
- And used it to challenge everyone involved to make the needed changes?
- Well, this is exactly what ACP’s New Vision for American Health Care is all about.
ACP’s *New Vision for American Health Care* will better define and communicate what we stand for, and why

- Offer what we hope to achieve, and why, through the public policy recommendations on coverage and cost, payment and delivery system reforms, and improving public health and reducing barriers to care, supported by a review of the evidence.
- Intended audience includes, but is not limited, to our members, legislative and regulatory policymakers, consumers/patients, health plans/payers (CMS and private payers), and industry.
- Timed to be released in early 2020, to influence health care debate preceding 2020 elections and next administration, Congress.
Why do we need to do better?

- ACP’s evidence review focused on four key questions about U.S. health care:
  - Why do so many American lack coverage for the care they need?
  - Why is U.S. health care so expensive and unaffordable for many?
  - What other barriers do patients face in accessing high quality, equitable, and affordable care?
  - What is the role of delivery and physician payment systems in contributing to higher costs, reduced access, uneven quality and lack of equity?
Lack of coverage

- Despite historic gains in coverage from the Affordable Care Act (ACA), the U.S. remains the lone high-income industrialized nation without universal health coverage, which can be defined as a system that ensures everyone can access quality health care without being subject to substantial financial burden.

- Affordability is among the most commonly cited reason for remaining uninsured.
Higher spending

The nation spends far more per-capita on health care compared to other wealthy countries and in 2016, nearly 18% of the nation’s gross domestic product was directed to health care. Price has been and continues to be the main driver of high health care spending in the U.S.
“It’s the prices, stupid.”

“The United States spent approximately twice as much as other high-income countries on medical care, yet utilization rates in the United States were largely similar to those in other nations. Prices of labor and goods, including pharmaceuticals, and administrative costs appeared to be the major drivers of the difference in overall cost between the United States and other high-income countries.”

Cost Concerns, Including Health Care Costs, Top List of Worries

Percent who say they are worried about each of the following:

- Your income not keeping up with prices: Very worried 32%, Somewhat worried 29%
- Not being able to afford health care services: Very worried 25%, Somewhat worried 24%
- Losing your health insurance: Very worried 22%, Somewhat worried 16%
- Not being able to afford prescription drugs: Very worried 21%, Somewhat worried 23%
- Not being able to pay your rent or mortgage: Very worried 19%, Somewhat worried 15%
- Being the victim of gun violence: Very worried 18%, Somewhat worried 18%
- Being the victim of a terrorist attack: Very worried 17%, Somewhat worried 25%
- Losing your job*: Very worried 12%, Somewhat worried 13%

NOTE: “Losing your health insurance” was asked among those who were insured and “Losing your job” was asked among those who were employed. Question wording abbreviated. See topline for full question wording.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted December 13-19, 2016)
A family of four with a $100,000 income and employer coverage spends $12,500 per year (13% of their income) on health.

By Cynthia Cox

Direct Spending on Healthcare

A family of four with a $100,000 income and employer coverage spends $12,500 per year (13% of their income) on health. This includes $2,900 (3% of their income) in out-of-pocket health spending, $4,550 (5% of their income) in health insurance premiums, and approximately $6,050 (5% of their income) in state and federal taxes that fund health programs.

Additional Contributions by Employers

Workers are not taxed on the contributions their employers make toward health insurance premiums. Economists generally believe that employer contributions offset wages. In this scenario, we estimate that the employer is contributing an additional $13,050 to health insurance premiums, as well as $1,450 in Medicare payroll taxes. These amounts are not shown in the chart above, but economists generally believe that they offset wages.

When combined, this family’s spending on health care and the money spent by their employer on their behalf totals $27,000.
Higher administrative costs

- Administrative costs account for 8% of total U.S. health care spending and include a myriad of services from billing and insurance related activities to quality improvement programs.

- Complex medical billing and documentation requirements, quality reporting requirements for value-based payment initiatives, and other administrative tasks have made the United States health care system one of the most, administratively burdensome in the world, contributing to less time treating patients, billions in unnecessary administrative costs, and unprecedented levels of physician burnout and dissatisfaction.
80% of billing-related costs are a result of our multi-payer US health system


Percent of total revenue spent on billing-related costs

- Emergency department visits: 25%
- Primary care visits: 15%
- Surgical procedures: 3%

Uneven and inequitable outcomes

- While the health care system of the United States excels in some areas, such as decent care process outcomes, it consistently ranks last or near-last in access, administrative efficiency, equity, and health care outcomes.
- Life expectancy has been decreasing in the United States since 2014, and ranks last when compared to other high income developed countries at 78.9 years.
- Environmental health hazards, poor nutrition, tobacco use, prescription drug abuse, firearm violence, and maternal mortality – are reversing progress made over generations of increasing life expectancy.
Four papers:

- Call to action on what ACP envisions a better health care system for all would look like and a call for others to join us.
- Three companion policy papers on coverage and cost, payment and delivery system reforms, and improving public health and reducing barriers to care
The 3 companion papers will propose specific policies to:

- Achieve universal coverage at a cost the country and the patient can afford—including lowering costs at the system-level (slow rate of increase, reduce per capita spending), and making care more affordable at the patient-physician level (affordability).
- Address excessive spending on health care administration and associated burdens on physicians and patients.
- Reform payment and delivery system with an emphasis on supporting primary care and specifically the value of care provided by internal medicines specialists.
- Propose specific policies to improve public health, address social determinants, and end disparities and discrimination based on personal characteristics.
Hamilton:
And I wanted what I got
When you got skin in the game, you
stay in the game
But you don't get a win unless you play
in the game
Oh, you get love for it, you get hate for it
You get nothing if you
Wait for it, wait for it, wait
God help and forgive me
I wanna build
Something that's gonna
Outlive me
“I wanna build something that’s gonna outlive me.”

By standing for something, and knowing how the sausage is made, ACP is in the room where it happens.

Our New Vision initiative gives us a chance to help build a better health care system for generations to come.
#SoMe Engagement: Tips, Tricks and Trolls

Amy S. Oxentenko, MD, FACP, FACG, AGAF
Program Director and Associate Chair, Dept. of IM
Professor of Medicine
Mayo Clinic

@AmyOxentenkoMD
Outline

• Describe the benefit that #SoMe may have for your career and branding

• Detail the ways that #SoMe can keep you up-to-date in medicine

• Outline the pitfalls and fears of using #SoMe and how to mitigate them
Show of Hands

- Who uses what?
- Novice, intermediate, expert?
Who Uses #SoMe?

Among all American adults, % who use social networking sites, by age

PEW Research Center
Step 1: Define Your Goal
Getting Started on #Some: What is Your Goal?

Social?

Career?

Focus?
Step 2: Pick your Platform
Common #SoMe Platforms

Facebook

Instagram

Twitter
Facebook and YouTube most popular... but plateaued.

Rest on the rise!
Social platforms like Snapchat and Instagram are especially popular among those ages 18 to 24

% of U.S. adults in each age group who say they use ...

<table>
<thead>
<tr>
<th>Platform</th>
<th>50+</th>
<th>30-49</th>
<th>25-29</th>
<th>18-24</th>
</tr>
</thead>
<tbody>
<tr>
<td>YouTube</td>
<td>56%</td>
<td></td>
<td></td>
<td>94%</td>
</tr>
<tr>
<td>Facebook</td>
<td>55</td>
<td></td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Snapchat</td>
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<td>Instagram</td>
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</tr>
<tr>
<td>Twitter</td>
<td>14</td>
<td></td>
<td>45</td>
<td></td>
</tr>
</tbody>
</table>

Source: Survey conducted Jan. 3-10, 2018. “Social Media Use in 2018”
PEW RESEARCH CENTER
On the day of the 2016 Presidential Election Twitter proved to be largest source of breaking news...

...40 million tweets that day!!!
Step 3: Consider Your Audience
Start to Follow Those That Are Aligned with Your Mission
Step 4: The Basics of Profiles and Branding
Anatomy of a Tweet
Amy Oxentenko M.D. @AmyOxentenkoMD · 2d
Before you submit your valuable science to a journal, consider if the journal is treating fairly!

#NeedHerScience
tinyurl.com/yy7zzurw

@PROWDWomen @AMWADoctors @AMWA_students @500WIM @WomenInMedicine

Julie Silver, MD @JulieSilverMD · 3d
Journals depend on the privilege of publishing the best scientific work & they need women’s research to be successful.

Before submitting & allies might ask themselves Is there evidence this journal is focused on treating women fairly?
#NeedHerScience
tinyurl.com/yy7zzurw
Twitter Profile

- Choose handle (@)
  - First and last name
  - Degree (MD, PhD)
  - If DO, MBBS, use Dr
- Enter full name/degree
- Description of interests
- Picture (of you!)
- Use background space
Who is this?
Would you remember this???
Susan Pitt, MD MPHS
@susieQP8  Follows you

Surgeon | NIH-funded Researcher | Speaker | #SoMe 4 Medicine | #Change | #Wellness | #PROWD | Started #NYerORCoverChallenge | Views my own | RT not endorsement

📍 Madison, WI

🔗 surgery.wisc.edu/profile/susan-

Joined April 2013

1,288 Following 6,861 Followers

Followed by Steven Bo...
BOLD branding!

Michael S. Sinha MD, JD, MPH
@DrSinhaEsq  Follows you

IP/pharma law & policy
@PORTAL_Research
@HarvardMIT_CRS @NUSLHealth
#HeForShe #WomenInMedicine
#NoMoreManels • Tweets ≠ medical/legal advice • RT ≠ endorsement

📍 Boston, MA
🔗 scholar.harvard.edu/sinha

Joined May 2012

4,591 Following 3,879 Followers
No one will remember you by a number
No one will tag/follow you if they cannot be sure it is you!

See the issue???
Unused real estate

Cannot see who they are

Handles you won’t remember
Step 5: The Basics of a Tweet
Handle versus Hashtag

**Handle**: identify user accounts

- @ACPInternists
- @500WomenInMedicine
- @PROWDDWomen
- @JulieSilverMD

**Hashtag**: identify subject matter

- #BeEthical
- #SheLeadsHealthcare
- #NeedHerScience
- #WomenInMedicine
- #TipsForNewDocs
- #MayoGRIT
- #MeetingNameYear
Public Relations Dept. of the American College of Physicians (ACP), the largest medical specialty organization and second-largest physician group in the U.S.

2,890 Following  30.9K Followers

Followed by Eli Voth, M.D., Gretchen Colbenson, MD, R Klein MD MEHP, and 145 others

FDA Update: Hepatitis C medicines have led to liver decompensation in 63 cases ow.ly/RCgm50nPWbC. #HCV
Why? Journals must address gender bias.

- Take the pledge (<1 min & anonymous) tinyurl.com/y64lqoQ
- Share the infographic tinyurl.com/y49xhj2z
- Learn more tinyurl.com/y2uh2tot

#HeForShe #BeEthical WomenInMedicine @AMWADoc

---

Amy Oxentenko M.D. @AmyOxentenkoMD · 9/21/19

It is great to get FIRED UP by Dr. Sharon Mulvagh! @HeartDocSharon

F = Find your passion
I = Identity your vision
R = Reach out/recruit members
E = Engage support
D = Develop structured
U = Understand obstacles
P = Prepare for challenges

#MayoGRIT

---

Take Home Points: Building Professional Networks

FIRED UP!

- Find your passion
- Identify your vision and mission
- Reach out and recruit members
- Engage system support
- Develop organizational structure, timelines, deliverables

- Understand obstacles
- Prepare for challenges
#DiversityAndInclusion

- #MedTwitter
- #MedStudentTwitter
- #WomenInMedicine
- #BlackMenInMedicine
- #WomenInSTEM
- #WomenToWatch
- #LatinasInMedicine
- #DiversityInMedicine
- #WhatDoctorsLookLike
Tips to Make Your Tweets Better

• Avoid all text (280 limit)
  • Add picture, gif, graphs
  • Use bullets, symbols
• Use #hashtags for concepts
• Tag others (@)
• TinyURL or bit.ly for articles
• Preview carefully (no edit)
• Ability to draft
Taxonomy of Tweeting

Create Tweet

Retweet w/ Comment

Retweet

Like
Step 6: The Power of #SoMe
How to Disseminate Your Expertise

• Tweet points from key studies
  • Add link
  • Yours, others
• Tweet from meetings
• Be active in chats
• Follow experts in field
  • Comment on work
Altmetric Attention Scores

STATISTICS FROM ALTMETRIC.COM

- Picked up by 63 news outlets
- Blogged by 11
- Tweeted by 7096
- On 5 Facebook pages
- Referenced in 2 Wikipedia pages
- Mentioned in 13 Google+ posts
- Reddited by 6
- 114 readers on Mendeley

See more details
How can you use social media to disseminate healthcare research? @AmyOxentenkoMD shares a case study with impressive results.

[Graph showing Altmetric Attention Score over time after chat announcement.

- Metrics: +113 points
- Promotion: +208 points
- Compensation: +120 points
- Pregnancy: +114 points
- Awards: +110 points
- Evaluation: +143 points
- Me Too: +91 points
- Judged: +113 points]
What happened to the dissemination of this important study when we implemented a social media strategy?

Impact of Pregnancy and Gender on Internal Medicine Resident Evaluations
Krause et al. (Oxentenko senior author)

1 year after strategy implemented

1 week after strategy implemented

1 year after publication of study

How did we do it?
Use of a Coordinated Social Media Strategy to Improve Dissemination of Research and Collect Solution Related to Workforce Gender Equity
Cawcutt et al. (Silver senior author)
Participate in a #Chat

- #JHMChat (Mon 9 pm EST)
- #PWChat (Tues 3 pm EST)
- #WomenInMedicineChat (Sun 9pm EST)
- #MedEdChat (Thurs 9 pm EST)

- And so many more!!!
Don’t miss out on this incredible conference that I get to co-direct with Dr. Jill Gaidos!

“Bridging the Leadership Gap in Gastroenterology”

See you in San Diego in January! 🌞🌴⛵️

gi.org/education/acgs...

#WomenInGI #WomenInMedicine #DiversityInGI @AmCollegeGastro

2020
ACG’S FUNCTIONAL GI DISORDERS SCHOOL &
BRIDGING THE LEADERSHIP GAP IN GASTROENTEROLOGY COURSE
A project of the Women in GI Committee
January 10-12, 2020 | MARRIOTT MARQUIS HOTEL | SAN DIEGO, CALIFORNIA
Register online: meetings.gi.org
Step 7: The Keys to Staying Up-to-Date
Choosing Wisely: Things We Do for No Reason

@TWDFNR
Great podcast series

Highlight key IM topics

@thecurbsiders

Dominate #Perioperative Medication Management: #Anticoagulation, antiplatelets, DMARDs, #diabetes meds and more! W/@aoglasser @OHSUSOM @Kashlakhospital
link.chtbl.com/curbsiders- mailchi.mp/ae861d9a9653/d...
@DoctorWatto @PaulNWilliamz @ACPinternists #medtwitter
#FOAMed #meded
@COREIMpodcast

Pearls
Mind the Gap
Hoofbeats
ACG
@AmCollegeGastro Follows you
The American College of Gastroenterology has a membership of more than 14,000 individuals dedicated to advancing gastroenterology and improving patient care.
Bethesda, MD gi.org
Joined August 2010
1,646 Following 16.5K Followers

AGA
@AmerGastroAssn Follows you
The American Gastroenterological Association is dedicated to advancing the science and practice of gastroenterology. Follow @AGA_Gastro, @AGA_CGH, @AGA_CMGH
Bethesda, MD gastro.org
Joined June 2009
3,218 Following 22.8K Followers

ASGE GI Endoscopy
@ASGEEndoscopy
The American Society for Gastrointestinal Endoscopy is a professional membership organization dedicated to promoting excellence and innovation in endoscopy.
Downers Grove, IL asge.org
Joined April 2010
435 Following 11.8K Followers

AASLD
@AASLDtweets
AASLD is the leading organization of scientists and health care professionals committed to preventing and curing liver disease.
aasl.org Joined August 2009
3,159 Following 14.9K Followers
Followed by Jordan Karlitz MD, CORE IM, Doug Sim...
Population-based cohort study of >450k individuals from 10 countries in Europe showed consumption of sugar-sweetened & artificially sweetened soft drinks was associated with a higher risk of all-cause mortality.

@JAMANetwork
@JAMA_current

Test for bile acid diarrhea in your patients with chronic functional diarrhea.

@PriyaVijayMD @ANMSociety
#ANMS19 @MayoClinicGIHep

What factors do applicants weigh most when picking residency programs?

@AmerMedicalAssn

Burning, Chest Pain, Nausea, and Vomiting: Dr. John Clarke discusses how to formulate diagnostic and management algorithms for functional upper GI symptoms.

bit.ly/30uHNpF

#UpperGI #gastroenterology
How to Use #SoMe for Your Program or Practice?

Volunteerism

Scholarly

Travel

Match
Just a shout out to my #AssociateProgramDirector’s and #ChiefResidents @MayoMN_IMRES...we are a crazy bunch, but these folks are like family! I cannot thank them enough for all they do. Not all are photoed here, but those missing were not injured in the filming of this tweet...
Step 8: Avoid #SoMe Pitfalls
Personalities on #SoMe

- Self-proclaimed expert
- Not so humble bragger
- Research disseminator
- Life advice coaches
- Critics
- Trolls
#SoMe Pitfalls

Trolls!

Controversy

HIPAA

OFFICIAL POLICY
Fears People Cite

• Not able to edit (Twitter)

• Saying something that will get you in trouble

• Time suck
My 18 Months with #Twitter

- Recruitment impact
- Collaboration on 3-4 manuscripts
- >8 VP talks
- Blogs, podcasts, opinion pieces
- 50 → ~5000 followers
- Finalist “Disruptive Influencer” for women in GI
Summary on #SoMe Use

• It is never too late to begin #SoMe use
• Go into it with a focus and #branding
• Can also use as a source of #unofficialCME
• Avoid #controversy and #HIPAA
• Don’t engage with the #trolls
• You control your #SoMe use; don’t let it control you
Thank you!!!

Email: oxentenko.amy@mayo.edu
Twitter: @AmyOxentenkoMD
Tips to Make Your Next Presentation Go Better Than Your Last

Scott Litin, MD  MACP
Professor of Medicine
Mayo Clinic College of Medicine
litin.scott@mayo.edu
Tips to Make Your Next Presentation Go Better Than Your Last

Scott Litin, MD  MACP
Professor of Medicine
Mayo Clinic College of Medicine

litin.scott@mayo.edu
Why is this Skill Crucial for us?
Time to Teach Workshop

Mayo Program of Professionalism

The Art and Science of Speaking – What They Didn’t Teach you in Medical School

Instructors:

Scott C. Litin, M.D.
Time to Teach Workshop

LA, New York, Houston, Boston, Washington DC, Tampa
Jacksonville, New Orleans, Philadelphia, Atlantic City,
Atlanta, Phoenix, Seattle, Portland, Huntsville,
Baltimore, St Paul, Fargo, Sioux Falls, Minneapolis,
Iowa City, Allentown, Detroit, Indianapolis, Orlando, SF,
San Diego, Ireland, Scotland, Switzerland, Italy, China

Scott C. Litin, M.D.
How I Became Interested In Presentation Skills
How I Became Interested In Presentation Skills
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How I Became Interested In Presentation Skills
Session Overview

• Didactic Presentation
  Presenting yourself
  Tips for successful presentations

• Videotaping Assignment
  Group critique
Presentation Goals

• Get your buy-in
• Teach tips to improve your future presentations
• Motivate you to work on improving these skills
• Demonstrate these skills
• Improve your constructive critiques of colleagues
Presentation Skills
Body Language
Presentation Skills
Body Language
Presenting Yourself and Your Credentials

• Always include your e-mail address:

litin.scott@mayo.edu

• Write your own intro

• Name Badge
PowerPoint

Are you addicted to PowerPoint?

• Bullet points
• Charts
• Graphs
PowerPoint Survey
Most Annoying

• Speaker reading slides 60%
• Text too small 51%
• Having the slides typed out in completely full sentences. 48%
• Hard to see colors 37%
• Moving /flying text 24%
• Overly complex charts 22%
PowerPoint Basics
Headings 36-40 Point Type

• Text point type
  
  I suggest 32….but at a minimum 24
  
  this is 28 and this is 24

• San serif fonts best (Arial)

• Serif fonts (Times New Roman) harder to read from the back of room

• Avoid the laser moth
Avoid Slide-uments

- Accreditation and Regulatory Compliance Ensure Safe Patient Care
- Accreditation/Regulatory Activities: ARZ | FLA | MHS | RST
- The Joint Commission, Centers for Medicare and Medicaid Services and other regulatory agencies provide health care organizations with a framework to assess and improve the systems that impact the quality and safety of patient care. Mayo Clinic adopts evidence-based standards and reports core measures in an effort to reduce mortalities, complications from care, patient length of stay and adverse events. This network of quality standards provides the underpinnings for Mayo's reputation as a leader in health care.
- Every Mayo Clinic employee has the opportunity to impact the safety and quality of care we provide for our patients and our compliance with regulatory agencies by:
  - Using standards to achieve and maintain excellent operational systems
UPPERCASE vs Mixed Case

• IT WILL TAKE THE AUDIENCE LONGER TO READ SLIDES THAT ARE ALL UPPERCASE CASE

• Instead use only uppercase to EMPHASIZE specific text

• Better still use **bold** or *color* instead
Presentation Tips

Meet the needs of the audience
Presentation Tips

Meet the needs of the audience

• W I I FM
Presentation Tips

Meet the needs of the audience

• W I I FM

3 Questions
Presentation Tips

Example:

The result when not thinking about your audience
Presentation Tips

Organize the presentation

• opening statement
• limited number of points
• strong closing
Time Management

Use less than allotted time
Presentation Tips

Concentrate on delivery

• face the audience
• avoid the dreaded monotone
• slow down
Presentation Tips

Concentrate on delivery

- face the audience
- avoid the dreaded monotone
- slow down
- use pauses
Presentation Tips

Make it a performance
- smile
- enthusiasm
- hand gestures
- tell a story
- pictures
Presentation Tips

Take the edge off of nervousness
  • most anxiety doesn’t show
  • comfortable posture
  • voice
  • eye contact
Presentation Tips
Presentation Tips

Use appropriate humor

Self-deprecating
"My doctor told me to avoid any unnecessary stress, so I didn't open his bill."
Video Clips
With Introduction
Video Clips
With Introduction
I Almost Forgot
Keyboard Secret

• The “B” Key
In Summary
If You Remember Only 3 things....

• Organize the presentation
In Summary
If You Remember  Only 3 things…..

• Organize the presentation

• Make it a performance

• Your presentation skills, are as important as your message
Questions or Observations

litin.scott@mayo.edu