Subject: Tweet by Westby Fisher, MD on Twitter

April 10, 2015
Simone Musco, MD, FACC (simone.musco@providence.org)

I don't know how many of you know/follow Wes Fisher. Along with others he has been very critical of ABIM and very verbal about it.
Please follow the link to a letter written by the ABMS to congress to lobby for MOC to be included in the upcoming legislation to repeal the SGR. I find appalling that on the one hand the ABIM writes its (handsomely paying) members a letter of apology stating that it "got it wrong", while it lobbies congress to make MOC the vehicle of choice for quality purposes and financial incentives.

I know that some of the members of the BOG have participated in question writing and other activities by the ABIM, and I do know that diplomacy take a lot of time. I am feeling more pressure from the member of my chapter and my partners to push the issue of ACC making its own MOC and board certification.

Simone

Immediate past Governor -MT

From: Simone Musco [mailto:smusco@yahoo.com]
Sent: Thursday, April 09, 2015 11:18 PM
To: Musco, Dr. Simone
Subject: Tweet by Westby Fisher, MD on Twitter

Westby Fisher, MD (@doctorwes)

4/9/15, 21:21
RT @AAPSonline: "ABMS MOC® ..shud b foundational to any future system" ABMS lobbied @HouseCommerce 2 b in SGR reform abms.org/media/1327/201…

April 10, 2015
Jay Alexander, MD, FACC (drjay100@aol.com)

Not only have I read Wes Fisher's blog but spoke to him this morning as he is one of my partners. We have a big problem in that there is a faction in the house of medicine willing to scuttle the SGR bill in order to further go after the ABIM.. A very disturbing prospect to say the least. My best advise is we need to be clear that fulfilling MOC is not a requirement in SGR bill otherwise there will be a splintering of the cardiology community as we have not seen before.. Here is where ACC can prove its relevance..

April 10, 2015
Norman Lepor, MD, FACC (norman.lepor@gmail.com)

Negotiating with the ABIM seems to be a similar process as the negotiations with a certain government in the Middle East over nuclear weapons. They clearly do not have anything close to our interests at heart. It is all about the preservation of the ABIM and that will always be the case. You cannot change Zebra stripes, meaning it is the nature of the beast.

April 10, 2015
Michael Mansour, MD, FACC (mmansour@cvdocs.com)

Excellent analogy Norman. Vivid, succinct, accurate.
Michael

April 10, 2015
Smadar Kort, MD, FACC (smadar.kort@stonybrookmedicine.com)

Unfortunately this is precisely the case. If negotiation doesn't work, maybe it's time to seriously consider a different solution for the house of medicine that will promote high quality care in a transparent fashion.

April 10, 2015
Simone Musco, MD, FACC (simone.musco@providence.org)

Smadar,

This is exactly my point. I have not seen nor heard anything concrete in the last year regarding negotiations. I hear that town hall meetings and private retreats have been held, but without any resolution of the MOC issue. The questions to be asked are:

1) Can the ACC offer its own initial board exam and MOC program
2) Does the ACC desire to split from ABMS/ABIM

I think all our members will find real value in the ACC if the answer to both questions is yes.
S

April 10, 2015
Bruce Lindsay, MD, FACC (lindsab@ccf.org)

I share the concern that the ABIM went down the wrong track with MOC, failed to listen to our complaints, and suffers a loss of credibility. They are heavily invested in the MOC process and probably will make substantive changes only if their survival is at stake.

As we consider whether the ACC should take on the responsibility of certification or recertification, the history behind this process is important to consider. As I understand it, one historical reason cardiologists supported the principle of secure examinations in the first place was that many internists with a passing interest in cardiology claimed to be cardiologists without undergoing rigorous training. The ABIM examination served to distinguish experts in the field. Subspecialty examinations have evolved much the same way. Development of a secure exam is very laborious and requires statistical analysis of every

question to determine whether it discriminates high from low scoring candidates and is fair. I have served on the Clinical Cardiac Electrophysiology Exam committee for several years and currently chair it. The philosophy of the committee has been that the exam should be exacting yet fair. If everyone passes, there is no point in having an exam. The results of each exam are reviewed by the Chair and questions that do not perform well can be thrown out or at a minimum will require revision. I have been impressed with the exacting standards of the people I have worked with at the ABIM and the efforts the committee makes to write a fair exam. I do not enjoy taking them any more than you do, but I think the initial certifying exam is needed. I do not see the need for a secure exam for recertification and would rather use attendance at educational courses such as the ACC , AHA, or HRS meetings as sufficient in my field. Open book modules are reasonable. In my opinion, the PIM is a complete waste of time.

If the ABIM does not make major changes in the approach to MOC, then the ACC should take on this responsibility, but it comes at great cost. The infrastructure needed to do this correctly is very substantial. It will require additional commitment from a wide spectrum of volunteers, subspecialty examinations with relatively few candidates are not profitable, and the legal fees are not trivial. Despite all the precautions the ACC would take to be fair, some members would be disgruntled with the net product. The College has always worked to support its members, but once it is in the position of testing them the relationship is fundamentally different and somewhat adversarial. Whether the College wants to be in this position is an important consideration. We have arrived at this discussion because the ABIM has lost our support, but there is a risk that the College could lose members who did not like the decisions it made.

Another reason professional organizations have supported the ABIM is that there is a potential conflict of interest for a professional organization to test its members. HRS has supported the International Board of Heart Rhythm Examiners (IBHRE), which used to be called NASPE exam. It is financially viable, requires a separate governance with substantial barriers, and serves to certify those with international backgrounds who may not be eligible for the ABIM exam. The process works and might serve as a model if the ACC is forced to take on certification or recertification on behalf of the members.

In short, the ACC could replace the ABIM if necessary, but do not underestimate the effort and expenses it would take to do this successfully. My recommendation is for the College to study what it would take to do this right in case the ABIM leadership continues down the wrong path.

April 10, 2015
Norman Lepor, MD, FACC (norman.lepor@gmail.com)

Great points Lindsay et al
We cannot wait till negotiations fail with ABIM to contemplate an alternative. We will not have time to develop any kind of infrastructure as an alternative. This needs to happen now. In my humble opinion, I think it is time for an official BOG sub committee to be formed with the charge to explore options to ABIM. This will have two effects in my opinion:
1. It will allow for a well thought out process to occur to look at viable options, interact with other medical organizations and societies and report to the BOG on them lets say in a 4-6 month timeline.
2. It will put ABIM on notice that we are moving forward with evaluating options
As long as it is all talk and no action, the needle will not be moved.

April 10, 2015
Anuj Gupta, MD, FACC (anujslink@gmail.com)

And to add to Dr. Musco's points-- can we do it for less cost?

April 10, 2015
Kim Williams, MD, FACC (kim_a_williams@rush.edu)

Great thoughts, Norm. The Executive Committee has had these deliberations. Last week, we set the following processes in motion:

ACC BoT Task Force for ABIM Liaison
Chair: Pat O'Gara
Vice-chair: Rick Chazal
Charge: To liaise with the ABIM and ABIM Cardiovascular Board for the purposes of (1) providing advice and direction for modification of Maintenance of Certification (MoC) processes and (2) providing input for the topics to be included in certification and recertification procedures.

This TF is comprised of the following BoT members and ACC subject matter experts:
Minnow Walsh
Bob Shor
Carole Warnes
Bob Hendel
Paul Casale
Dick Kovacs
Deepak Bhatt
Eric Williams
Jeff Kuvin
Roxana Mehran
Jodie Hurwitz
Eric Bates

ACC BoT Task Force on a New Cardiology Board
Chair: Rick Chazal
Vice-chair Minnow Walsh

Charge: To advise the ACC BoT on options and recommendations with regard to developing or participating in a cardiovascular board outside of ABIM
This TF is composed only of current ACC BoT members:
Bob Shor
Carole Warnes
Bob Hendel
Paul Casale
Dick Kovacs
Deepak Bhatt
Pat O'Gara

We will deliberate in all due haste, yet all due diligence.

Best, Kim

April 10, 2015
Simone Musco, MD, FACC (simone.musco@providence.org)

Kim,

I don't mean to be disrespectful to the ACC leadership and to a group of EXTREMELY talented, smart and successful cardiologists that make up the task force. I think our members need to know that there are no potential conflict of interest. How many members of the task force have worked with the ABIM in the past?

Again, I want to stress that I do not mean to be insulting to anyone and I am by no means insinuating that anyone's decision would be influenced by past relationship with the ABIM. This is a very complicated and delicate issue and we owe it to our members to be very diligent.

Thank you
Simone

April 10, 2015
Kim Williams, MD, FACC (kim_a_williams@rush.edu)

Hi Simone,

Not disrespectful at all. In my time of leadership in the College, we have had, and continue to have, issues with both the positives and the negatives of cross-fertilization with other organizations.

We have a propensity toward selecting talent volunteers for leadership in ACC based on proven capability and leadership experience with other organizations, including ABIM. Some of this interdigitation provides perspective and knowledge that would not be otherwise available to the College. Personally, I spent 6 years with ABIM CV (evident on some of your certificates between 2006 and 2012), which as a current ACC leader gives me insight about, rather than bias toward or against, ABIM.

We have, therefore, carefully selected these two taskforces. They will represent the College well, not setting out to support or undermine ABIM, but to make recommendations that will be best for our membership in the areas of a) shepherding the ABIM processes and b) considering fully any alternatives to ABIM.

Now, that said, I believe that the answer is ONE person, but they were not selected solely based on ABIM experience. While this may be seen by some as not enough ABIM history, these are highly knowledgeable and fair ACC leaders whom I am confident will deliberate quickly and thoroughly.

Best regards,
Kim W

April 10, 2015
Smadar Kort, MD, FACC (smadar.kort@stonybrookmedicine.edu)

Thank you Kim for sharing the information with us. The composition of both TF is spectacular, and it is reassuring to know that these talented individuals are charged with looking at all the issues we all identified as critically important to our members.

Would be extremely appreciated if both groups can update us as they make progress.
Thanks
Smadar

April 10, 2015
Norman Lepor, MD, FACC (norman.lepor@gmail.com)

This is a pretty delicate issue where even the potential appearance of a conflict would be important to avoid. My preference all things being equal is to populate these special committees with folks who are not also on important committees with ABIM

April 10, 2015
Jay Alexander, MD, FACC (drjay100@aol.com

I don't agree.. I think the committee make up is fine .. It's a group with experience and expertise.. That being said we need to understand that the future relevance of the ACC rests on them.. This issue may be the single most important issue we face in this decade..

April 10, 2015
Edward Toggart, MD, FACC (etogg1@mac.com)

Should we consider a hybrid approach?

As already pointed out the infrastructure and support needed to develop, pretest, adjudicate and vet each individual question, administer a secure test, score the test and analyze the results are enormous.

My impression is that the initial certification process not the major source of consternation. MOC seems to be the central area of concern.

Perhaps we should focus our efforts on reforming the re-certification process, as a more practical goal and not over reach into initial certification.

April 10, 2015
Matthew Phillips, Md, FACC (mattphillips1@me.com)

All

I would echo that,. Attorneys take the bar once

So everyone takes every exam once. In every speciality

1. In office you participate in Pinnacle
2. Imaging you are in accredited labs - doing QA and conferences
3. Cath- you do NCDR
4. EP - its coming
5. You do 25 CV specific (no cruises)-CME/year

You are not current and probably now licensed in your state

I think this is more than reasonable to protect the public when you look at the time commitment knowing that every doc will be in pinnacle and at least one more program plus CME

Matt

April 10, 2015
Lawrence Rudski, MD, CM, FACC (Lawrence.rudski@gmail.com)

A Canadian Perspective
We have a tough initial exam including Osce stations
Then we have 5 year cycles whereby we have to submit evidence of a total of 400 hours (average of 80 hours per year) of CME in 5 years.
This is composed of accredited rounds/lectures/conferences, independent learning (max 20 hours per year), morbidity and mortality reviews, participation in guidelines or program development etc.
There is a great website to enter this, and a very simple enter as you go App.
An audit is done randomly of a few % every year, as well as plans to help those who are not meeting their goals.
This is done by the Royal College via a program called MOCOMP.
You should check it out.
Each province sets its own requirements for licensure with a requirement to submit evidence of a CME program. All accept MOCOMP.
My province of Quebec allows you to define your own program, setting goals based on your self-perceived deficiencies. Also audited randomly.
When we renew our licenses each year, we have to attest that we participate in either of these programs.
This method encourages life long learning but also mandates it by tying it to licensure.
People are very supportive of this program since it allows flexibility, adds no cost for administration (the Canadian way - though membership to the Royal College is required to use the MOCOMP program, and is easy to use.

Lawrence
Gov -Quebec

April 10, 2015
Edward Toggart, MD, FACC (etogg1@mac.com)

We have a fellowship program at our hospital that started about 5 years ago. Our hospital has a reasonable support system for clinical research. We are a community tertiary facility with 4 outlying hospitals in our system. We have participated in the CORAL trial, and are participating in CIRT.

I am developing a research project with one of our fellows and require $$$. Probably about 35K. Does ACC have a mechanism for funding fellow initiated clinical research?

April 10, 2015
Andrew Miller, MD, FACC (amiller@cvapc.com)

Thanks Lawrence! Sounds utopic, professional, and robust. And hypertension guidelines are updated yearly and there are no prior authorizations in Canada!

This is a much more optimistic read than the US MOC conversations and seems to offer a model for the ACC.

It looks like MOCOMP uses Fellowship in the Royal College as a mark of a professional and empowers self education/licensure/policing after a robust initial exam. Can you tell us more about how this program developed, got its mandate, and is administered? Is it government supported and/or government monitored, or run by an independent board? How is the initial board exam developed - independent body or extension of this program? Along those lines, what is one Canadian's perspective on the ABIM and our MOC system?

This sounds really ideal. It seems we have most of the infrastructure for this: FACC, comprehensive CME programs, NCDR portfolio, lifelong learning portfolio, and acc.org professional home. And, it will get us doing things we will need to do in the present - look at our data! This seems to be a great model and important addition to the current conversation. A solution to our current problems should be both at/above the current standard and fit into our current workflow in a way that does not further jeopardize the provider-patient relationship. It will also require a great deal of transparency to restore the trust of our professional members. I'm hopeful with our task force, and perhaps it needs a representative from the North? Perhaps it needs a solution that is transferable across borders?

Let me know if anyone in Montreal is retiring soon. Oh wait, it snows there.

Warmest Regards,
Andy

April 10, 2015
Edward Fry, MD, FACC (fr5@comcast.net)

Lots of great ideas generated (which is the power of the BOG) for the Task Forces to consider and to integrate into an overall BC/MOC strategy. Kim is the "Chuck Daly" of cardiology and has assembled a "Dream Team" to successfully drive the process (way too many sports metaphors!).

As the goals, desired outcomes, mechanisms to create meaningful Life Long Learning, and tools to validate that "certified" clinicians are truly effective are being defined by the Task Forces, they will also need to address the very practical and real impact of the certification process at the hospital and payer credentialing level. This is, and will continue to be, a primary focus for the majority of the membership. It is the "gun to the head" that ABIM has wielded along. If members did not think that their hospital appointments, ability to move jobs, or their ability to be on insurance panels were threatened by not being Board Certified, they would have abandoned ABIM long ago.

Such concerns may be exclusive to the initial Certification event and less meaningful to Maintenance of Certification, but will need to be carefully addressed by the Task Forces. This could be a dual-edged sword when it comes to deciding how ACC is to proceed. Payers, many of whom would love to restrict and regulate providers, could use this opportunity to do just that (remember United Healthcare's decredentialing of cardiologists in NJ, DE, and PA two years ago?). ABIM may well use that fear to

undermine any efforts to challenge their stranglehold on clinicians, at least for the initial Certification. Similarly, health systems may find it difficult to change their historic, staid approach to individual clinician credentialing. These concerns are also where the proposed National Board of Physicians and Surgeons (NBPAS) falls short to be a viable alternative body.

Accordingly, the Task Forces will have their work cut out to address these multiple constituencies effectively to avoid any unexpected consequences if ACC were to take over or were to advise a third party regarding BC/MOC. They may find that, indeed, a hybrid approach serves all best; i.e. leverage the ABIM's infrastructure and relationship to payers and health systems to administer the initial Certifying exam and turn over MOC to ACC or another professional body.

The "Dream Team" was undefeated, by the way.

Ed

April 11, 2015
Lawrence Rudski, MD, CM, FACC (Lawrence.rudski@gmail.com)

I am in the middle of a Montreal-Cupertino-Tel-Aviv (will see some of the ACC leadership in Tel Aviv) trip, so will give a more detailed account when I get back.
The Canadian system is not perfect since there are many similarities between the Royal College and the ABIM, in terms of monopolies for certifying exams and the way that the exams are developed.
I will get more info upon my return

Lawrence

April 13, 2015
Jesse Adams, III, MD, FACC (jadams03@bluegrass.net)

Kim,

I want to join my colleagues on the BOG in welcoming this decision. Certainly an august selection of individuals for both of these very important task forces, and I want to thank each and every one of these members in advance for what I know will be a significant commitment of time to confront an issue that is a great importance to our College.

Is this information able to be shared publicly? We're just finalizing our spring newsletter, and I would love to include this strong imminent action on the part of the ACC as we work to confront the issues raised by the ABIM. However, I certainly would not want to include that if it would be premature.

Thanks very much, Jesse