Subject: MOC and recertification

August 13, 2015
Robert Shor, MD, FACC (rshor@tcg.md)

To ALL:

By now you have probably seen the motions regarding MOC and ABIM from the BOT. I wanted to share my thoughts and add some background information. Needless to say there was a lot of discussion. Below are the motions passed by the BOT and I have added some comments in red that I have already been asked. I have also added some general information regarding the task forces and the effort s undertaken to inform this decision.

- The BOT recommends that the 10 year exam be replaced with a new externally validated process for maintenance of competence and the ACC work with ABIM to develop this. No time line or "drop dead" date for action has been given, rather conveying a sense of urgency for response.
- The BOT decided that the ACC will continue its work toward an alternative Board pending ongoing discussions with ABIM. This is the purvue of TASK Force #2. Task Force #1 will sunset.
- The BOT appoints Patrick T. O'Gara MD,MACC and William J Oetgen MD, MBA, FACC to serve as liaisons for ABIM continued communications. Both have worked closely and well with the ABIM leadership.
- Will work with ABIM to research into best practices for maintenance and demonstration of competence with eventual link to patient outcomes, cost and cost effectiveness. We wish to define what actually makes sense for our members and improves outcomes.
- Recognizing that elements of Part IV and patient experience are federally mandated, these should be integrated into existing ACC hospital and practice programs. Elements are apparently imbedded in MACRA and we are trying to recognize and get credit for the work we all do regularly and integrate this in to our normal workflow.
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Task Force #1

TF #1 Charge

- Facilitate ACC-ABIM communication
- Prioritize MOC issues for ABIM consideration
- Determine whether *meaningful changes to MOC process can be made over a reasonable time frame*

●Defining the needs of the members in the context of public welfare and how we can "co-create" a new standard for MOC.

●A Board would need to be at arms length from ACC and thus working with ABIM existing structure is appealing. Once set up, any new Board would need to be completely separate from the ACC as would their decisions regarding MOC. Our hope is that we will be able to work with ABIM to achieve the goals of our members and in the best interest of patient care.

●Four parts of the Physician Charter on Professionalism are particularly relevant:

●The principle of the primacy of patient welfare

●The commitment to professional competence

- The commitment to improving quality of care
- The commitment to professional responsibilities

Summary of prior

ACC Recommendations and	**ABIM Action**
Eliminate "double Jeopardy	Eliminated
Correct cert status for new diplomates	Corrected w/refund if requested
Harmonize MOC-CME	In progress with ACCCME
Reconfigure Part IV	As above
Reduce fees	Fees frozen for 2 years

TASK Force #2

- Reviewed discussions with:
- ABIM
- Alternative Boards: Neurosurgery and Neurology
- Input from Key Stake Holders
- "Break away" ABMS Board
- Independent Boards such as Nuc, echo
- NBPAS-Dr. Teirstein
- Patient Perspective
- Payers
- Cost
- Certificate of Continuing cardiovascular Development Program(C3PD)

This was an extensive look at options performed with alacrity as we tried to understand the landscape to provide information to the BOT to make the best decisions for our members and patients. I would add that I was impressed with the efforts and time spent by the Task Force members researching, calling and gathering the information.

Elements TF #2 felt should be included

- (Current certification process acceptable)
- Expansion of MOC part II to include elements from LifeLong Learning Clinical Competency Statement (to be completed in August 2015)
- Elimination of MOC III/Ten year test, allowing instead, credit for ongoing prescribed education/confirmation of successful completion

- Further exploration (during 2 year ABIM grace period) of options for MOC IV, patient safety and patient voice: TF feels that part IV and patient voice should be integrated into existing ACC, hospital and practice programs in such a way that it is not burdensome to physicians.

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I hope this information is helpful and I am cautiously optimistic as we push for more of the needed reform.

August 14, 2015
Matthew Phillips, MD, FACC (mattphillips1@me.com)

All

Having attended the BOT I would like to echo Bob and applaud him and the task forces for their work

The meeting was excellent with a robust dialogue to say the least.

I think it is fair to say (at least I did anyway), that most of us would agree to programs that were shown to meaningfully improve our skills and patient care

The problem is that we are being overwhelmed by the " doc can you just do this one more thing" request

In addition, there are federal mandates for quality programs. We are trying to be compliant in this regard and should not duplicate and perform redundant activities.

The most valuable health care commodity is provider time. In the quest for improved value; metrics for competence and QA programs it is easy to lose sight of this resource

The benchmark for non direct patient care activity should have the following attributes

1. Does the activity improve patient care ?
2. Does the activity improve physician competence ?
3. Do meaningful and measurable metrics exist to support #1 and # 2?
4. Do the benefits warrant the time expenditure?

Ignoring this reality does make it go away. It is hard to receive good health care if you cannot find a provider

It was eye opening to learn of the rapid exit and the extent of pcp providers now in concierge care.

The two tier system is here.

Population health is a goal. As providers get hammered with more "to do" things in the name of quality, the more that look for other options of practice.

Unintended consequences can be challenging