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*The mission of the American College of
Cardiology and the American College
of Cardiology Foundation is to transform
cardiovascular care and improve heart health.*

November 30, 2015

Richard J. Baron, MD, MACP
Chief Executive Officer
American Board of Internal Medicine
510 Walnut Street, Suite 1700
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Via E-Mail: rbaron@abim.org

Dear Rich:

This letter is in response to the ABIM request that medical specialty societies provide feedback on the recently published "Assessment 2020." As you know, we were the representatives of the American College of Cardiology at the recent Internal Medicine (IM) Summit hosted by the ABIM in Philadelphia on November 2, 2015. We expressed our responses to the "Assessment 2020" during the discussions at the Summit, and we are taking this opportunity to document those responses to the ABIM.

The three recommendations for "Assessment 2020" have been summarized as follows:

- **Change the Maintenance of Certification ten-year examination.**

The Task Force recommends replacing the 10-year MOC exam with more meaningful, less burdensome assessments.

- **Focus assessments on cognitive and technical skills.**

Assessment of cognitive skills assures the public that physicians are staying current with the clinical knowledge relevant to patient care. Assessment of technical skills ensures that physicians can apply that knowledge to adequately perform the technical procedures appropriate to the discipline.

- **Recognize specialization.**

The Task Force recommends exploring the need for certification in specialized areas, without the requirement to maintain underlying certificates, while being transparent about specialization to the public.

The ACC recognizes that, over the past year, the ABIM has clearly moved its position substantially in response to the many inputs that it has received from Diplomates and specialty organizations. These specifics are well known to you and to the IM community. For example, the third recommendation, "recognize specialization," has already been adopted by the Board.

At the IM Summit, representatives from the ACC and from virtually all IM subspecialty societies were clear that the construct of the "more frequent low stakes" re-evaluation (in place of 10 year examination) needs to be carefully vetted. The ACC's MOC Task Forces and Board of Trustees have favored use of melding this re-evaluation into verifiable education (*i.e.* the "SAP" model), moving the paradigm from one of eliminating unworthy diplomats to one of floating all boats, but also recognizing that failure to successfully complete required modules successfully (the "test" part) must have consequences. Ideally, all should eventually pass, but some

(those who do not successfully participate) will not. This is essentially moving from the quality assurance to the quality improvement paradigm.

While the focus on such re-evaluation was on professional societies, it is possible that other organizations (or private companies) might participate. We proposed that ABIM certify the re-evaluation process put forth by these groups (*i.e.* the ACC would present to ABIM the materials that would be sent out for each category of MOC with rationale for use and metrics). Physicians who successfully completed the ACC process would then be recertified by ABIM. This would be a rigorous, standards-based process that would be founded on the ACC's Board-approved Lifelong Learning Core Competencies, which are in the final stages of approval now.

The question of open- vs. closed-book examination becomes moot if the model proposed above is adopted for MOC. It may be a relevant question for the initial certification process, but we (and most specialty societies, we believe) believe that the current initial ABIM certification process works well and does not need substantial revision.

The ongoing issues of patient voice and patient safety requirements can be dealt with if Diplomates can seamlessly receive credit for these activities in which they lead and participate in on behalf of external entities such as hospitals, health care systems, payers, and state medical boards. Reduction of redundancy should be the key operative goal in these areas. We believe that these issues can be handled by attestations with Diplomates' preserving their relevant documentation for periodic audits. This model works well for many state medical boards' requirements for CME documentation.

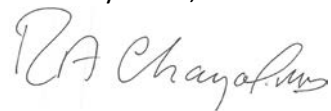
Regarding Part IV, the "Assessment 2020" report makes it clear that the ABIM's expertise is in assessing cognitive and (in the future) technical skills. Practice improvement assessment as part of the MOC process has not been a resounding success. The requirement for practice improvement activities is part of Federal law in the MACRA legislation. Our current understanding is that elective participation in ABIM practice improvement activities will likely fulfill these future payment requirements, but specific participation with ABIM will not be a requirement. This, in our view, is how it should be. ABIM (and by extension) the ACC should offer programs by which our members and the ABIM's Diplomates can fulfill MACRA requirements for meaningful and patient-centered practice improvement activities. We are currently developing programs that utilize our clinical registry data to fulfil this requirement. In our view, the ABIM and the ACC should facilitate practice improvement activities and these activities should count towards fulfilling MoC point requirements, but specific practice-improvement activities should not be required in the context of MoC.

Finally, we want to restate the ACC's interest in collaborating with the ABIM to mount projects that test the outcome of MOC activities on the actual improvement in patient care and outcomes.

We see this as a real opportunity for the ABIM to focus on actually helping facilitate true improvement in physician knowledge and the ability to "keep up," rather than simple testing and certification.

Thank you for seeking our input on these important questions.

Sincerely Yours,



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