4-22-2014

New Payment Models: What's driving them, and what do they mean for what it takes to be a good doctor?

Richard Baron, MD
MACP, President & Chief Executive Officer, American Board of Internal Medicine

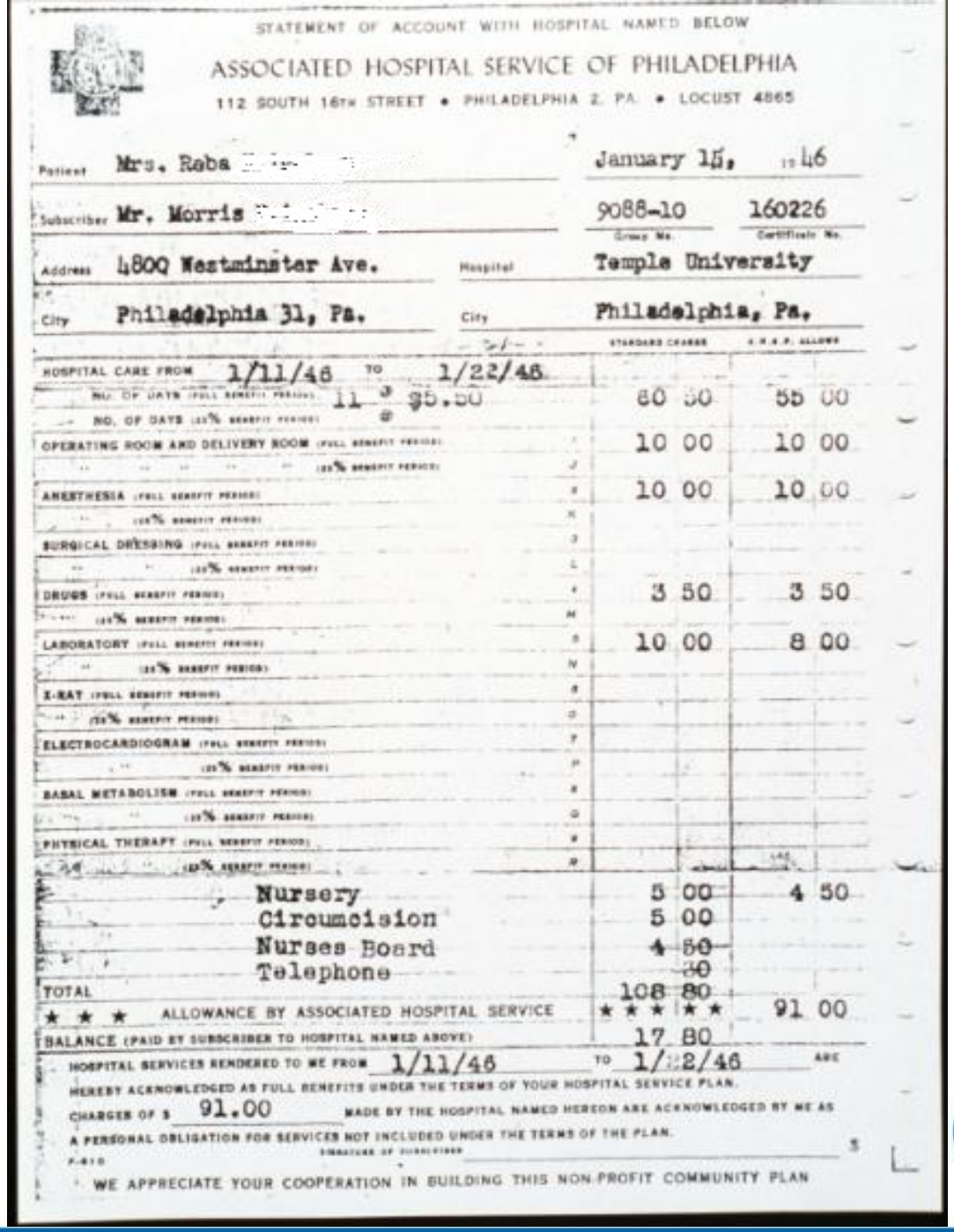
American Board of Internal Medicine

New Payment Models: What's driving them, and what do they mean for what it takes to be a good doctor?

Thomas Jefferson University
Medical Grand Rounds
April 22, 2014

Richard J. Baron, MD, MACP
President and Chief Executive Officer
American Board of Internal Medicine and ABIM Foundation

Bill for the delivery of a healthy baby boy in 1946



STATEMENT OF ACCOUNT WITH HOSPITAL NAMED BELOW

ASSOCIATED HOSPITAL SERVICE OF PHILADELPHIA

112 SOUTH 16TH STREET • PHILADELPHIA 2, PA. • LOCUST 4865

Patient Mrs. Reba [redacted] January 15, 1946

Subscriber Mr. Morris [redacted] 9088-10 (Group No.) 160226 (Certificate No.)

Address 4800 Westminster Ave. Hospital Temple University

City Philadelphia 31, Pa. City Philadelphia, Pa.

	STANDARD CHARGE	A.H.S.P. ALLOWS
HOSPITAL CARE FROM 1/11/46 TO 1/22/46		
NO. OF DAYS (FULL BENEFIT PERIOD) 11 @ $5.00	60 00	55 00
NO. OF DAYS (25% BENEFIT PERIOD)		
OPERATING ROOM AND DELIVERY ROOM (FULL BENEFIT PERIOD)	10 00	10 00
OPERATING ROOM AND DELIVERY ROOM (25% BENEFIT PERIOD)		
ANESTHESIA (FULL BENEFIT PERIOD)	10 00	10 00
ANESTHESIA (25% BENEFIT PERIOD)		
SURGICAL DRESSING (FULL BENEFIT PERIOD)		
SURGICAL DRESSING (25% BENEFIT PERIOD)		
DRUGS (FULL BENEFIT PERIOD)	3 50	3 50
DRUGS (25% BENEFIT PERIOD)		
LABORATORY (FULL BENEFIT PERIOD)	10 00	8 00
LABORATORY (25% BENEFIT PERIOD)		
X-RAY (FULL BENEFIT PERIOD)		
X-RAY (25% BENEFIT PERIOD)		
ELECTROCARDIOGRAM (FULL BENEFIT PERIOD)		
ELECTROCARDIOGRAM (25% BENEFIT PERIOD)		
BASAL METABOLISM (FULL BENEFIT PERIOD)		
BASAL METABOLISM (25% BENEFIT PERIOD)		
PHYSICAL THERAPY (FULL BENEFIT PERIOD)		
PHYSICAL THERAPY (25% BENEFIT PERIOD)		
Nursery	5 00	4 50
Circumcision	5 00	
Nurses Board	4 50	
Telephone	30	
TOTAL	108 80	
★ ★ ★ ALLOWANCE BY ASSOCIATED HOSPITAL SERVICE	★ ★ ★ ★	91 00
BALANCE (PAID BY SUBSCRIBER TO HOSPITAL NAMED ABOVE)	17 80	

HOSPITAL SERVICES RENDERED TO ME FROM 1/11/46 TO 1/22/46 ARE HEREBY ACKNOWLEDGED AS FULL BENEFITS UNDER THE TERMS OF YOUR HOSPITAL SERVICE PLAN.

CHARGES OF $ 91.00 MADE BY THE HOSPITAL NAMED HEREON ARE ACKNOWLEDGED BY ME AS A PERSONAL OBLIGATION FOR SERVICES NOT INCLUDED UNDER THE TERMS OF THE PLAN.

SIGNATURE OF SUBSCRIBER

P-610

WE APPRECIATE YOUR COOPERATION IN BUILDING THIS NON-PROFIT COMMUNITY PLAN

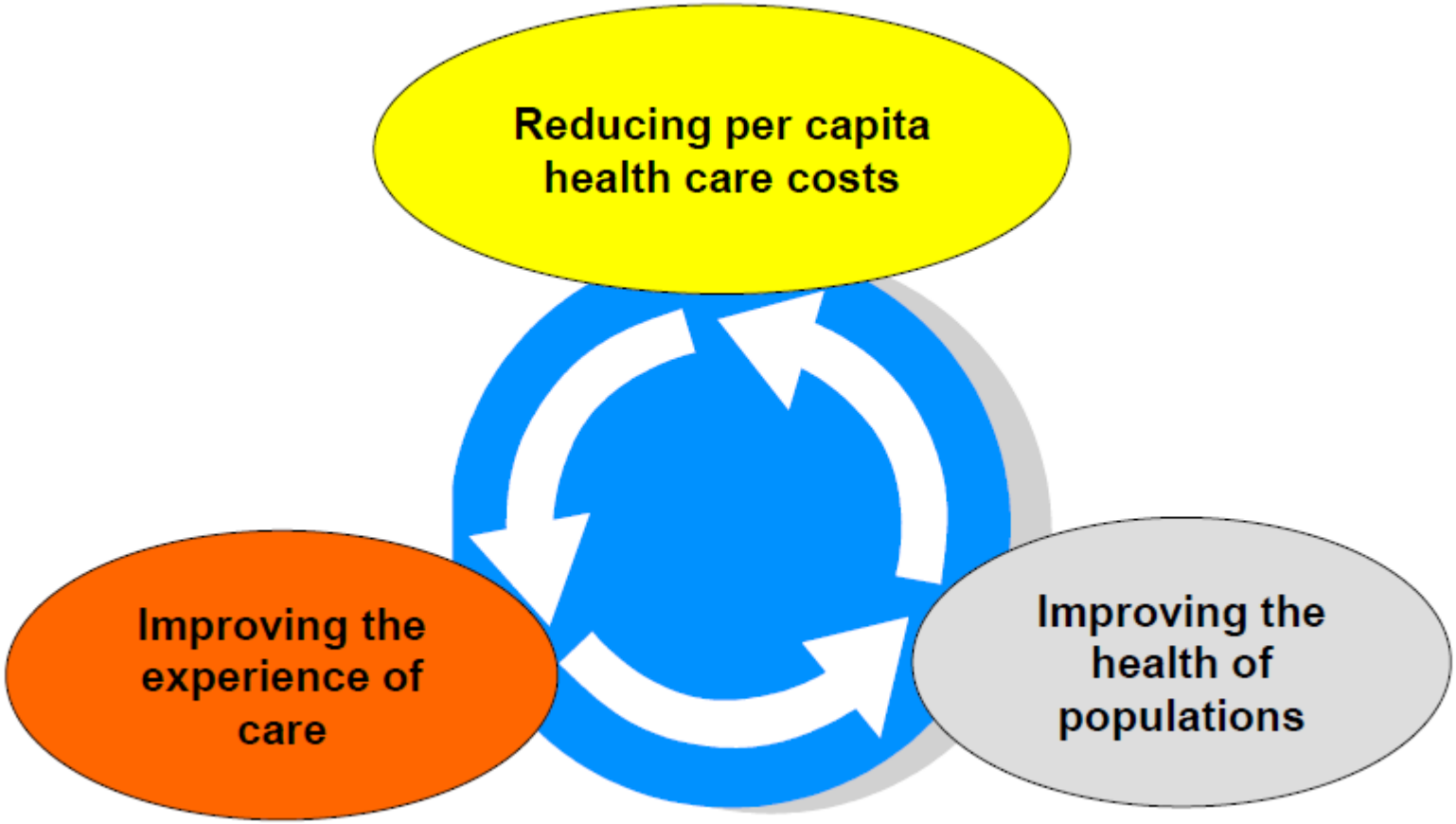
It is not the fault of our doctors that the medical service of the community, as at present provided for, is a murderous absurdity. That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity. But that is precisely what we have done. And the more appalling the mutilation, the more the mutilator is paid. He who corrects the ingrowing toe-nail receives a few shillings: he who cuts your inside out receives hundreds of guineas, except when he does it to a poor person for practice.

GB Shaw, The Doctor's Dilemma: Preface on Doctors, 1909

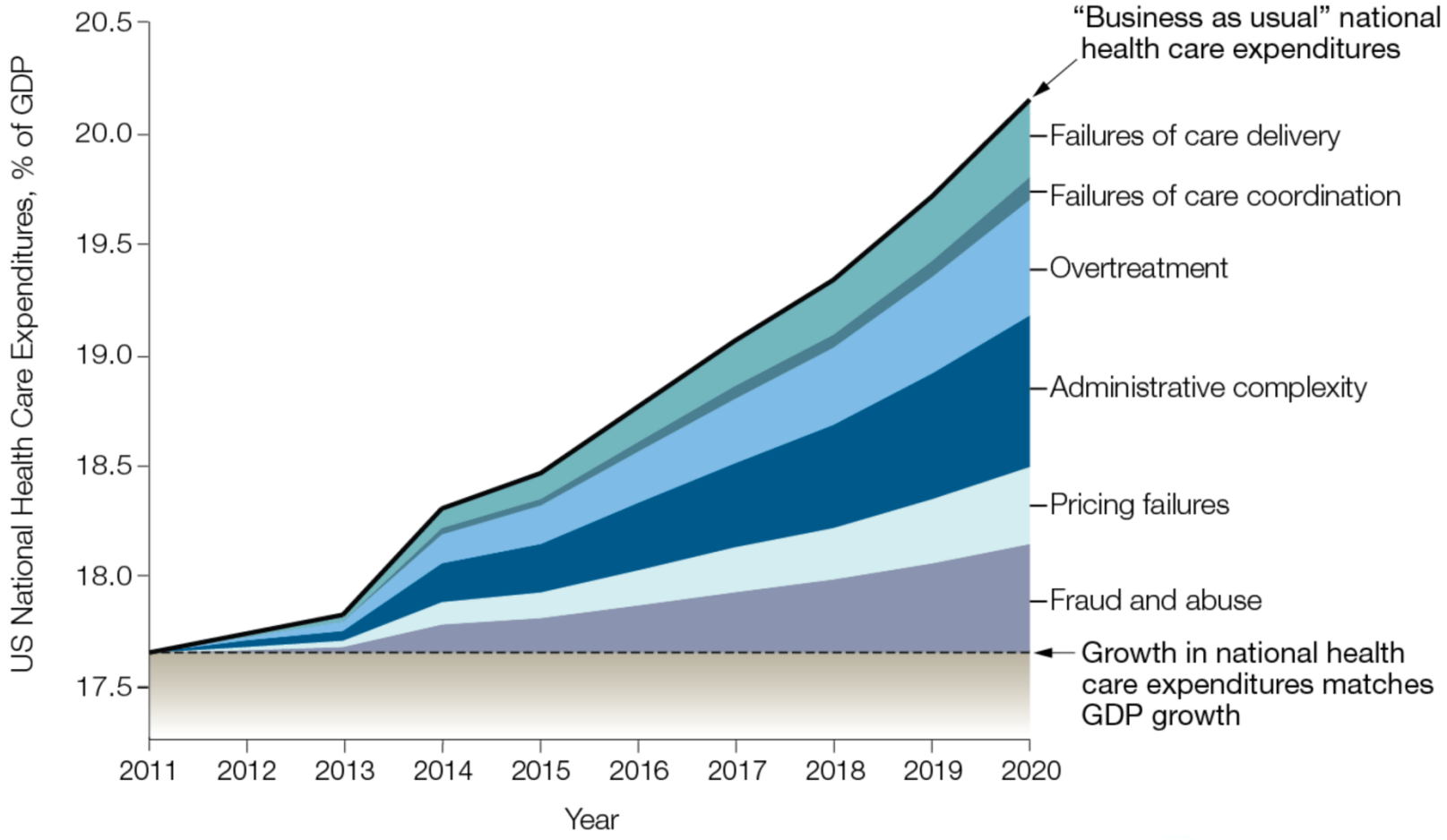
Another way to think about our healthcare challenges:

- We have **defective procurement**
- We are buying **the wrong things**
- We have not **adequately specified what it is we want to buy**
- But we sure are **getting a lot of it**

The "Triple Aim" for Health Care



From: Eliminating Waste in US Health Care



Donald M. Berwick, MD, MPP; Andrew D. Hackbarth, MPhil

JAMA. 2012;307(14):1513-1516. doi:10.1001/jama.2012.362

The Cost of Waste In US Health Care

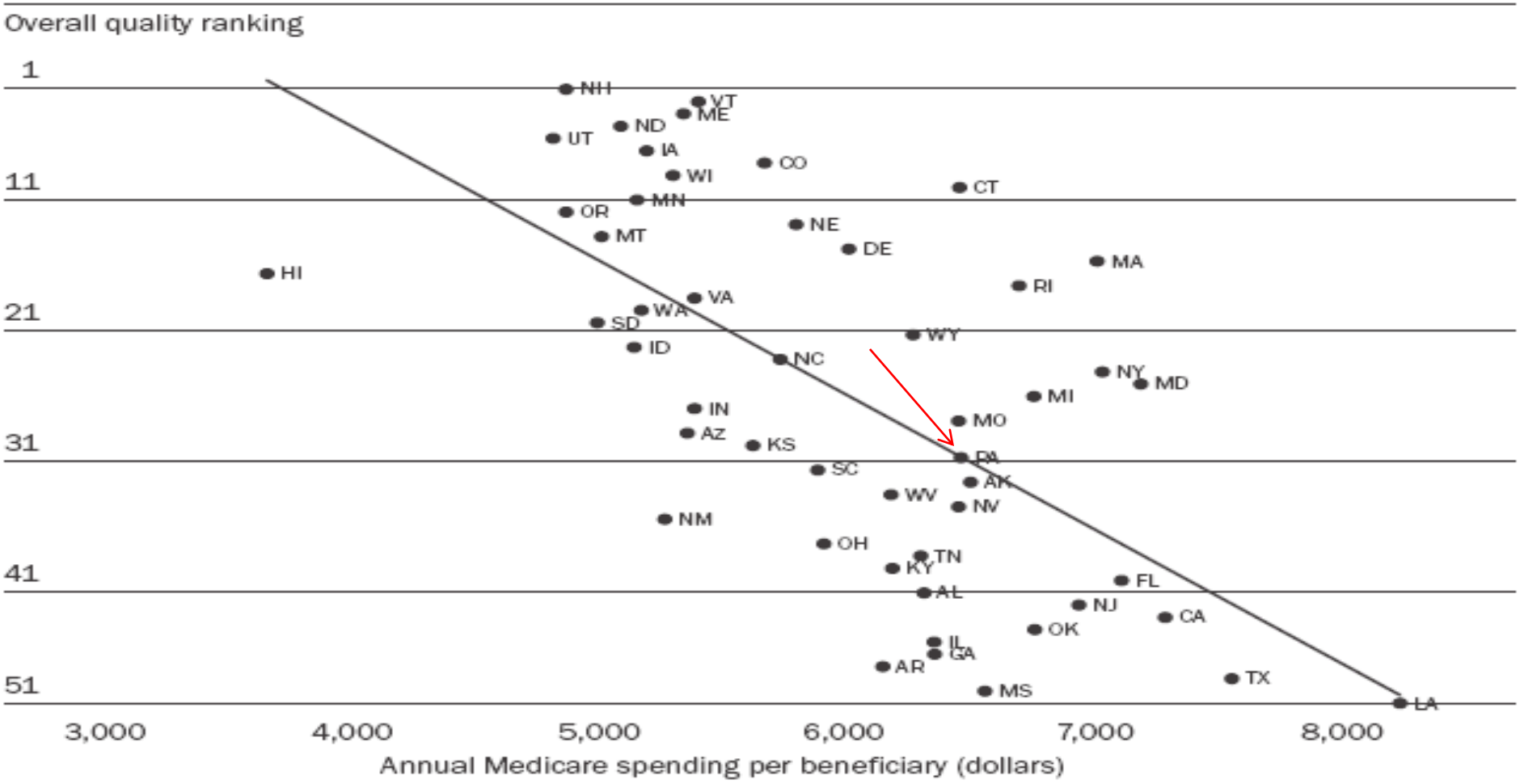
- National studies estimate that inefficiencies and the overuse, underuse and misuse of medical services waste 30 cents of every health care dollar.
- National studies show that nearly 1/3 of Medicare spending goes to services that do not help people improve their health.
- Estimated waste = $765 billion.

JE Wennberg, Variations in Use of Medicare Services, Commonwealth Fund, December 2005.

As it turns out, cost is *inversely* related to quality

EXHIBIT 1

Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001



SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
NOTE: For quality ranking, smaller values equal higher quality.

How Do We Reduce Health Care Costs?

- New payment models to improve quality and decrease costs
  - Accountable Care Organizations (ACOs)
  - Bundled purchasing
  - Stronger primary care
- Financial reform or delivery system reform?
- Activating professionalism in any approach

Accountable Care – Balancing Competing Goals

- Defining parameters for ACOs requires balancing competing, important goals:
  - Risks and rewards for providers, payers and purchasers
  - Cooperation among providers vs. the requirement to prevent anticompetitive behaviors
  - Assuring high quality care vs. minimizing burden of quality reporting
  - Data sharing with ACOs vs. beneficiaries' privacy needs.
  - Speed, which our nation needs, vs. the time for learning, which many providers need

The Pioneer ACO Model
32 organizations, launched 1/1/2012

- Designed for organizations well on their way to changing their care delivery and business models

- A few key features:
  - *Financial Gain* – higher risk but larger reward for participating organizations – **always "2-sided"**
  - *Payment Structure* – population-based payment starting in 3rd year, which gives providers flexibility
  - *Payment Arrangements with Other Payers* – Over 50% of total revenues must be derived from outcomes-based contracts by year 3
  - *Length of Agreement* – agreement period lasts up to five years

Pioneer ACO Results: Care Quality

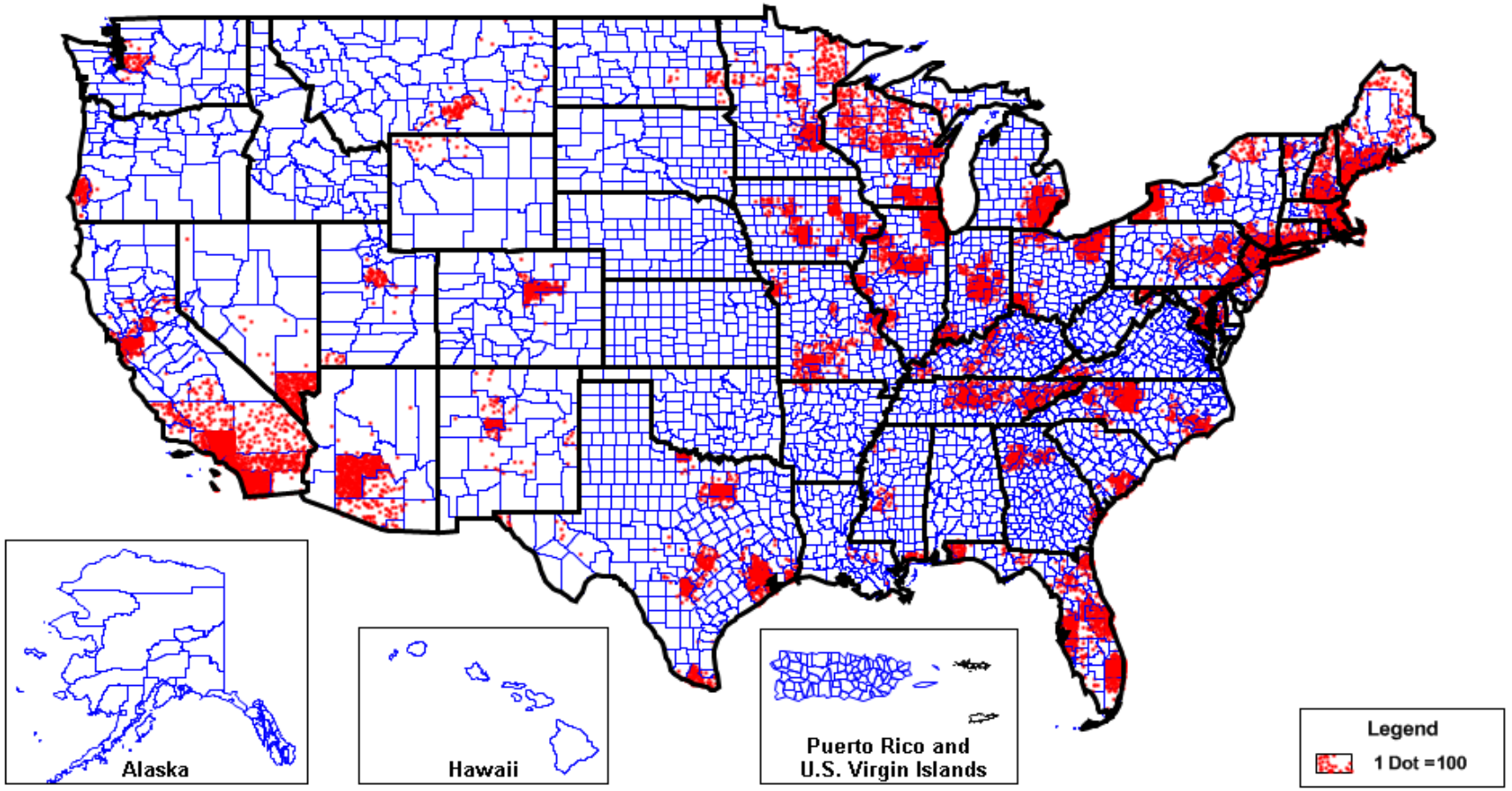
- All 32 Pioneer ACOs successfully reported all quality measures
- Pioneer ACOs performed better than published rates in fee-for-service Medicare for all 15 clinical quality measures
  - Pioneer ACOs rated higher on all four patient experience measures relative to 2011 Medicare fee-for-service results
  - 25 Pioneer ACOs generated lower risk-adjusted readmission rates than benchmark rate for all Medicare fee-for-service beneficiaries

Pioneer ACO Results: Cost Savings

- 18 Pioneer ACOs reduced costs
- 13 saved enough to share savings with CMS
- Gross savings in 2012: $87.6 million
  - Nearly $33 million in savings went back to the Medicare Trust Funds
- 23 Pioneer ACOs intend to stay in program
  - 7 Pioneer ACOs intend to join Medicare Shared Savings Program (another ACO model)
  - 2 Pioneer ACOs intend to leave ACO program

Geographic Distribution of ACO Assignees

(2.6 million total assignees in all programs as of 1/1/2013)



American Board of Internal Medicine

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Primary Care

- Primary care is critical to achieving the three-part aim of promoting health, improving care, and reducing overall system costs
- Current visit-based fee-for-service system does not provide resources for comprehensive primary care
- CMS is exploring new care delivery and payment models

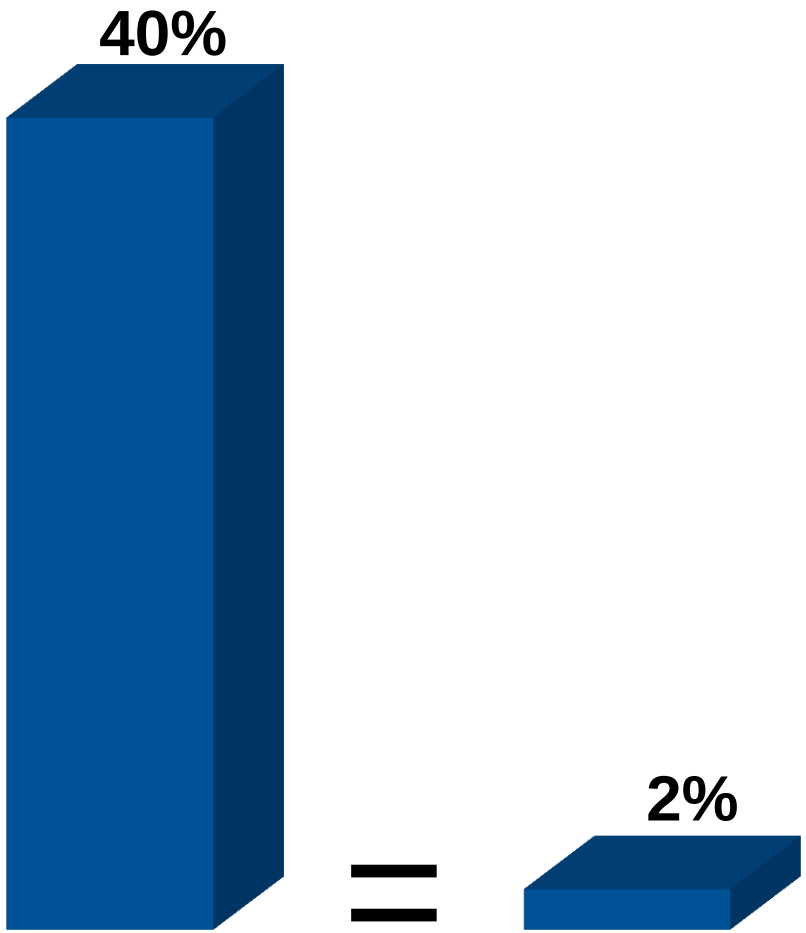
CMS Initiatives for Primary Care

- Medicare and Medicaid enhanced payments to primary care physicians (Affordable Care Act)
- Multi-payer Advanced Primary Care Practice Initiative
- FQHC Advanced Primary Care Practice Demonstration
- Medicaid Health Home
- Comprehensive Primary Care Initiative

5 out of every 100 health care dollars is spent on primary care reimbursements.

A significant – 40% – increase in investment for primary care

would only cost the system 2%.



increase in primary care payments

=

additional total health care expenditures from primary care investment

- Do you think that spending 40% more in primary care could generate at least 2% cost savings?

- What could you support with that 40% that might yield 2% cost savings?

Comprehensive Primary Care initiative

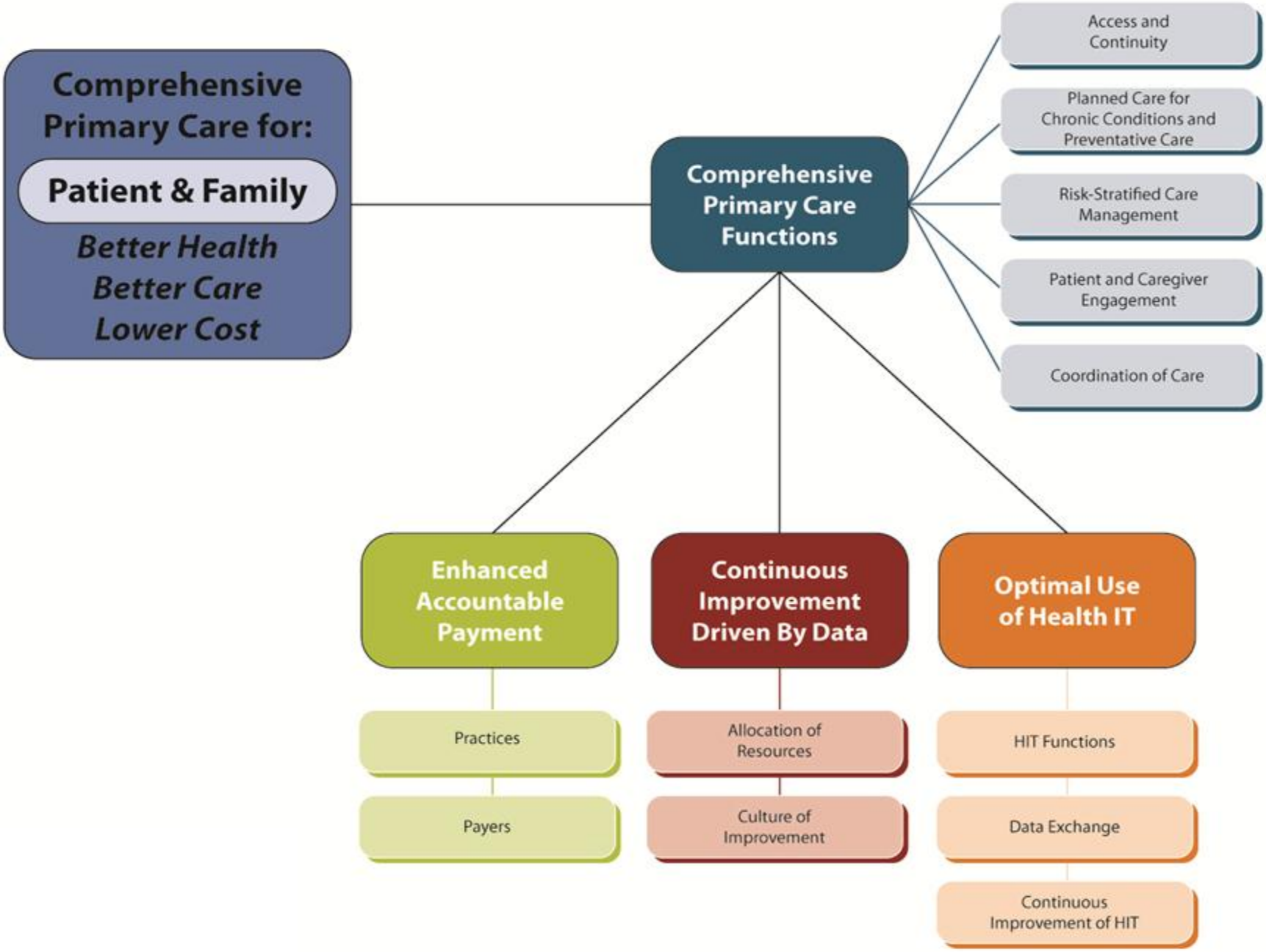
- A major barrier to transformation in *practice* is transformation in *payment*
- The CPCi tests two models simultaneously:

Practice Redesign

- Provision of core primary care functions
- Better use of data
- Focus on total cost of care

Payment Redesign

- PBPM care management fee
- Shared Savings opportunity


Comprehensive Primary Care for:
Patient & Family
Better Health
Better Care
Lower Cost
Comprehensive Primary Care Functions
Access and Continuity
Planned Care for Chronic Conditions and Preventative Care
Risk-Stratified Care Management
Patient and Caregiver Engagement
Coordination of Care
Enhanced Accountable Payment
Practices
Payers
Continuous Improvement Driven By Data
Allocation of Resources
Culture of Improvement
Optimal Use of Health IT
HIT Functions
Data Exchange
Continuous Improvement of HIT

The 9 CPC Milestones

- Annual budget
- Care management for high risk patients
- 24/7 access by patients
- Assess/improve patient experience
- Use data to guide improvement
- Care coordination
- Shared decision making
- Participation in learning community
- Meaningful use (if not already there)

ABIM Foundation

Mission:

To improve health care through the advancement of medical professionalism.

FOUNDATION

abimfoundation.org

ABIMF Choosing Wisely Campaign

Choosing Wisely is an initiative of the ABIM Foundation to help physicians and patients engage in conversations about the overuse of tests and procedures and support physician efforts to help patients make smart and effective care choices.

Choosing Wisely®

An initiative of the ABIM Foundation

choosingwisely.org
#choosingwisely

ABIM FOUNDATION

How do we reduce health care costs?

- Reduce waste
  - Initiatives such as Choosing Wisely that identify areas of potential waste (unnecessary tests and procedures) and encourage physicians to openly discuss options with patients
    - Physician decisions account for 80% of all health care expenditures
      - Crosson FJ. Change the microenvironment. Modern Healthcare and The Commonwealth Fund [Internet]. 27 Apr 2009
    - One-third of all physicians acquiesce to patient requests for tests and procedures—even when they know they are not necessary
      - Campbell EG, et al. Professionalism in medicine: results of a nation physicians. Ann Intern Med. 2007; 147(11):795-802

Choosing Wisely®
An initiative of the ABIM Foundation

LESS IS MORE

Too Little? Too Much? Primary Care Physicians' Views on US Health Care

A Brief Report

Brenda E. Sirovich, MD, MS; Steven Woloshin, MD, MS; Lisa M. Schwartz, MD, MS

"Forty-two percent of US primary care physicians believe that patients in their own practice are receiving too much care; only 6% said they were receiving too little."

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Call to the Profession: Where Are the Health Care Cost Savings?

Deficit pressures are making cost control inevitable. It will only be successful if physicians stop looking to others to find solutions and focus on approaches that improve the care for patients with chronic illnesses.

-Ezekiel J. Emanuel, MD, PhD

VIEWPOINT

Where Are the Health Care Cost Savings?

Scan for Author Audio Interview

Ezekiel J. Emanuel, MD, PhD

AS OF JULY 2010, THE UNITED STATES SPENT $2.6 TRILLION per year on health care.[1] It is not just the level of spending that is of concern but the rate of growth over time. During the last 30 years, the growth in US health care spending has been 2.1% more per year than growth in gross domestic product (GDP). This is why the percentage of GDP attributable to health has nearly doubled in 30 years. At this rate, projections suggest that by 2040 1 of every 3 dollars will be spent on health care and by 2080, it will be nearly 1 of every 2 dollars.[2] In 2010, the entire GDP of France was $2.58 trillion, the world's fifth-largest economy. That means US health care spending is equivalent to the world's fifth-largest economy.

False Cost Control

Physicians often gravitate to cost control proposals that do not involve their own role and changing their practices, whereas policymakers may propose solutions that will not significantly reduce costs. In assessing cost control proposals, 2 criteria are fundamental. One criterion is that 2% growth in health care costs over growth in GDP amounts to $52 billion a year; serious proposals are aimed at reducing the growth in health care costs to 1% over GDP growth. Consequently, anything short of $26 billion in savings is not credible. A second criterion is that cost control proposals should transform the delivery of care and lead to improved quality as well as patient and physician satisfaction.

Malpractice Costs. Physicians frequently cite malpractice premiums and the cost of defensive medicine as drivers of high costs. A recent Congressional Budget Office (CBO) analysis estimated that a package of reforms consisting of a $250 000 cap on noneconomic damages, a $500 000 cap on punitive damages, reducing the statute of limitations (1 year for adults and 3 years for children), and implementing fair-share liability could reduce malpractice premiums by 10% ($3.5 billion per year) and reduce defensive medicine for the entire health care system by 0.3% ($7 billion), for a total savings of approximately $11 billion or 0.5% of national health care spending per year.[3] No reliable data indicate that other malpractice reforms would generate cost savings.

Importantly, more than 30 states have instituted similar caps and limits. If these measures have reduced costs, they are insufficient to counter other factors increasing costs. In addition, physicians in those states, such as California, do not seem to indicate that the practice environment is better. There is little research on the effects of malpractice caps on quality, although 1 study cited by the CBO suggested that caps lowered the quality of care.[4] This suggests that limits on malpractice liability would not likely both reduce costs and improve quality.

Insurance Company Profits. Another proposed cost control mechanism focuses on the profits of insurance companies. In 2010, the combined profits of the 5 largest insurers—Wellpoint, United, Aetna, Humana, and Cigna—increased substantially, reaching $11.7 billion.[5] It may be worthy to reduce these profits, but in the scheme of $2.6 trillion in national health care spending, this amount constitutes just 0.5% of total spending.

Drug Costs. In 2010, the United States spent $262 billion on prescription drugs, 10% of total health care spending.[1] There is a worrisome trend that new drugs and biologics costing tens of thousands of dollars per year do not provide cures, but achieve only modest disease benefit. One approach to cost savings is drug reimportation, which would allow brand-name drugs sold at lower prices in Canada or other countries to be imported into the United States. Assuming the logistical and supply problems were solved, the CBO estimated that reimportation could save approximately 1% of drug costs, an insignificant $2.6 billion.[6]

Another approach might be to substitute generic drugs for brand-name drugs. Between 2004 and 2009, use of generic drugs increased substantially from 57% to 75% of all prescriptions.[7] Despite this change, costs for health care and for prescription drugs have both increased by approximately 25% during those years. By increasing generic prescription levels to 100%—an unrealistic level—CBO estimated that an additional $900 million could be saved for Medicare Part D in 2009.[8] Of the $502 billion spent on Medicare in 2009, this would amount to a savings of less than 0.2%. The US Department of Health and Human Services recently concluded that increased savings from expanding generic use "are likely to be small relative to total spending on drugs"[7]—not to mention total health care costs.

"The Million Dollar Baby." Many physicians believe the US health care system expends excessive amounts on so-called "million dollar babies"—patients who spend long periods in intensive care units and require tracheostomies, gastrostomy tubes, and myriad other interventions. However, an analysis of nearly 20 million commercially insured patients revealed that only 255 patients had consumed more than $1 million each on health care expenditures in 2010. Extrapolating to the entire health care system suggests these patients use 0.5% of all health care costs. Even if all costs attributed to care of these "million dollar babies" could be eliminated, there are not enough of such patients to significantly reduce health care spending. Expanding this group to patients who consume more than $250 000

Author Audio Interview available at www.jama.com.

Author Affiliation: Office of the Provost and Department of Medical Ethics and Health Policy, University of Pennsylvania School of Medicine, Philadelphia. Corresponding Author: Ezekiel J. Emanuel, MD, PhD, Office of the Provost and Department of Medical Ethics and Health Policy, University of Pennsylvania School of Medicine, 122 College Hall, Philadelphia, PA 19104 (emanuel@upenn.edu).

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Choosing Wisely: "Five Things" Lists

- Over 30 United States specialty societies representing more than 500,000 physicians developed lists of "Five Things Physicians and Patients Should Question"

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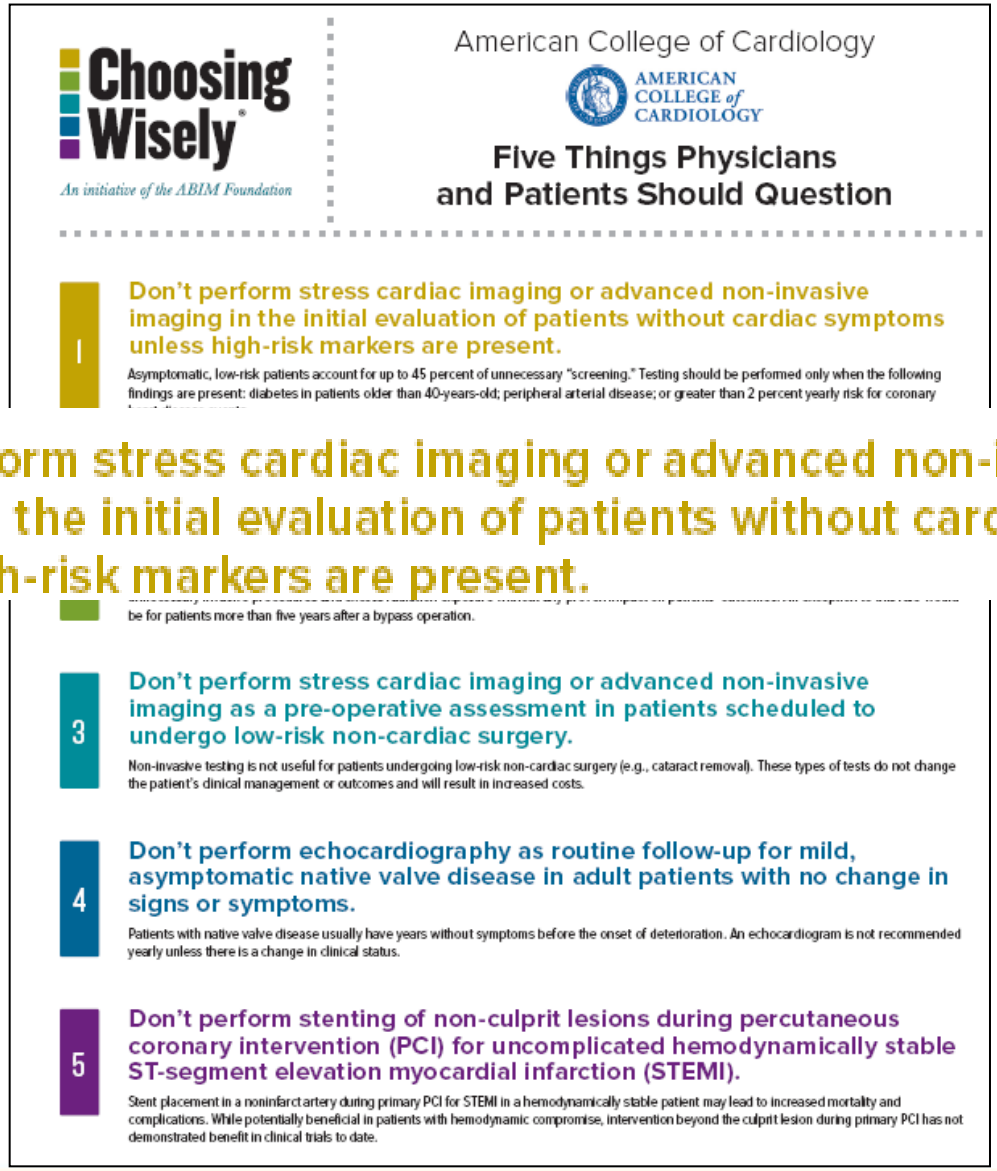
“Five Things” lists



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American College of Cardiology
AMERICAN COLLEGE of CARDIOLOGY

Five Things Physicians and Patients Should Question

1 Don’t perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.

Asymptomatic, low-risk patients account for up to 45 percent of unnecessary “screening.” Testing should be performed only when the following findings are present: diabetes in patients older than 40-years-old; peripheral arterial disease; or greater than 2 percent yearly risk for coronary

be for patients more than five years after a bypass operation.

3 Don’t perform stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.

Non-invasive testing is not useful for patients undergoing low-risk non-cardiac surgery (e.g., cataract removal). These types of tests do not change the patient’s clinical management or outcomes and will result in increased costs.

4 Don’t perform echocardiography as routine follow-up for mild, asymptomatic native valve disease in adult patients with no change in signs or symptoms.

Patients with native valve disease usually have years without symptoms before the onset of deterioration. An echocardiogram is not recommended yearly unless there is a change in clinical status.

5 Don’t perform stenting of non-culprit lesions during percutaneous coronary intervention (PCI) for uncomplicated hemodynamically stable ST-segment elevation myocardial infarction (STEMI).

Stent placement in a noninfarct artery during primary PCI for STEMI in a hemodynamically stable patient may lead to increased mortality and complications. While potentially beneficial in patients with hemodynamic compromise, intervention beyond the culprit lesion during primary PCI has not demonstrated benefit in clinical trials to date.

1 Don’t perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.

Choosing Wisely Partners

Societies That Announced Lists April 2012

- American Academy of Allergy Asthma & Immunology
- American Academy of Family Physicians
- American College of Cardiology
- American College of Physicians
- American College of Radiology
- American Gastroenterological Association
- American Society of Clinical Oncology
- American Society of Nephrology
- American Society of Nuclear Cardiology

Societies That Announced Lists February 2013

- American Academy of Family Physicians
- American Academy of Hospice and Palliative Medicine
- American Academy of Neurology
- American Academy of Ophthalmology
- American Academy of Otolaryngology-Head and Neck Surgery
- American Academy of Pediatrics
- American College of Obstetricians and Gynecologists
- American College of Rheumatology
- American Geriatrics Society
- American Society for Clinical Pathology
- American Society of Echocardiography
- American Urological Association
- Society of Cardiovascular Computed Tomography
- Society of Hospital Medicine
- Society of Nuclear Medicine and Molecular Imaging
- Society of Thoracic Surgeons
- Society of Vascular Medicine

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Societies Announcing Lists in Late in 2013 and Early 2014

- American Academy of Clinical Toxicology
- American Academy of Dermatology
- American Academy of Family Physicians
- American Academy of Neurosurgery
- American Academy of Orthopaedic Surgeons
- American Association of Blood Banks
- American Association of Clinical Endocrinologists
- American Association for Pediatric Ophthalmology and Strabismus
- American College of Chest Physicians
- American College of Emergency Physicians
- American College of Medical Toxicology
- American College of Occupational and Environmental Medicine
- American College of Rheumatology
- American College of Surgeons
- American Geriatrics Society
- American Headache Society
- AMDA—Dedicated to Long Term Care Medicine
- American Medical Society for Sports Medicine
- American Psychiatric Association
- American Society of Anesthesiologists
- American Society of Clinical Oncology
- American Society of Colon and Rectal Surgeons
- American Society of Hematology
- American Society of Plastic Surgeons
- American Society for Radiation Oncology
- American Society for Reproductive Medicine
- American Thoracic Society
- Commission on Cancer
- The Endocrine Society
- Heart Rhythm Society
- North American Spine Society
- Society for Cardiovascular Angiography and Interventions
- Society of Cardiovascular Magnetic Resonance
- Society of Critical Care Medicine
- Society of General Internal Medicine
- Society of Gynecologic Oncology
- Society for Maternal-Fetal Medicine

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"I appreciate when a patient comes to me armed with questions about the value or safety of their medications or treatments. That way, we can discuss costs and benefits -- and agree on a treatment that is best for them."

-- Kelly Kyanko, MD, internist and Health Ratings Center consultant

Discover our campaigns

Choosing Wisely — An initiative of the ABIM Foundation

BEST BUY DRUGS

Engage with Health

For consumers: Our free reports and videos

Informed patients make smarter choices. You can be safer, save money, avoid

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ConsumerReportsHealth

AMERICAN ACADEMY OF FAMILY PHYSICIANS

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Treating sinusitis

Don't rush to antibiotics

Millions of people each year are prescribed antibiotics for sinusitis, a frequent complication of the common cold, hay fever, and other respiratory allergies. In fact, 15 to 21 percent of all antibiotic prescriptions for adults in outpatient care are for treating sinusitis. Unfortunately, most of those people probably don't need the drugs. Here's why.

The drugs usually don't help

Sinusitis can be uncomfortable. People with the condition usually have congestion combined with yellow, green, or gray nasal discharge plus pain or pressure around the eyes, cheeks, forehead, or teeth that worsens when they bend over. But sinus infections almost always stem from a viral infection, not a bacterial one—and antibiotics don't work against viruses. Even when bacteria are responsible, the infections usually clear up on their own in a week or so. And antibiotics don't help ease allergies, either.

They can pose risks

About one in four people who take antibiotics have side effects, including stomach problems, dizziness, or rashes. Those problems clear up soon after stopping the drugs, but in rare cases antibiotics can cause severe allergic reactions. Overuse of antibiotics also encourages the growth of bacteria that can't be controlled easily with drugs. That makes you more vulnerable to antibiotic-resistant infections and undermines the benefits of antibiotics for others.

Consumer Groups
Through Partnership with Consumer Reports

- AARP
- Alliance Health Networks
- Covered California
- Leapfrog Group
- Midwest Business Group on Health
- Minnesota Health Action Group
- National Business Coalition on Health
- National Business Group on Health
- National Center for Farmworker Health
- National Hospice and Palliative Care Organization
- National Partnership for Women & Families
- Pacific Business Group on Health
- Puget Sound Health Alliance
- SEIU
- Union Plus
- Univision (with HolaDoctor)
- Washington State Medical Association
- The Wikipedia Community

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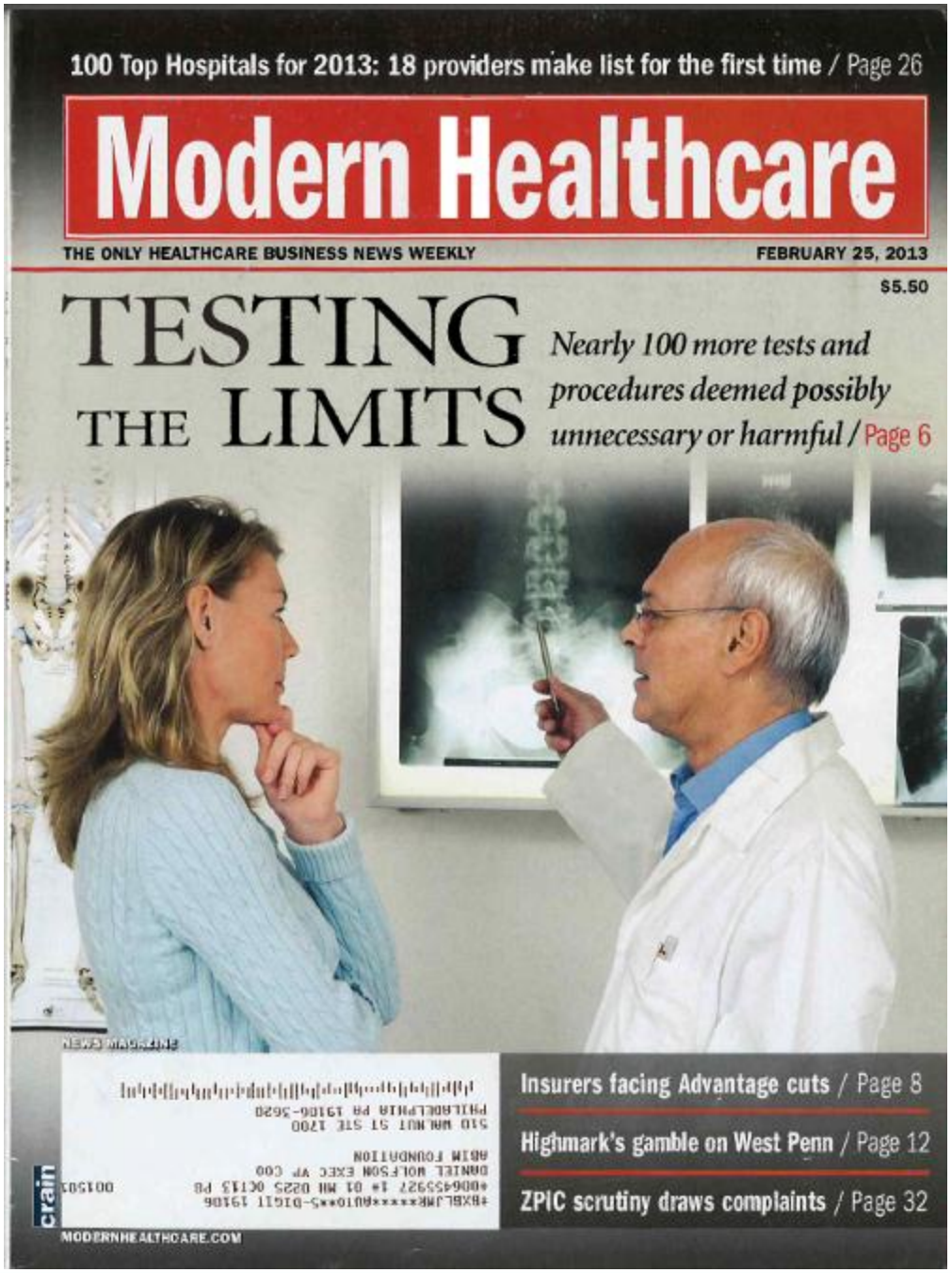

"We have created a medical ecology based on overprescription and overconsumption on the part of both physicians and patients," Erb said. **"What *Choosing Wisely* has done is legitimize our ability to cut back on what's unnecessary."**

Choosing Wisely®

An initiative of the ABIM Foundation

Donald M. Berwick, MD

CEO, Institute for Healthcare Improvement; Senior Fellow, Center for American Progress

"Choosing Wisely": Physicians Step to the Front in Health Care Reform

Posted: 04/ 8/2012 5:02 pm

But, "Choosing Wisely" is a game-changer. The advice comes not from payers or politicos, but from pedigreed physician groups. The specialty societies are not guessing; their lists of procedures contain copious scientific citations supporting the claims of overuse.

Choosing Wisely®

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American Board of Internal Medicine (ABIM)

Mission:

To enhance the quality of health care by certifying internists and subspecialists who demonstrate the knowledge, skills, and attitudes essential for excellent patient care.

Role:

- Defines specialties and subspecialties in internal medicine
- Sets standards for the profession
- Primary accountability to the public

American Board of Medical Specialties®

Higher standards. Better care.™

24 Member Boards

Certify more than 750,000 physicians

- Allergy & Immunology
- Anesthesiology
- Colon/Rectal Surgery
- Dermatology
- Emergency Medicine
- Family Medicine
- Internal Medicine (200,000+)
- Medical Genetics
- Neurological Surgery
- Nuclear Medicine
- Obstetrics & Gynecology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Pediatrics
- Physical Medicine & Rehabilitation
- Plastic Surgery
- Preventive Medicine
- Psychiatry & Neurology
- Radiology
- Surgery
- Thoracic Surgery
- Urology

The Breadth of Internal Medicine

- Adolescent Medicine
- Adult Congenital Heart Disease
- Advanced Heart Failure & Transplant Cardiology
- Cardiovascular Disease
- Clinical Cardiac Electrophysiology
- Critical Care Medicine
- Endocrinology, Diabetes, & Metabolism
- Focused Practice in Hospital Medicine
- Gastroenterology
- Geriatric Medicine
- Hematology
- Hospice and Palliative Medicine
- Infectious Disease
- Interventional Cardiology
- Medical Oncology
- Nephrology
- Pulmonary Disease
- Rheumatology
- Sleep Medicine
- Sports Medicine
- Transplant Hepatology

- ✓ Certify 1 of every 4 practicing physicians in US
- ✓ More than 200,000 ABIM Board Certified Physicians
- ✓ Internal Medicine has more Board Certified Physicians than any other Board

American Board of Internal Medicine
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Maintenance of Certification

- Designed to ensure that physicians keep current and practice high quality medicine
  - Employs active learning rather than passive lectures
  - Secure exam is a requirement
  - Performance improvement focuses on behavior, not just knowledge

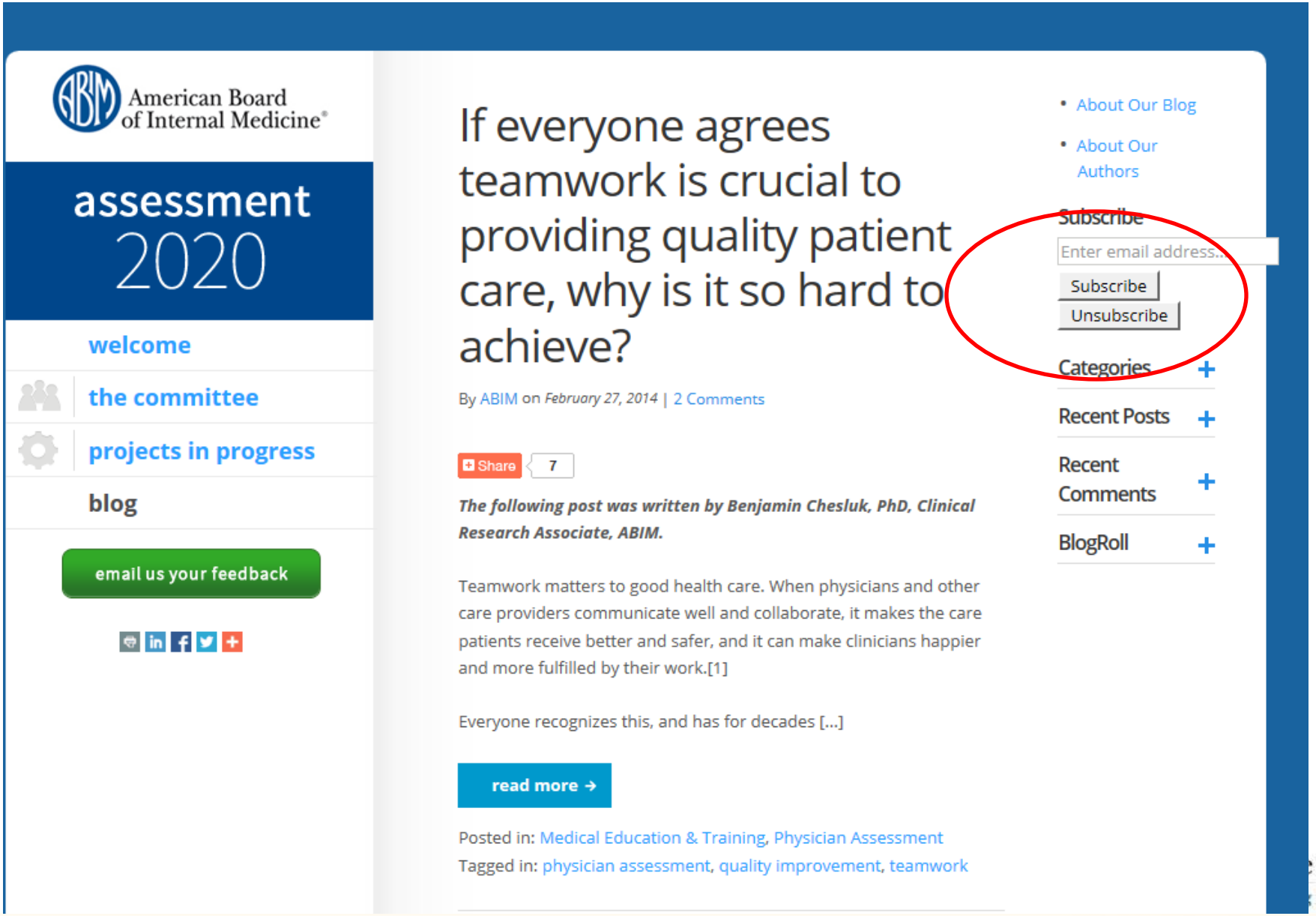
Assessment 2020

- A new initiative to define what competencies physicians will need as the field of medicine evolves
- Seeks to engage physicians, patients, assessment experts and other stakeholders in conversations about future of physician assessment
- ABIM will use feedback from the community, analysis of the latest assessment research and focus groups and surveys to inform future enhancements to ABIM's Certification and MOC programs

Assessment 2020

- Participate in conversations on the Assessment 2020 Blog
- Weigh in, via polls, on issues related to changes in assessment
- Learn about ABIM exam enhancements that are in R&D
- Find out about the work of the ABIM Assessment 2020 Task Force

http://assessment2020.abim.org/



Payment models depend on important physician skills and behaviors

- Teamwork
- Care coordination
- Preventive Care
- Resource awareness
- Attention to “non-medical” issues
- Clinical system re-design
- Ongoing improvement
- Use of health information technology

We will need to change training

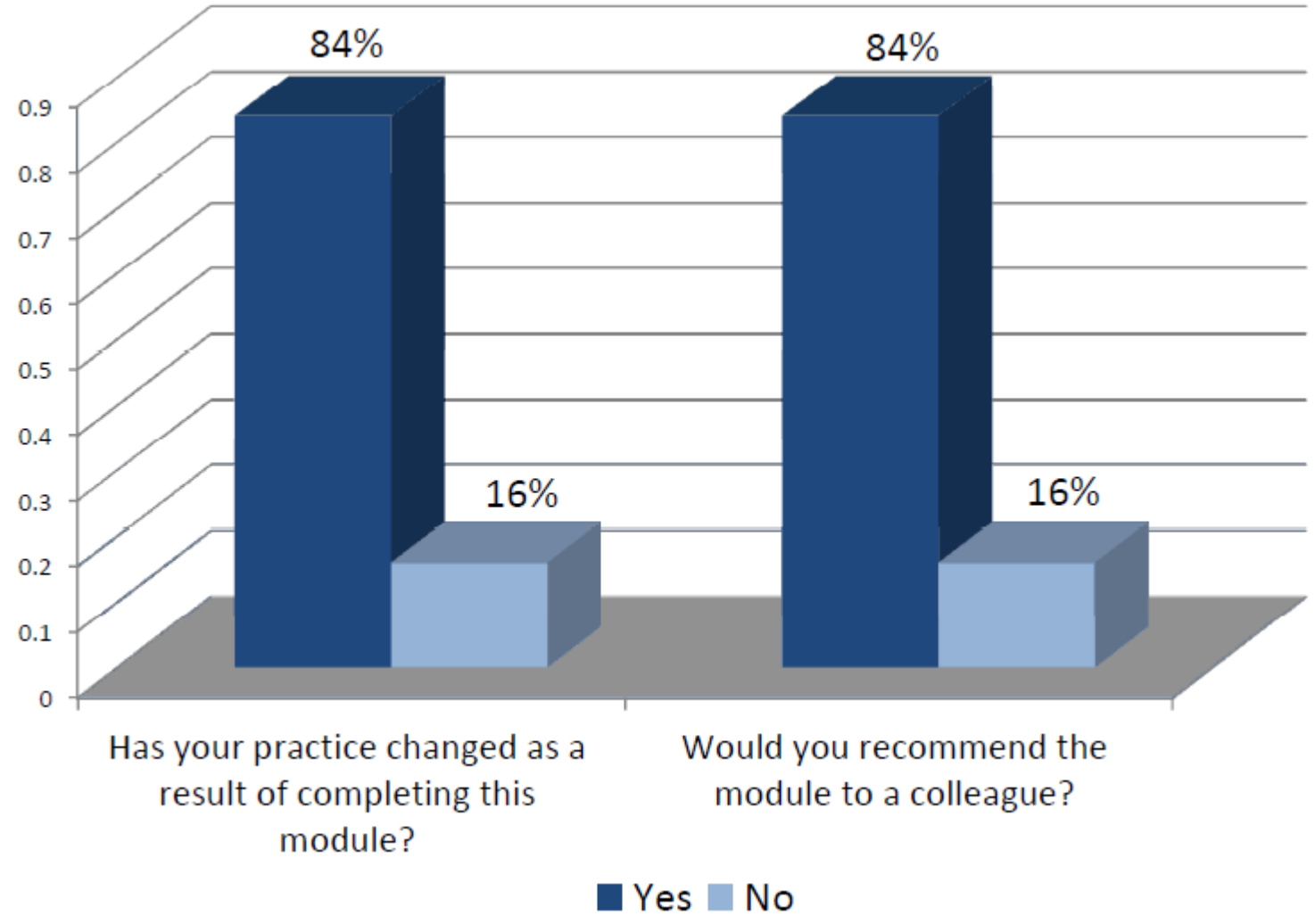
AND

We will need to change practice

Role for ABIM?

- What does the good doctor know and do in the 21st century?
- How do we prepare trainees to function in these new models?
- How do we support those in practice by articulating new skills they will need?
- How do we assess it all in a publicly credible way?

Feedback: PIM Survey, Jan. 2011 – July 2013



Response rate: 74% (6,033/8,152)

Questions?