



# THE PHOENIX

A Diplomates' Newsletter

## A Message from the President

James C. Puffer, M.D.

In the last issue of the Phoenix, I described how we used the data you provide to us in your evaluations to influence the decisions we make about improving assessment tools that we use in the continuous certification process, discarding tools that have been shown to be of little benefit, and creating new tools in an effort to make the process more efficient. We have evolved into a data-driven organization, and we have spent considerable resources to create the infrastructure to manage the large amounts of data that drive our enterprise and its ability to constantly improve the work that it does.

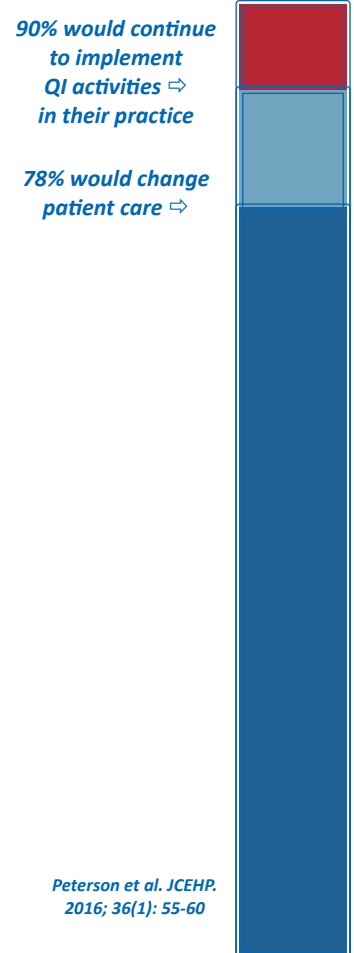
However, while our research team has been exceptionally successful in using this data to publish our outcomes in peer-reviewed journals, we have not done as well communicating our findings to you in a meaningful way. Accordingly, we frequently hear our Diplomates comment “there is no evidence to support what you are doing” or “show me the evidence that this is going to improve my care.” To better communicate how we are utilizing the data that you provide to us, we have decided to provide brief “sound bites” (actually, “word/graphic bites”) in each issue of the Phoenix.

The first of these appears to the right of this column and reflects a few important findings in an article published by our research team last year in the Journal for Continuing Education for the Health Professions in which we analyzed the feedback more than 25,000 of you provided after completing our Performance in Practice Modules. As the graphic shows, 78% of you indicated that you would change aspects of the way in which you delivered patient care after completing the module, and 90% of you would continue quality improvement activities.

If you are interested in reading the full article, you will further learn that of those indicating they would change the way in which they provided care, 86% provided concrete examples of how they would do so. Interestingly, the findings were durable; as diplomates completed additional modules, they reported increasing usefulness of the activities to their practices and a stable intention to continue quality improvement activities. For those of you not familiar with the continuing medical education literature, these change behaviors are remarkable as most traditional continuing medical education activities are considered extremely successful if they result in a change in practice patterns of 50% of the participants.

We will be providing more of these snippets in each subsequent issue of this newsletter, but I also want to share some other important work that is highlighted in this issue. The first of these is our new Continuous Knowledge Self-Assessment (CKSA) activity. We introduced this new assessment tool in January of this year, and your experience with the tool to date has exceeded even our optimistic expectations. Approximately 8,000 Diplomates have participated in the activity during the first and second quarters of this year, and after analyzing evaluation data from the first quarter, 87% of more than 5,400 users had a favorable impression of the activity, and 95% were likely to continue the activity.

### Physician Feedback on Performance in Practice Modules



Peterson et al. JCEHP. 2016; 36(1): 55-60



## A Message from the President

I have participated for the first two quarters and have enjoyed the process. I particularly enjoyed reading the comments that you have provided after answering each question; they have added additional clinical flavor and perspective that simply cannot be captured in a single, multiple-choice question. They also provide a unique supplementary learning environment from which we all benefit. This platform will be even easier to access when we introduce our new mobile app this summer that will allow you to access and complete this activity with additional convenience.

I have written to you previously about the considerable resources that we have invested in the development and roll out of our PRIME Registry, a tool that we have designed to integrate seamlessly into your practice to help you improve the care you deliver to your patients. We have almost 500 practices and 2,000 clinicians for whom our technology partner, FIGmd, is actively extracting data from their electronic health records, reformatting it into a quality dashboard with over 40 quality indicators and sending it back to the clinicians for their review in a dynamic feedback loop. For those more than 1,200 clinicians that asked us to do so, we reported 2016 data this year from their measures to the Center for Medicare and Medicaid Services to meet Physician Quality Reporting System (PQRS) and Meaningful Use requirements.

We have another 1,500 clinicians in 400 practices that are in various stages of the “onboarding” process with FIGmd to allow data from their electronic health records to be extracted. All ABFM

certified family physicians will eventually have data seamlessly flow into our new Performance Improvement (PI) activity platform that has been developed with FIGmd and which will be integrated with the registry. This will allow family physicians participating in the registry to complete their Performance Improvement Activity requirement for continuous certification more efficiently. We will introduce this new platform with additional new tools to enhance quality improvement activities later this year.

As part of our Support and Alignment Network grant for the Transforming Clinical Practice Initiative, we provided three years of free participation in PRIME for ABFM certified family physicians who enrolled in a Practice Transformation Network. We would now like to expand free participation to an additional 2,000 ABFM diplomates who would like to enroll in the registry. For those 900 diplomates that were not enrolled in Practice Transformation Networks but nevertheless joined the registry and paid the \$295 annual fee to do so, we would like to offer three additional years of participation in PRIME for free. Please see the story inside this issue for further information.

If you are participating in Comprehensive Primary Care Plus (CPC+), please be certain to view the article inside this issue describing how PRIME can assist you in meeting your reporting requirements. We also want to make certain that you are aware that you can receive Performance Improvement credit for the work that you are doing to meet the requirements of CPC+, and the article provides important information on how to do so.

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You will find additional articles within this issue that will interest you. Take time to learn about how the changes in the examination that we instituted this year resulted in improved pass rates for both certification and continuing certification candidates. You will also want to read about the important work that your family physician peers performed on the Differential Item Functioning Review Panel that met this summer in Lexington. This panel performs critical analyses to make certain that unintended bias has not been introduced into our examination questions. This guarantees that the exam fairly assesses the ability of all candidates irrespective of gender, race or ethnicity. The American Board of Family Medicine has been a pioneer in the use of this process within the American Board of Medical Specialties (ABMS), and we had colleagues from several ABMS member boards join us in Lexington to observe this process.

I hope you will take time to acquaint yourself with our new officers and directors that sit on our Board of Directors. They work voluntarily and tirelessly to assure the public that the family physicians that we certify have met the highest standards required to provide high quality care to their patients.

On a final note, on behalf of all of us here at the ABFM, let me express our hope that you enjoy a most memorable summer with your families and loved ones.





## Continuous Knowledge Self-Assessment Activity Enhancements

Since its January launch, the Continuous Knowledge Self-Assessment (CKSA) has garnered an overwhelmingly positive response from those who have participated in the activity. Almost 8,000 family physicians have signed onto and completed the CKSA in both the first and second quarters of this year. The CKSA provides feedback to help understand where you are on the ABFM certification examination scale, to get a sense of how accurate your judgments are regarding your knowledge base, and to identify clusters of content that need general improvement across the broad framework of family medicine. As the newest self-assessment activity available to fulfill certification process requirements, the CKSA is a set of 25 questions that can be answered anytime during each calendar quarter. You receive 2.5 certification points and 3 AAFP Prescribed CME credits per quarter. If you complete four CKSA quarters in a stage, that will complete your minimum KSA requirement. New enhancements to make the CKSA an even better experience will roll out in July.

CKSA Feedback Analysis Q1 – Quantitative Responses				
N=5430				
Ratings	Current Content	Favorable Opinion	Likely to Continue	Likely to Recommend to Others
Extremely	34% (1860)	38% (2064)	62% (3368)	45% (2428)
Very	58% (3146)	49% (2647)	33% (1812)	40% (2169)
<b>Subtotal</b>	<b>92%</b>	<b>87%</b>	<b>95%</b>	<b>85%</b>
Somewhat	8% (408)	12% (668)	4% (235)	12% (675)
Not at all	0.3% (16)	1% (51)	0.3% (15)	3% (158)

Beginning in July, the CKSA will be available to family medicine resident physicians. Residents may login to their ABFM physician portfolio at [www.theabfm.org](http://www.theabfm.org) and access the CKSA under the self-assessment certification activities listing. The CKSA will apply to the overall certification points requirement, and if a total of four CKSA quarters are completed during the Resident Certification Entry process, the minimum of one KSA requirement will be met as well.

The screenshot shows the ABFM CKSA interface. The header includes the ABFM logo and the text "ABFM CKSA". A user is logged in as "Dr. [Name] Logout". A navigation menu on the left includes: Home, Questions, Report, Settings, Withdraw, and Return to Portfolio. The main content area displays "Question 1" with the following text: "A 50-year-old male is brought to the emergency department because of a syncopal episode. Prior to the episode, he felt bad for 30 minutes, then developed nausea followed by vomiting. During a second bout of vomiting he blacked out and fell to the floor. His wife did not observe any seizure activity, and he was unconscious only for a few seconds. His history is otherwise negative, his past medical history is unremarkable, and he currently takes no medications. A physical examination is normal." Below the text is the question: "Which one of the following would be the most helpful next step?". The answer options are: "CT of the head", "Carotid ultrasonography", "A CBC and complete metabolic profile", "Echocardiography", and "An EKG". A "Submit" button is located at the bottom right of the question area.



## Continuous Knowledge Self-Assessment Activity Enhancements

In addition to making the CKSA available for residents, other improvements to the CKSA include reporting the difficulty (as a scaled score) for each item in the item critique and including the Metacognitive Accuracy Index (MCAI) for each quarter. This can give you a sense of how appropriate your confidence in your response is, and added performance graphs show you what these statistics mean, as you can easily navigate back to any question that you wish to review. By including the additional information such as item difficulty and blueprint category with each question, the goal is for Diplomates to have the detail available to assist with assessing strengths and weaknesses.

The screenshot displays the ABFM CKSA interface. The top navigation bar includes the ABFM logo, the text "ABFM CKSA", and a user profile icon labeled "Dr." with a "Logout" link. A left sidebar contains navigation options: Home, Questions, Report, Settings, Withdraw, and Return to Portfolio. The main content area has tabs for "Question", "Critique", and "Comment". The "Critique" tab is active, showing a "Question's Difficulty" score of 444 on a scale from 0 to 1000, and a "Blueprint Category: Nonspecific". Below this is a "Critique" section with text explaining the workup for syncope, including history, physical examination, and the use of an EKG. A "References" section lists a citation: Saklani P, Krahn A, Klein G. Syncope. *Circulation* 2013;127(12):1330-1339. At the bottom, there are "Previous" and "Next" navigation buttons.

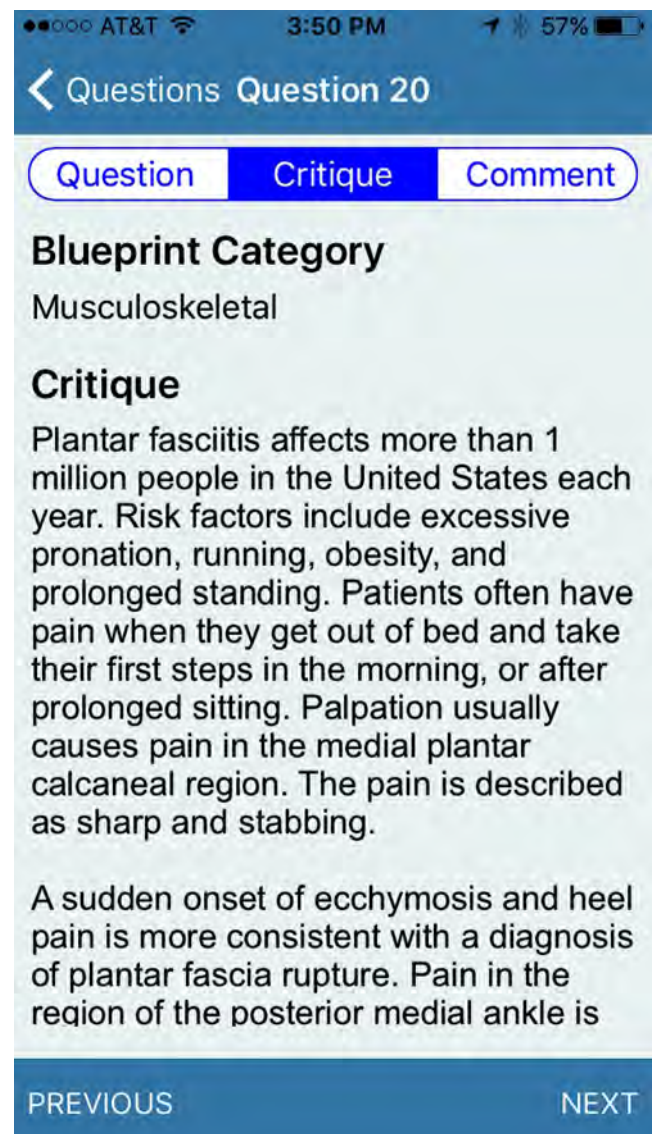
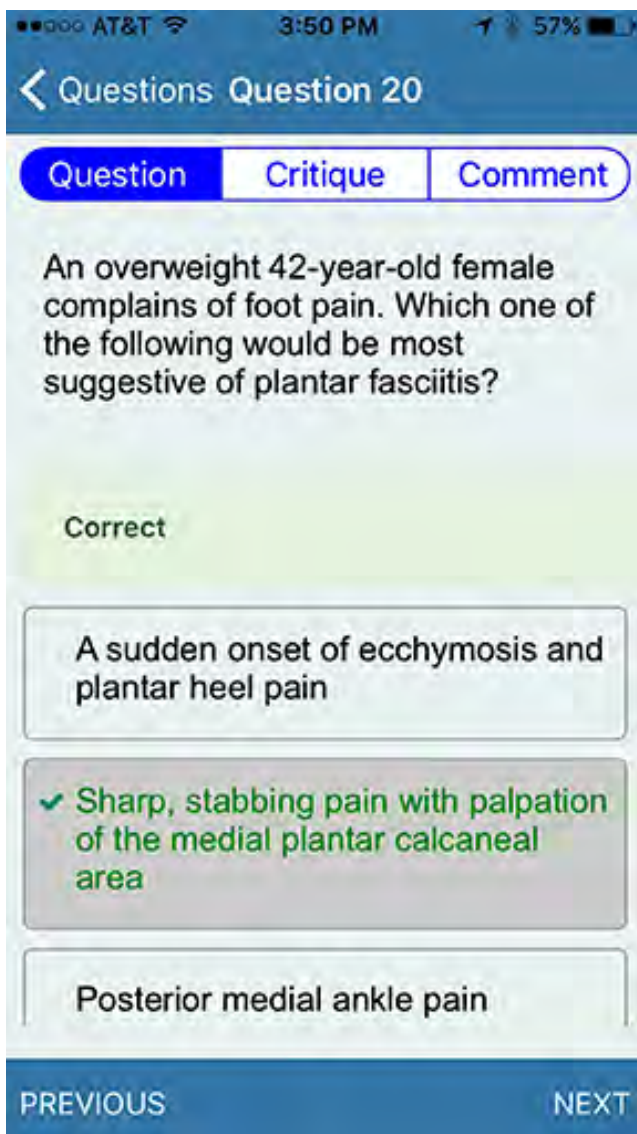
Another improvement to the CKSA involves the removal of the question regarding whether external resources (collaboration with colleagues, looking things up, etc.) were used in determining an answer. Very few questions were answered using assistance, and participants found the repeated question annoying. So this question will no longer be asked and instead the platform directs participants to not use external resources. Whether a participant is following this direction is not monitored; however, the feedback that participants receive (predicted score, predicted probability of passing, MCAI, etc.) will be degraded to the extent that external resources are employed.

The screenshot displays the ABFM CKSA interface, specifically the "User Comments" section. The top navigation bar and sidebar are identical to the previous screenshot. The "Critique" tab is active, and the "User Comments" section is visible. It shows a text input field with a "Submit" button. Below the input field, there are three comments from users, each with a timestamp and a "Reply" button. The first comment reads: "There was no physical exam information, I would have checked a pulse, if abnormal then get an EKG stat. In reality the EKG would be performed and the blood test performed, as an electrolyte abnormality could cause an arrhythmia." The second comment reads: "This patient would never leave the ER without a CT of his head." The third comment reads: "In this clinical scenario a ruptured or bleeding intracranial aneurysm is also on the differential (increased ICP leading to NVV), thus a head CT to r/o acute bleeding and mass effect at least as important as an EKG."



## Continuous Knowledge Self-Assessment Activity Enhancements

Perhaps the most exciting enhancement to the CKSA is the mobile version coming in July. Physicians will be able to access and complete the CKSA on a hand-held Android or iOS device. A number of physicians have expressed interest in being able to easily access the CKSA while in a shopping line waiting to checkout or at other short downtimes in the day so they can easily continue to assess their knowledge. Look for an announcement coming out in the next month about the release of the new CKSA app that can be downloaded on Android or iOS devices.





## Conversations on Practice—Dr. Edward Blumen

Edward A. Blumen, MD first certified with the ABFM in 1976, and in April took his 6th recertification examination. He has been with the same group practice in Evanston, Illinois for the last 40 years. The practice started as a group model HMO, then became a staff model HMO, and is now employed by a hospital network. The ABFM was interested to learn more about Dr. Blumen's long career in family medicine and his thoughts about and experience with the ABFM and the certification process.

### *Family Medicine*

“Growing up I realized I had an interest in science and people, especially relationships with people. Medicine seemed to meet these interests, and I selected Family Medicine because it exemplified these interests. I have been very satisfied. I would do it again. It has become my passion. It seems that everything I do is aimed at improving patient care. This includes improving the efficiency in the office, to now electronically communicating with hospitalists (I retired from hospital work about 15 years ago when I studied and received my MBA), to communicating through a patient portal and whatever other means, to advocating for high quality cost-controlled patient care. I am happy to see the promotion of USPSTF, Choosing Wisely, Beers Criteria (Potentially Inappropriate Medication Use in Older Adults), and the AAFP Health is Primary campaign—all of which seem to take a page back and forth with ABFM. I am a strong believer in ‘farm to table.’ Perhaps, in our case, the ‘farm’ is the vetted evidence which when harvested comes to ‘table’ in the patient care settings.”

### *Certification*

“I have always enjoyed learning and as such sharing what I have learned with others, in this case to patients, students, residents and colleagues. I see this process as a 2-way street—each learning from each other and progressing on. During medical school I realized that medicine was an ever changing field. That was exciting. I was thrilled that Family Medicine insisted that I continue to learn to maintain myself and that the ABFM would validate that I was doing this appropriately.

I believe that the certification process has evolved for the better, as the specialty has evolved and grown. We have always needed certified CME. The variations of this have increased to meet the needs of all types of Family Physicians. When we had the opportunity to go from 7 to 10 years, I took it because it was a busy time in my life and I could better juggle the additional CME than the intensity of review I personally do for the exam itself. I thank ABFM for this opportunity.

The exam too has evolved for the better. From fill-in-the-dot and multi-multi-choice in an open arena to succinct electronic questions and answers in a private space. I do believe this better fits the specialty of Primary Care Family Medicine rather than some of the sub-specialty areas in medicine. The one issue I personally had with a few questions on the recent exam was with the longer question and answer and the need to scroll back and forth. This seemed to break my concentration and induce anxiety.

Value = Benefit/Risk, and our profession creates a Value Exchange. I have mentioned above the tremendous personal benefit I have in the entire process. The risk denominator for me includes the time, expense and, of course, possible failure. This enters into my professional Activities of Daily Living and becomes limited. For my patients, the other avenue of the exchange, the Value benefit has exploded into vetted evidence-based quality with understanding of the personal aspects of care. The risk can be debated depending upon multi-societal/cultural attributes and circumstances that we attempt to understand. I definitely believe there is 2-sided Value for maintenance of certification.

I believe the confidence I have achieved by continuing to maintain my certification has allowed me to extend myself into my professional and personal community with voluntary work for both these public domains.”

### *Maintaining Balance*

“Well into my career as a clinical Family Physician I returned to school to get my MBA. For about 20 years prior to this time I was adding administrative work on top of my clinical work. Docs were turning to me to help put together their understanding of the ‘business of medicine’ which was forever changing. To improve my confidence, I went for the MBA.

One late night studying the two courses of financial accounting and teamwork, my pager went off.

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## ABFM Supports Family Physician Practices in CPC+

Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through multi-payer payment reform and care delivery transformation. Currently, 13,090 clinicians serving more than 1.76 million Medicare beneficiaries in 2,891 primary care practices are participating in CPC+ Round 1. A second round is currently open through July 13, 2017 in the following regions:

1. Louisiana: Statewide
2. Nebraska: Statewide
3. North Dakota: Statewide
4. New York: Greater Buffalo Region (Erie and Niagara Counties)

CPC+ payment redesign gives practices the additional payment and flexibility to make investments that will improve quality of care. CPC+ also provides practices with actionable feedback to guide their decision making and practice transformation.

CPC+ is included on the list of Advanced Alternative Payment Models for 2019-2024. Clinicians who meet requirements are excluded from the Merit-based Incentive Payment System (MIPS) and qualify for a 5% incentive payment.

CPC+ practices receive a risk-adjusted, prospective, monthly care management fee for their CPC+ Medicare beneficiaries. For Track 1 the average fee is \$15 per beneficiary per month (PBPM). For Track 2 practices the average fee is \$28 PBPM, but up to \$100 PBPM for highest risk patients.

In CPC+, Comprehensive Primary Care Functions will guide practices: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health. Track 2 also focuses on patients with complex medical, behavioral, and psychosocial needs.

Continuing Certification Practice Improvement Credit: The ABFM feels strongly that family physicians participating in CPC+ are making meaningful efforts to improve care and transform their practices. For this reason, we will offer Practice Improvement activity credit via attestations in your Portfolio later this summer.

The PRIME Registry supports CPC+ Tracks 1 & 2. CPC+ requires monitoring and reporting of quality measures and this can be a high hurdle for many practices. The ABFM hosts the PRIME Registry which is open to all primary care clinicians and which is certified to support all CPC+ participants. In addition, the PRIME Registry also provides you with a dashboard of your own measures, comparisons to other clinicians, and the ability to identify patients that aren't meeting your measure goals and to report your data for the Quality Payment Program—in fact, we reported to PQRS for more than 1,100 clinicians in 2017 and provided Meaningful Use attestation for even more. It facilitates ongoing ABFM Continuous Certification and will enable your ABFM Practice Improvement efforts to be reported for the Quality Payment Program as well. To learn more about the PRIME Registry, go to [www.primenavigator.org](http://www.primenavigator.org) or email [prime@theabfm.org](mailto:prime@theabfm.org).

Practices located in the four CPC+ Round 2 regions are eligible to apply here: <https://app1.innovation.cms.gov/cpcplus/> through July 13, 2017. For questions please email [CPCPlusapply@telligen.com](mailto:CPCPlusapply@telligen.com) or call 1-877-309-6114.

## Conversations on Practice—Dr. Edward Blumen

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I dealt with the acute patient issue, turned back to the computer for school and 'AH-HA,' I realized, 'it's all about balance.' I later explained this to each of my professors. They understood for their individual 'silo,' but only when I explained it to the Dean did he understand how it all comes together with medicine. We are all engaging in these constant 2-sided value exchanges seeking equilibrium and looking towards the future.

I am proud that the ABFM has helped me maintain my balance for 40+ years.”



# ABFM Elects New Officers and Board Members

The American Board of Family Medicine (ABFM) is pleased to announce the election of four new officers and four new board members. The new officers elected at the ABFM's spring board meeting in April are: Elizabeth Baxley, MD of Greenville, North Carolina elected as Chair; Jerry Kruse, MD of Springfield, Illinois as Chair-Elect; Montgomery Douglas, MD of West Hartford, Connecticut as Treasurer; and Joseph Gravel, Jr., MD of Lawrence, Massachusetts as Member-at-Large, Executive Committee. Keith L. Stelter, MD of Mankato, Minnesota will serve as Immediate Past Chair. In addition, the ABFM welcomes this year's new members to the Board of Directors: Beth Bortz of Richmond, Virginia; Lauren Hughes, MD, MPH, MSc of Philadelphia, Pennsylvania, John Mellinger, MD of Springfield, Illinois, and Daniel Spogen, MD of Sparks, Nevada.

The remaining current members of the Board are: Wendy Biggs, MD of Overland Park, Kansas; John Brady, MD of Newport News, Virginia; Colleen Conry, MD of Aurora, Colorado; Christopher A. Cunha, MD of Crestview Hills, Kentucky; Lorna Anne Lynn, MD of Philadelphia, Pennsylvania; Michael K. Magill, MD of Salt Lake City, Utah; Robert J. Ronis, MD, MPH of Cleveland, Ohio; David E. Soper, MD of Charleston, South Carolina; and Melissa Thomason of Pinetops, North Carolina.

The ABFM Board of Directors looks forward to working with the new members as it continues to implement and enhance the Family Medicine Certification program and the important task of sustaining the mission of the ABFM. For more information on the current Board members, please visit the Board of Directors page on our website. ●



Elizabeth G. Baxley, MD



Jerry Kruse, MD



Montgomery Douglas, MD



Joseph Gravel, Jr., MD



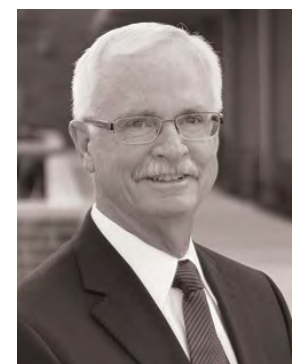
Beth Bortz



Lauren Hughes, MD, MPH, MSc



John Mellinger, MD



Daniel Spogen, MD





## ABFM Convenes the 2017 DIF Review Panel



From left to right, front row: Traci Edwards, MD, Jesse Hsieh, MD, Viola Chen, MD, Ying Du, PhD, Jennifer Cramer, PhD, Xian Wu, Rongxiu Wu. Back row: Gaddiel Rios, MD, David Lowe, MD, Thomas O'Neill, PhD, Michael Peabody, PhD.

Passing the ABFM Certification Examination is intended to be a standardized process through which an examinee can demonstrate that they have at least the minimum knowledge necessary to be a board-certified family physician. Sources of bias that are not related to this purpose degrade the test's ability to differentiate examinees who can demonstrate this level of performance from those who cannot. The ABFM test development process aims to minimize bias related to cultural or ethnic biases. The ABFM has been using Differential Item Functioning (DIF)<sup>1</sup> for that purpose since 2013.

DIF procedures are based upon the idea that a test item is biased if individuals from different subpopulations, who are of equal ability, do not have the same probability of answering it correctly<sup>2,3</sup>. DIF analyses are able to identify questions that behave differently across subpopulations; however, it cannot identify the source of the bias, nor can it determine whether the source of that bias is related to an important aspect of the practice of family medicine. Therefore, DIF is used as a screening tool to find biased items. Identifying the source of the bias and determining if it is an important aspect of family medicine is better left to subject matter experts (SME), board-certified family physicians. That group should represent both genders and a diversity of ethnicity.

Consequently, the ABFM devised a 3-stage process to address this. The first stage is conducting a DIF analysis to flag potentially biased items. The second stage is to have SMEs, a linguist, and a psychometrician examine the flagged questions' content to try to identify sources of bias unrelated to important aspects of family medicine. This group is independent of the item development group who creates the items and independent of the ABFM's Examination Committee. The third stage is to have the ABFM's Examination Committee review the items referred by the DIF Review Panel and determine the items' final disposition—to retain or send back to item development to be reworded or deleted.



## ABFM Convenes the DIF Review Panel

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On June 9, the ABFM convened a DIF Review Panel to review the 2017 items flagged for DIF. There were five family physicians from Indiana, Kentucky, Tennessee, and Texas. The panel received an orientation to DIF, an overview of the process, and then spent the rest of the day reviewing the items. Across the many forms of the examination, there were a total of 953 scored items. Of these, 73 were flagged for review by the panel. There were eight items that were flagged for more than one group.

Although the ABFM uses ethnicity information to test for item bias, it is important to emphasize that the ABFM does not release ethnicity information to external parties. Furthermore, ethnicity and gender are not used to adjust the difficulty of the examination questions. The item calibrations used in scoring are based on responses from the entire group, not a particular ethnicity or gender reference group. There are not different passing standards or different scales for the different ethnic groups or genders. There is only one scale with a single passing standard that applies to everyone.

References.

1. O'Neill TR, Peabody MR, Puffer JC. The ABFM Begins to Use Differential Item Functioning. *J Am Board Fam Med* 2013; 26:807-809.
2. Lord FM. *Applications of Item Response Theory to Practical Testing Problems*. Hillsdale, NJ: Lawrence Erlbaum Associates; 1980: 212.
3. Angoff WH. *Differential Item Functioning Methodology*. In Holland PW, Wainer, H, eds. *Differential Item Functioning*. Hillsdale, NJ: Lawrence Erlbaum Associates; 1993: 4.

## Performance Improvement-Continuing Medical Education Combined Approval Process for ABFM Certification Activity Credit

The American Academy of Family Physicians (AAFP) works with continuing medical education (CME) provider organizations that would like their CME activities certified for AAFP Prescribed and/or Elective CME credit. Using the AAFP Credit System, CME provider organizations can seek approval for their activities, including performance improvement activities.

Beginning this October, the ABFM and the AAFP are working together to allow CME providers the opportunity to apply for AAFP Performance Improvement CME Credit and ABFM Certification Activity credit using one application process. Those providers looking to receive ABFM Certification Activity credit for their performance improvement (PI) activities will now be able to apply through the AAFP Credit System. There will be no additional fee charged to the CME providers for the ABFM Certification Activity credit approval.

ABFM Diplomates will gain more performance improvement activities to choose from as a result of this unified process, and completion of the PI certification activity will be communicated automatically to the ABFM when CME credit is reported to the AAFP and vice-versa.

Using the same AAFP PICME application process, performance improvement activity providers may apply for performance improvement certification activity credit as long as the activity meets the ABFM Industry Support Policy, the activity meets the ABFM Requirements for Performance Improvement activities, and the provider agrees to periodic audit by the ABFM.



## ABFM's Performance Improvement (PI) Activity Platform Update

When the ABFM introduced Maintenance of Certification, limited resources existed to assist Diplomates in completing the Performance in Practice requirement. To fill this void, the Board introduced Performance in Practice Modules, or PPMs. ABFM ultimately produced seven of these: six disease-focused modules (diabetes, hypertension, asthma, depression, coronary artery disease, and heart failure) and a comprehensive module that includes a broad range of measures reflecting those adopted in the Ambulatory Quality Alliance (AQA) "starter set." The PPMs required entry of data for only 10 patients and provided feedback regarding performance vis-à-vis other Diplomates completing the modules. The modules also provided a menu of quality improvement interventions organized along the dimensions of the Chronic Care Model.

In recognition of the growing adoption of performance improvement activities generally, the ABFM has discontinued producing new PPMs and instead has focused on reviewing and approving externally-produced alternatives and self-directed quality improvement projects.

Development of the PRIME registry necessitated revision of the ABFM's Performance Improvement (PI) activity platform to accommodate automatic direct data entry from the registry. In addition, over the years Diplomates have expressed a desire for more didactic resources regarding quality improvement methodology. Accordingly, the new platform includes instructional materials created by consultants from Case Western Reserve University. To support those Diplomates who don't participate in the PRIME registry, the new platform also includes tools for manual data entry.

As opposed to the disease-based organization of the PPMs, the new PI activity platform instead provides access to a broad range of measures developed by organizations such as the NCQA, the National Quality Forum, the Physicians Consortium for Performance Improvement, and others. The new platform will support Diplomates' reporting requirements, such as submission to the Centers for Medicare and Medicaid Services (CMS) for the Merit-based Incentive Payment System (MIPS), as well as meeting Diplomates' Performance in Practice continuing certification requirements.

Like the old PPMs, the new platform provides resources for developing quality improvement interventions (still organized by Chronic Care Model categories) and feedback regarding performance in comparison to peers.

The new platform should become available in early third quarter 2017 and is currently undergoing beta-testing before deployment. The new platform obviates the need for the PPMs, and the ABFM plans to retire those modules in the fall of 2018, providing Diplomates sufficient time to complete modules that they have in progress.

ABFM staff have worked diligently with our vendor, FIGmd, to create a new PI activity product that provides broader and more flexible functionality than the PPM platform. We hope that you will find using this new tool a welcome addition to the ABFM certification portfolio.

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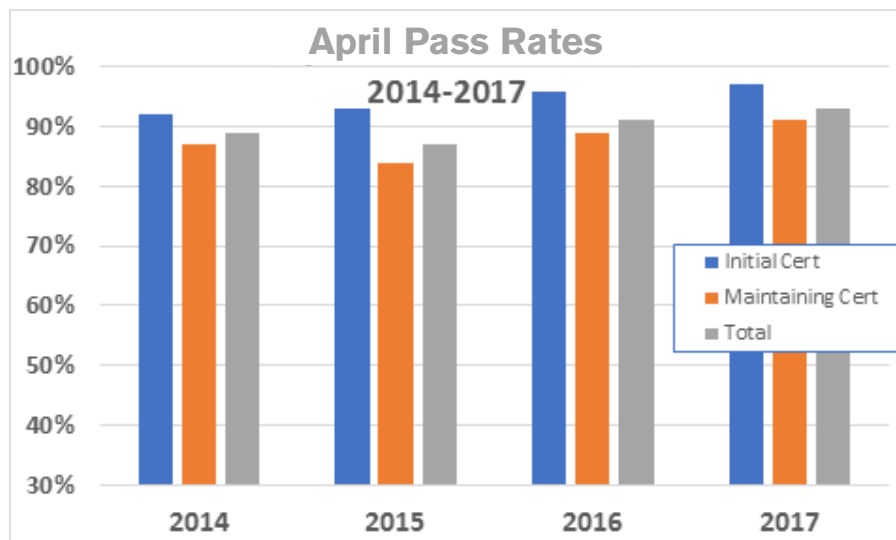
<http://twitter.com/TheABFM>



## Family Medicine Certification Exam 2017—Shorter Test Form

Since 2009, the American Board of Family Medicine has been studying the impact of requiring examinees to select content-specific modules. An article in the January 2017 issue of *Journal of the American Board of Family Medicine (JABFM)* concluded that having examinees select one module rather than two would likely produce a slight score increase for examinees and simultaneously improve the standardization of the examination across examinees. As a result, the ABFM revised its policy to require only one module as implemented with the April 2017 administration. Although there were 50 fewer questions in 2017, examinees had more time per question because the total time was not reduced.

As predicted, the 50-question reduction had a negligible impact on the reliability of the results. The April 2016 examination had a reliability of 0.94, and the April 2017 examination had a reliability of 0.92. Also, the pass rates were higher on the April 2017 examination than they have been since 2014. The minimum passing standard has been 380 since 2014.



## Family Medicine Certification

Examination Dates – Fall 2017

*November 6, 7, 8, 9, 10 & 11*

*Registration Begins (online applications available) July 21*



## PRIME Registry Special Offer for ABFM Diplomates

The American Board of Family Medicine PRIME Registry launched successfully last year, and currently hosts nearly 900 practices. We are also through our first season of Meaningful Use attestation and PQRS reporting. We are preparing new measures that are more meaningful for primary care, and have submitted all of our Practice Improvement Activities for recognition under the MACRA Quality Payment Programs so that, as you do Continuous Certification, you are also meeting QPP requirements. Most PRIME practices are small and rural, and these were our initial target audience since they may struggle most in a value-based payment environment. As a next phase, we would like to bring in many other practices and are offering PRIME enrollment FREE for 3 years to the first 2,000 ABFM Diplomates who successfully complete the PRIME Registry sign up at <http://primenavigator.org/primeregistry/>. The annual fee for non-ABFM Diplomates is \$360 per year, and after 3 years the cost for ABFM Diplomates will be the subsidized rate of \$295 per year.

The American Board of Family Medicine is grateful to early PRIME Registry adopters for taking this leap of faith with us. Almost 900 Diplomates made the initial investment of time and effort to bring this tool into their practices, and almost 1,200 PRIME clinicians were able to use the tool for their Meaningful Use and PQRS requirements for 2016.

**In recognition of that faith and effort, the ABFM will pay for your participation in PRIME for years two, three and four.**

The PRIME Registry allows you to:

- View and track patient care quality
- Identify patients who are not meeting quality goals
- Automate measure data submission for your ABFM Certification/Performance Improvement activities
- Automate measure submission for federal quality reporting for both Quality Payment Programs: Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)
- PRIME also supports participation in several federal payment and practice transformation demonstration projects including CPC+

With PRIME, the ABFM aims to help put your EHR data to work for you, to reduce your reporting and quality improvement burden, and to return joy to practice.

The deadline to Register for PRIME Registry for physicians interested in utilizing it for 2017 Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) is July 31, 2017.

More information on PRIME Registry is available at: <http://primenavigator.org/primeregistry/> or by emailing [prime@theabfm.org](mailto:prime@theabfm.org)



## ATTENTION: Diplomates Who Certified in 2008

Diplomates who initially certified or continuously certified last in 2008 are required to complete the following Certification Activities for Stage Three: a minimum of one (1) Knowledge Self-Assessment activity, a minimum of one (1) Performance Improvement activity, and a minimum of 50 Certification Points. Diplomates must also complete 150 CME credits during the 3-year Stage and remain in compliance with the ABFM Guidelines for Professionalism, Licensure, and Personal Conduct.

**Diplomates planning to take the Family Medicine Certification Exam in April 2018 may open and begin an examination application in December 2017, but until certification requirements are met, the application cannot be approved and finalized. Test centers and dates may not be chosen until an application is complete.**

## ATTENTION: Diplomates Who Certified in 2011

Diplomates who initially certified or continuously certified last in 2011 are required to complete the following Certification Activities for their current Stage by December 31, 2017: a minimum of one (1) Knowledge Self-Assessment activity, a minimum of one (1) Performance Improvement activity, and a minimum of 50 Certification Points. Diplomates must also complete 150 CME credits during the 3-year Stage and remain in compliance with the ABFM Guidelines for Professionalism, Licensure, and Personal Conduct.

**Diplomates who do not complete Stage requirements on schedule will be listed as "not certified" on the ABFM website. A Diplomate has three years after becoming 'not certified' to regain certification status by completing the required certification activities. Once the delinquent requirements are completed, the Diplomate will again be listed as board certified.**

## ATTENTION: Diplomates Who Certified in 2014

Diplomates who initially certified or continuously certified last in 2014 are required to complete the following Certification Activities for their current Stage by December 31, 2017: a minimum of one (1) Knowledge Self-Assessment activity, a minimum of one (1) Performance Improvement activity, and a minimum of 50 Certification Points. Diplomates must also complete 150 CME credits during the 3-year Stage and remain in compliance with the ABFM Guidelines for Professionalism, Licensure, and Personal Conduct.

**Diplomates who do not complete Stage requirements on schedule will be listed as "not certified" on the ABFM website. A Diplomate has three years after becoming 'not certified' to regain certification status by completing the required certification activities. Once the delinquent requirements are completed, the Diplomate will again be listed as board certified.**



## INITIAL CERTIFICATION ...

### ARE YOU CURRENTLY CERTIFIED?

So, you passed the ABFM Family Medicine Certification Examination and successfully completed residency training. . . now what?

Does that mean you are now a certified Diplomate of the American Board of Family Medicine?

That will depend on your answer to this 2-part requirement:

1. Have you obtained an active, valid, full, and unrestricted license to practice medicine in any state or territory of the United States or any province of Canada?
2. If so, have you provided your medical license to the ABFM by entering the information into your Physician Portfolio?

Certification is granted once you have met all requirements, which includes having obtained a medical license and entered the medical license details into your ABFM Physician Portfolio. The effective date of certification is the date upon which you have met all certification requirements. (Example: Physician successfully completes the exam on April 13, completes residency training on June 30, and obtains an active, valid, full, and unrestricted medical license July 15; the certification is effective July 15.)

**Board Eligibility:** Any initial certifying candidate who successfully completes the examination and is verified by his/her residency program of satisfactorily completing residency training, but does not obtain a valid, full, and unrestricted medical license has a 7-year board eligibility period in which to meet all requirements for certification. The successful exam attempt will remain valid during the 7-year board eligibility period.

### Update Your Contact Information

Please remember to update your contact information so that we may stay in touch with you! During residency, your contact information was probably different than it is now. For accurate delivery of email communication and postal mail, it is important to update your contact information. The ABFM communicates mostly through email, but we also utilize postal addresses and phone numbers as needed, especially when trying to assist physicians with achieving certification status.



**The American Board  
of Family Medicine**

1648 McGrathiana Parkway, Suite 550

Lexington, Kentucky 40511-1247

Phone: 859-269-5626

Fax: 859-335-7501

**[www.theabfm.org](http://www.theabfm.org)**

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