Winter 2013

American Board of Family Medicine, Inc.

THE PHOENIX

A Diplomates' Newsletter

A Message from the President

James C. Puffer, M.D.

Shortly before the Thanksgiving Holiday, our staff that oversees Part IV activity in Maintenance of Certification for Family Physicians (MC-FP), which has been designed to measure performance in practice, showed me a project utilizing one of our self-directed Part IV pathways. It was developed by one of our Diplomates currently deployed in Afghanistan, and I was so impressed with the project that I immediately emailed him to ask for permission to share this incredible effort with you in this issue of The Phoenix. He kindly granted me permission to do so.

Dr. Koji D. Nishimura is a Commander in the 30th Medical Command of the United States Army. In reviewing survival data, he and his team realized that only 22% of combat injured soldiers survive. He sought to identify ways in which his team could improve care to double the survival rate. They identified several gaps in the chain of care, including use of pain medication in the field that exacerbated hypotension; the drawbacks of using conventional tourniquets for the treatment of severe exsanguinating injuries; and the lack of intensive care, including the administration of tranexamic acid (TXA) and blood in route, during the medical evacuation (MEDEVAC) of wounded soldiers to a field hospital where definitive care could be provided.

While space does not permit me to fully explain each of the quality improvement interventions employed by Dr. Nishimura and his team, suffice it to say that they found potential solutions to each of the gaps that they identified – the use of ketamine for pain relief in the field instead of morphine or fentanyl; the use of newly designed junctional tourniquets; aggressive administration of TXA and blood during MEDEVAC; addition of critical care nurses on the MEDEVAC flights to provide intensive care; and the creation of Flexible Forward Surgical Teams that could provide surgical care at the point of injury.

Dr. Nishimura and his team used the Lean Enterprise Transformation process developed by Toyota to develop their model for process improvement and organizational culture change. They used tools inherent in this process to monitor progress, rapidly implement change based upon their analyses, and refine their delivery of care design. The learnings from his project have been shared with the military's Joint Theater Trauma System, which is beginning to share this information at civilian trauma conferences.

I know that you share with me the sense that this effort will have tremendous impact on improving survival not only for soldiers on the battlefield, but also for civilians who suffer serious trauma. Critically important for us at the ABFM is the realization that this compelling story would suggest that our strategies for developing Part IV activity for MC-FP are beginning to demonstrate demonstrable changes in the quality of care delivered by family physicians.

When we began the development of our assessment tools for MC-FP, multiple design parameters had to be considered. These included sound evidence to support the assessment methodology being developed; the psychometric validity and reliability of the instruments utilized; the ability, in most instances, for the tool to be accessible via the web; and the "user friendliness" of the application. However, one design element was paramount – namely, the assessment tool needed to measure what was important and relevant to the Diplomate's practice.

Nowhere was this more important than in the development of our Part IV activities, which as you know were designed to help improve the quality of care that you deliver in your practice. The initial modules that we created to assist Diplomates with this task were the Performance in Practice Modules (PPMs).

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These modules were viewed as "first generation" quality improvement tools that would introduce Diplomates to the science of quality improvement and would also provide a step-wise approach for the creation and implementation of a quality improvement intervention in the Diplomate's practice.

While we were developing our first several PPMs, we were simultaneously developing the strategy for the implementation of our second generation of Part IV activities. These would be activities that would be developed by outside entities using rigorous standards established by us, reviewed prospectively by us for approval, and then offered to Diplomates as an ABFM approved, alternative activity. Almost 50 of these alternative activities have now been developed and made available to Diplomates. An important variant of these second generation products was the development of the Multispecialty Portfolio Approval Project (MS-PAP), which was originally created by the three Primary Care Boards (ABFM, ABIM, ABPeds) and the Mayo Clinic. This initial collaboration has now expanded to include 18 member boards of the American Board of Medical Specialties (ABMS) and over 20 participating institutions, with many more having submitted applications to participate.

We have just recently added the third generation of Part IV activities, of which Dr. Nishimura's project is an excellent example, to our armamentarium. These are customized Part IV activities that Diplomates design to fit their specific practice settings. Two options exist—a web-based module originally developed by the ABIM and now shared with us that guides Diplomates through the customization of their activity, or submission of an activity individually developed by the Diplomate for our approval. The project can be either an administrative (for those Diplomates that no longer see patients) or clinical activity. The development of these pathways now allows Diplomates maximum flexibility in meeting their MC-FP Part IV requirement.

Before finishing this discussion on Part IV activities, which are described in greater detail in several stories in this issue, I would be remiss if I did not let you know that we are totally redesigning the platform from which these activities are accessed and launched from our website. Building on our collaboration with Kurt Stange and his team at Case Western Reserve University that I have mentioned previously in this column, we will be creating a new interface with which you will interact when you access the Part IV activity page at our website. This interface will help you decide which Part IV activity is best suited for you and will also provide a wide array of resources that have been developed for us by Dr. Stange and his team.

Are we finished with the development of Part IV options? If you are a habitual reader of this section of our newsletter, you know that the answer to this question is an emphatic "no!" Last year I related to you our vision for the dynamic, real time assessment of quality data from physician practices using technology that would constantly query the electronic health record. Doing so would allow us to assess practice data and repurpose it into a quality dashboard that would allow you to continuously monitor and improve the quality of care that you deliver to your patients. We have embarked on the development of this fourth generation Part IV product this year, and while we know that it will take many years to develop this technology, we believe that eventually it has the possibility of replacing the MC-FP examination for those family physician Diplomates who consistently demonstrate that they are delivering high quality care to their patients.

While much of this issue is devoted to MC-FP and Part IV, several other important articles deserve your attention. These include the recent election of the Chair Elect of our Board of Directors, Carlos Jaén, MD, PhD, to the Institute of Medicine (IOM). We congratulate Dr. Jaén on this prestigious accomplishment, one that is well-deserved. We also introduce you to our newest Puffer Fellow at the IOM, Dr. Katherine Gold from the University of Michigan. She was selected from an exceptional group of applicants, and will join Dr. Jennifer DeVoe, who is beginning her second year of the fellowship. Dr. Sean David, our first fellow, completed his fellowship earlier this fall.

Tom O'Neill and his staff have begun the process of using differential item functioning (DIF) to ensure that

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our examinations are fair and unbiased for all who take them. This important process is explained in an article that describes the multiple steps that we now employ to guarantee that our examinations now meet this standard. It is a critical best practice to guarantee that we accurately measure the ability of the person taking the exam regardless of their ethnicity or gender.

For those of you who hold Certificates of Added Qualifications (CAQs) in Sports Medicine, please be certain to read the important information in the article on the application requirements for certification in Brain Injury Medicine. For those interested in certification in this area, a five-year practice eligibility window will exist within which you may apply by demonstrating that you meet eligibility requirements by virtue of extensive practice experience in traumatic brain injury. After this five-year window closes, the only way that one will be eligible to apply for certification is by completing an ACGME-accredited fellowship.

As a final reminder, it is still not too late to submit data to our Center for Medicare and Medicaid Services (CMS) approved registry to meet your PQRS reporting requirements. We will accept data until January 10, 2014. Further details for participation are included in the article inside this issue.

As we enter the Holiday Season, let me extend to you and your family my best wishes for a joyous Holiday and a healthy and prosperous New Year.

Research vs. Quality Improvement in ABFM MC-FP Part IV Activities

As described in Dr. Puffer's message, the ABFM recently began supporting self-directed QI activities as an option for completing Maintenance of Certification for Family Physicians (MC-FP) Part IV requirements. Using self-directed options, Diplomates can receive credit for quality improvement activities that they've developed for their own clinical contexts rather than rely on the ABFM-developed Performance in Practice Modules (PPMs). Since this option became available, ABFM has received many truly innovative and interesting quality improvement projects.

These self-directed options have also generated some confusion regarding projects that represent primary research rather than applied quality improvement activities. For the purposes of Part IV activities, ABFM defines "research" as an activity designed specifically to address an investigative hypothesis (e.g., "Does drug X produce an outcome superior to drug Y in disease Z?") with the purpose of generating potentially generalizable new information. Specific features that might characterize a research project include the need for patient consent and institutional review board (IRB) approval.

On the other hand, quality improvement (QI) activities represent application of (ideally) evidence-based interventions to improve specified outcomes. Examples might include the use of a flowchart in managing hypertensive patients, or the use of registries to follow the care of diabetics.

A gray area lies at the interface between QI and research: QI research, or investigation of QI strategies to identify those interventions that might have the greatest impact when generalized beyond the research population. These projects, in which the investigators examine an intervention for effectiveness and then follow outcomes prospectively through a number of quality improvement cycles, will indeed qualify for Part IV credit. Likewise, a research project designed to demonstrate the efficacy of a particular intervention that also includes application of that intervention prospectively over time (reported for example as a "run chart" over an appropriate time period) would also qualify for MC-FP Part IV credit.

If you have a great project you'd like to use for a self-directed option, but you're not sure whether the activity represents non-eligible research, please contact the ABFM to discuss the project and to apply to the ABFM for approval.

Application Requirements for the Subspecialty Examination in Brain Injury Medicine Examination

In September 2011, the American Board of Medical Specialties (ABMS) approved the application cosponsored by the American Board of Physical Medicine and Rehabilitation (ABPMR) and the American Board of Psychiatry and Neurology (ABPN) to offer subspecialty certification in Brain Injury Medicine (BIM). The Brain Injury Medicine Examination will be offered every other year beginning October 6, 2014.

Application for subspecialty certification in BIM is open to qualified Diplomates of the ABPMR and ABPN, as well as physicians who hold subspecialty certification in sports medicine through the American Board of Internal Medicine (ABIM), the American Board of Family Medicine (ABFM), the American Board of Pediatrics (ABP), or the American Board of Emergency Medicine (ABEM).

Prospective applicants who are not Diplomates of the ABPMR or ABPN may apply for the BIM Examination via the ABPMR and should follow these steps:

1. Apply for an ABPMR Online Services user account here: www.abpmr.org/request.

2. Apply for the BIM Examination online between January 1 and March 15, 2014.
   Late applications are accepted with an additional fee between March 16 and March 31, 2014.

More information about the application requirements for subspecialty certification in BIM is available in the 2014 Certification Booklet of Information: https://www.abpmr.org/boi/Cert_BOI.pdf#page=35.

About Brain Injury Medicine
The subspecialty of BIM will focus on the prevention of brain injury and the evaluation, treatment, and rehabilitation of individuals with acquired brain injury age 15 years or older. BIM physicians provide a high level of care for patients with brain injury and their families in the hospital and post-acute setting, as well as over the continuum of care to facilitate the process of recovery and improve medical and functional outcomes.

Contact
To learn more about subspecialty certification in Brain Injury Medicine, visit www.abpmr.org/candidates/bim.html.

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ABFM Board Chair-Elect Carlos Roberto Jaén, MD, PhD, Elected to Institute of Medicine

ABFM Board Chair-Elect Carlos Roberto Jaén, MD, PhD, was elected to the Institute of Medicine of the National Academy of Sciences in the class of 2013. Dr. Jaén is the Dr. and Mrs. James L. Holly Distinguished Professor and Chair of Family & Community Medicine at the University of Texas Health Science Center at San Antonio. He is a bi-cultural researcher and research ambassador to Latin America who advises US federal agencies developing health prevention projects for US Hispanic communities. Dr. Jaén also led the evaluation of the first national Patient-Centered Medical Home demonstration. He continues to practice outpatient and inpatient medicine.

The Institute of Medicine (IOM) is unique in its structure as both an honorific membership organization and an advisory organization. Established in 1970 by the National Academy of Sciences, IOM has become recognized as a national resource for independent, scientifically informed analysis and recommendations on health issues. Fewer than 2000 physicians are elected members, and just 70 US physicians are invited to join each year. The National Academy of Sciences was created by President Lincoln in 1863.

Katherine J. Gold, MD, MSW, MS, Selected as Puffer/IOM Fellow

The Institute of Medicine (IOM) has selected Katherine J. Gold, MD, MSW, MS, an Assistant Professor at the University of Michigan (UM) in the Department of Family Medicine and the Department of Obstetrics & Gynecology, as the 2013 James C. Puffer, MD/American Board of Family Medicine Fellow. She is board-certified in family medicine, and holds a Master in Social Work and a second Master in Health and Health Services Research. As a Puffer/ABFM/IOM Anniversary Fellow, Katherine is working with eminent researchers, policy experts, and clinicians from across the country as they collaborate on initiatives convened by the IOM to provide nonpartisan, evidence-based guidance to national, state, and local policymakers, academic leaders, health care administrators, and the public. She also receives a research stipend of $25,000. Named in honor of James C. Puffer, president and chief executive officer of the ABFM, the fellowship program enables talented, early career health policy and science scholars in family medicine to participate in the work of the IOM and further their careers as future leaders in the field.

After finishing her family medicine residency in 2005, Dr. Gold completed two research training fellowships, the Robert Wood Johnson Foundation Clinical Scholars Program and the NIH K-12: Building Interdisciplinary Research Careers in Women's Health/Physician Scientist Award program. She joined the faculty at UM in 2009. Prior to medical school she served as Senior Policy Analyst for the US Environmental Protection Agency working on transportation, climate change, and air quality.

Dr. Gold's research focuses on clinical and health services research on maternal and child health, concentrating on bereavement training for health professionals, perinatal mental health, and mental health and bereavement outcomes for families after stillbirth or infant death. She holds a K-23 career development award from the National Institutes of Mental Health to fund her Michigan Mothers Study, a longitudinal investigation examining the mental, physical, and reproductive health outcomes of perinatally-bereaved mothers. She was recently invited to join the Board of the International Stillbirth Alliance, the most prominent international organization promoting stillbirth prevention and bereavement research, and currently serves on its Science Advisory Board.

IOM Anniversary Fellows continue their main responsibilities while engaging part-time over a two-year period in the IOM's health and science policy work. A committee appointed by the president of the IOM selects fellows based on their professional accomplishments, potential for leadership in health policy in the field of family medicine, reputation as scholars, and the relevance of their expertise to the work of the IOM.

ABFM Convenes the DIF Review Panel

The ABFM 2013 DIF Review Panel. L to R: Michael Peabody, MA, Gaddiel Rios, MD, Karyn Mallett, PhD, Duane Dickens, MD, Joy Chesnut, MD, Marilyn Whitney, MD, Traci Edwards, MD, Thomas O'Neill, PhD.

Passing the MC-FP examination is intended to be a standardized process through which the examinee can demonstrate that he or she has at least the minimum knowledge expected of a board-certified family physician. Sources of bias that are not related to this purpose degrade the exam's ability to differentiate examinees who can demonstrate this level of performance from those who cannot. The ABFM's item development activities are designed to minimize such bias; however, an empirical test of the extent to which that intention has been achieved is warranted. To do this, the ABFM has begun using Differential Item Functioning (DIF).[1]

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.[2,3] DIF analyses are able to identify questions that manifest different levels of difficulty across subpopulations; however, DIF analyses cannot identify the source of the bias, nor can they determine whether the source of that bias is related to an important aspect of the construct, in this case, the practice of family medicine. For this reason, DIF is best 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. This group of SMEs should represent both genders and a diversity of ethnicity. Consequently, the ABFM devised a 3-stage process to address this concern. The first stage is conducting a DIF analysis to flag potentially

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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 that 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 item's final disposition—retain or send back to item development to be reworded or deleted.

On October 25 the ABFM convened a DIF Review Panel to review the 2013 items flagged for DIF. Across the many forms of the examination, there were a total of 1,017 scored items. Of these, 94 were flagged for review by the panel. There were five items that were flagged for more than one group.

Five SMEs were selected from Ohio, Indiana, Kentucky, and West Virginia. The panel received an orientation to DIF and an overview of the process. The panel spent the rest of the day reviewing the items. Of the 94 items reviewed, the panel found 15 items with an identifiable source of bias, and in 10 of the items the identified source was an important aspect of family medicine. The remaining five items were referred to the Examination Committee. When the Examination Committee meets in January 2014, it will review the recommendations of the DIF panel and make a final decision on whether an item is sent back to the ABFM content development department for revision/deletion or whether the item is permitted to stand.

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.

ABFM Support Center Holiday Hours (all times Eastern)

Christmas Coverage

Tuesday, December 24	Closed
Wednesday, December 25	Closed

The Support Center will maintain its regular schedule on all other days.
The Support Center will also be available every Sunday through December 29 from 12:00pm – 5:00pm.

New Year's Day 2014 Coverage

Tuesday, December 31	8:00am – 5:00pm
Wednesday, January 1, 2014	Closed

Contact us at 877-223-7437 or at help@theabfm.org

2013 Physician Quality Reporting System

Are you an eligible professional (EP) needing to participate in the Physician Quality Reporting System (PQRS) before the end of 2013? EPs satisfactorily report data to the Center for Medicare and Medicaid Services (CMS) on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries. Those EPs that do not report in 2013 will see a payment adjustment of -1.5% for their covered professional services beginning in 2015. The CMS website www.cms.gov/pqrs serves as the primary source for all information for PQRS.

To help you meet this CMS reporting requirement, the ABFM has qualified as an approved registry for the Physician Quality Reporting System since 2008. Diplomates are able to participate at no cost in the ABFM Diabetes PQRS registry online from their physician portfolio. The deadline for data entry in the online activity is January 10, 2014.

For the 2013 Physician Quality Reporting System, physicians who meet the 2013 PQRS criteria for satisfactory submission of quality measures on 20 unique patients, of which at least 11 are Medicare Part B beneficiaries, are eligible to earn an incentive payment of 0.5% of their total allowed charges for Physician Fee schedule (PFS)-covered professional services furnished during the reporting period (January 1, 2013 – December 31, 2013). CMS-approved financial incentives earned for 2013 reporting are scheduled to be paid in mid-2014 from the federal Supplementary Medical Insurance (Part B) Trust Fund. Again, the deadline to complete all necessary data entry for the 2013 Physician Quality Reporting is January 10, 2014.

Those physicians participating in the 2013 Physician Quality Reporting System should make certain the following three important details are accurate. First, make absolutely certain the National Provider Identifier (NPI) and Taxpayer Identification Number (TIN) numbers provided are accurate and associated with each patient for whom the data is submitted. If the NPI and TIN numbers are not accurate, an incentive payment will not be provided. For the 2012 reporting period, 10 ABFM participants missed out on incentive payments because the wrong TIN/NPI combination was provided. Second, make sure that at least 11 of the 20 patients included are patients covered under Medicare Part B. Those patients that are Medicare Advantage beneficiaries only do not qualify as part of the required 11 Medicare Part B beneficiaries. Third, the performance criteria must be met and reported for at least one patient for each diabetes mellitus measure. These helpful tips are offered to improve the chances to be eligible to receive an incentive payment. Physicians can review other frequently asked questions on our website at www.theabfm.org/moc/pqrs.aspx.

Diplomates also have the added opportunity to combine PQRS participation with their MC-FP activity. Basically, any Diplomate who successfully completes the 2013 Physician Quality Reporting System can continue the activity for MC-FP credit and CME credit by implementing a quality improvement plan along with a post-quality improvement data collection to complete the activity as a Performance in Practice Module (PPM).

To access the PQRS Diabetes registry, visit the ABFM website at www.theabfm.org, log in to your Physician Portfolio, and look under Spotlight Programs. If you have any questions about how to start taking advantage of the Physician Quality Reporting opportunity, please contact the ABFM Support Center at 877-223-7437 or at help@theabfm.org.

MC-FP Parts I – IV

Part I - Professionalism

The professionalism component of the ABFM Maintenance of Certification for Family Physicians (MC-FP) is designed to assess professional standing, which Diplomates are required to demonstrate continuously throughout the MC-FP process.

Fulfillment of this component requires Diplomates and candidates to meet the standards of professionalism, licensure, and personal conduct as detailed in the American Board of Family Medicine Guidelines for Professionalism, Licensure, and Personal Conduct in order to obtain and maintain certification. All currently certified Diplomates, as well as physicians seeking certification, are subject to this policy, including commissioned medical officers of the armed forces of the United States and medical officers of the United States Public Health Service or the Department of Veterans Affairs of the United States.

Among the specifics of the Guidelines, physicians are required to continuously hold an active, valid, full, and unrestricted license to practice medicine in any state or territory of the United States or any province of Canada, and all medical licenses held by the physician must be full and unrestricted, regardless of whether or not the Diplomate currently practices in the given state, territory, or province. Diplomates are required to retain a full and unrestricted medical license in the United States or Canada even if they are out of the country for extended periods of time. A physician's professionalism or personal conduct shall be called into question and reviewed by the Credentials Committee of the ABFM at such time as the physician is sanctioned by a legally constituted entity with control over aspects of a physician's practice of medicine, including, but not limited to, entities of the Federation of State Medical Boards, the US Drug Enforcement Administration, the Centers for Medicare and Medicaid Services, and Institutional Review Boards and Ethics Committees of Medical Schools, Hospitals, and Medical Clinics.

Failure to maintain compliance with the Guidelines for Professionalism, Licensure and Personal Conduct will result in the loss of ABFM certification and/or eligibility. Please note that we do not receive license data from other sources, and therefore it is necessary for our Diplomates to provide the information. To maintain your current licensure information with the ABFM, login to your Physician Portfolio and click the Medical License button to review/update all licenses held. If you have questions about license entry, the ABFM Support Center is available to answer your questions at 877-223-7437 or help@theabfm.org.

Part II – Self-Assessment and Lifelong Learning

This component of the ABFM Maintenance of Certification for Family Physicians process has two parts that allow Diplomates to assess specific areas of knowledge of their own choosing. The purpose is to enhance knowledge and skills in areas that are of interest in each Diplomate's practice.

First, Self-Assessment Modules (SAMs), categorized as Part II modules, can be accessed through the Physician Portfolio, and each module consists of two parts:

- **Knowledge Assessment**—an assessment of the Diplomate's knowledge in a particular domain. Each domain consists of core competencies that the Diplomate must master. In order to successfully complete the assessment, eighty percent (80%) of the questions in each competency must be answered correctly. If the Diplomate is not successful initially, he/she moves to a review mode, in which a critique and reference for each incorrectly answered question can be reviewed before inputting new answers to the missed questions. When the Knowledge Assessment is successfully completed, the Diplomate progresses to the computer-based Clinical Simulation.

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MC-FP Parts I – IV

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- **Clinical Simulation**—presents patient care scenarios corresponding to the topic chosen in the Knowledge Assessment. Simulated patients evolve in response to therapeutic interventions, investigations, and the passage of time, providing an opportunity for Diplomates to demonstrate proficiency in patient management skills, and to practice applying information required in the Knowledge Assessment.

Each Diplomate is required to complete a minimum of one Self-Assessment Module during each stage. Diplomates can access a module as many times as necessary to achieve successful completion. The ABFM-developed SAMs are awarded 15 MC-FP points in addition to 12 CME credits for successful completion.

Modules may be clustered within each Stage, meaning more than one module can be completed within a single year. As long as the required number of modules is successfully completed by the end of each Stage, the requirement will be met. Diplomates will not be able to work ahead to the next stage for MC-FP credit, but additional modules can be taken for extra CME credit.

Second, all Diplomates of the American Board of Family Medicine must meet the continuing medical education requirements before being allowed to take the MC-FP Examination. Additional CME required beyond that earned for completion of MC-FP modules/activities may be required.

Candidates last certified in years 2003-2010 will be required to earn 300 credits of acceptable CME accumulated during the six calendar years prior to applying for the examination. Credits earned for completion of MC-FP modules apply toward this requirement. CME credits must be submitted/verified by the published deadline for completing all application components. All CME credits are subject to final approval by the American Board of Family Medicine. Candidates may verify their CME either through membership in the American Academy of Family Physicians (AAFP) or by manual entry of CME activities in the online application.

Candidates last certified in 2011 & beyond will be required to earn 150 credits of acceptable CME for each stage of the MC-FP process. The CME credits can be entered through the Physician Portfolio, or if a member of the AAFP there will be continued communication between the AAFP and ABFM to automatically exchange CME data.

Part III – Cognitive Expertise

This component of ABFM Maintenance of Certification for Family Physicians (MC-FP) process involves the successful completion of a cognitive examination. It is a test of cognitive knowledge and problem-solving ability relevant to Family Medicine.

The ABFM MC-FP Examination contains multiple-choice (one best answer) questions and is the same for certification and recertification candidates. The examination is computer-based, a full day in length, consisting of a morning and afternoon session (with a lunch break in between). Candidates must satisfactorily complete the application process including MC-FP requirements before being approved to take the cognitive examination. Diplomates who are unsuccessful on the cognitive examination by the end of the MC-FP cycle will lose certification.

The examination is currently administered in April and November. The fall examination has limited seating and is primarily for those physicians who were unable to take the spring examination and for off-cycle residents who did not complete training in time to take the spring examination. In addition, candidates who are unsuccessful on the April administration can apply to retake the examination in the fall. There is no limit to the number of times a candidate may take the examination, provided qualifications are met with each reapplication.

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MC-FP Parts I – IV

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Part IV – Performance in Practice

This component of ABFM MC-FP assesses a Diplomate's competence in systematic measurement and improvement in patient care. There are four pathways to consider for Part IV credit, depending on a physician's work environment.

If a physician provides continuous patient care, consider the following quality improvement (QI) activity types:

Performance in Practice Modules (PPMs)—These are board-developed activities that are web-based. They are generally topic specific and considered a solid, basic introduction to QI. These modules can be accessed by logging in to the Physician Portfolio. Participants should allow a minimum of two weeks to complete these activities.

Approved Alternative Part IV Activities—These are board-approved activities that are developed by external providers. There is a wide range of activities, from diabetes to osteoporosis to maternal depression. Information about these activities, and about participating in these activities, can be accessed by using the link provided in the Physician Portfolio or at https://www.theabfm.org/moc/partivact.aspx. These activities require anywhere from one month to more than a year to complete. The ABFM's Part IV options also include activities conducted within the multi-specialty portfolio approval program.

Self-Directed QI Efforts—There are two pathways for this option, which allow physicians to have QI efforts that have not been developed by the board considered for the Part IV requirement: the American Board of Internal Medicine (ABIM) web-based Self-Directed Practice Improvement Module (PIM), and the ABFM application process for a Self-Directed QI Effort. Both options can be accessed through the Physician Portfolio. Participants should allow six to eight weeks for applications to be reviewed and approved.

If a physician does not provide continuous care, or no longer sees patients, consider the following QI activity types:

Methods in Medicine Modules (MIMMS)—These are board-developed or board-approved activities that do not require patient data. These activities can be accessed by logging in to the Physician Portfolio. Participants should expect to allow several days to complete these activities.

Self-Directed QI Effort.—This pathway allows physicians to have QI efforts relevant to their work context considered for the Part IV requirement. This involves submission of an application to the ABFM for approval of a Self-Directed QI Effort. This option can be accessed through the Physician Portfolio. Participants should allow six to eight weeks for applications to be reviewed and approved by the ABFM.

Diplomates are required to complete a minimum of one Part IV activity during each MC-FP stage. Participants who successfully complete a PPM, a MIMM, an Approved Alternative Part IV Activity, the ABIM PIM, or a Self-Directed QI Effort, will receive MC-FP credit for 1 Part IV module or 20 Part IV points, as appropriate.

For more information about available Part IV options, visit https://www.theabfm.org/moc/partivact.aspx or contact the support center at help@theabfm.org.

For more information about QI efforts and how to develop one, see the following article: "What is a Part IV Activity and How Do I Do One?" in this edition of the Phoenix.

Our data indicates that most Physicians complete either an ABFM PPM or an externally approved Part IV module:

Total Part IV modules completed:	81267	
ABFM PPM:	45358	55.81%
External Part IV modules:	35858	44.12%
ABFM Self-Directed PPM:	31	0.04%
ABIM Self-Directed PIM:	20	0.03%

What is a Self -directed Part IV Activity and How Do I Do One?

QI efforts can be very large, complex, high investment (both cost and manpower) undertakings, but they also can be simple and straightforward, as we hope the following guide illustrates.

Part IV focuses on assessing your practice with the goal of improving the care you provide patients; or, if you do not see patients, assessing your work context with the goal of improving your work processes. In very basic terms, it means identifying a problem, looking at relevant data, setting an improvement goal, identifying an intervention, developing and implementing a quality improvement (QI) plan, looking at data again, tweaking and repeating as necessary, and reflecting on the process.

Most physicians do some, if not all, of this in their practices now. With the requirements of insurance companies, the Center for Medicare and Medicaid Services (CMS), and Maintenance of Certification by the medical specialty boards, deliberate QI is inevitable.

Identify a Problem. How do physicians identify QI topics that are relevant to their practices? No doubt physicians are reading medical journals, reference books, and websites, so they could use current literature, research, and even guidelines to help determine a gap in their practice. Perhaps you read the Institute of Medicine (IOM) report "Relieving Pain in America,"[1] and it made you wonder how your chronic pain patients compare with others, and if there is something you could or should be doing differently in your practice to improve their care.

What is the quality gap in your practice? A quality gap is the difference between something (maybe a process or an outcome) in your practice and what potentially could be obtained in your practice, based on current professional knowledge and benchmarks from other organizations.

According to the IOM report, more than 100 million Americans suffer with chronic pain, many going untreated; it costs society up to $635 billion annually. The occurrence of pain and effective treatments for pain vary by patient. The report goes on to say that pain "is much more than a biological phenomenon and has profound emotional and cognitive effects" (p. 2). One of the report's recommendations is to "provide consistent and complete pain assessments." Recommendation 3-6 states that, "health care providers should provide pain assessments that are consistent and complete and documented so that patients will receive the right care at the right place and the right time." The recommendation goes on to say that:

- Pain assessment should focus on soliciting a careful history of the pain experience, the impact of pain on functioning and quality of life and emotional suffering, and the patient's goals and values.
- Pain assessment should be multifaceted and include self-report, observations by significant others, and careful examination by the health care provider (p. 165).

Is this something you do in your practice? Do you have a standardized tool? Do you use it regularly? Maybe you think you do, or maybe you are not sure. How do you find out?

Assess Relevant Data. How do you collect and document relevant information about your patients? You need to identify what to measure and how to measure it. There are several resources for identifying nationally-endorsed measures, such as those from the National Quality Forum or the Physician Consortium for Quality Improvement. Keep in mind that QI efforts should use at least two or three nationally-endorsed measures (although for some topics, nationally-endorsed measures may not be available).

For example, accessing the National Quality Measures Clearinghouse (NQMC) website[2] and doing a search on "chronic pain" produces a long list of measures, but there are two in particular that are of interest:

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- Assessment and management of chronic pain: percentage of patients with chronic pain diagnosis with documentation of a pain assessment completed at initial visit using a standardized tool that addresses pain intensity, location, pattern, mechanism of pain, current functional status and follow-up plan (NQMC: 007423).[3]

- Major depression in adults in primary care: percentage of patients with chronic pain with documentation of screening for major depression (NQMC: 007598).[4]

If you have an electronic health record (EHR), you may be able to pull data straight from your EHR—if you have captured it. Otherwise, you will need to do a manual, random chart review of patients meeting the measure criteria.

Set an Improvement Goal. Once you collect and review your data, you can use this information to establish the project's aim and determine a reasonable improvement goal. The aim statement should be specific, time limited, and measurable. In this case, the aim statement might be:

> Within six months, improve by 25% the number of adult patients presenting with chronic pain who have documentation of a pain assessment and screening for depression.

When determining the aim of your effort, keep in mind that several factors can impact the duration of your effort and your overall improvement goal. If you see only a few chronic pain patients every month, it may take a year or more to see enough patients to assess your QI effort. If you set a high improvement goal, it may take numerous tests of change to reach the desired outcome.

Assemble a Team, and Identify Interventions. The next steps are to assemble your improvement team and identify possible interventions to improve your practice. You should include on your team people who are knowledgeable about the issue, who will support the effort, and who are motivated to make it a success. This might simply include your office staff. The team should work with you to identify and vet interventions, and to develop a QI plan and implement the interventions you choose.

The obvious intervention is identifying standardized tools to assess patients. Results from an internet search for "chronic pain assessment" include an Institute for Clinical Systems Improvement (ICSI) guideline called "Assessment and Management of Chronic Pain."[5] The guideline includes several assessment tools, including the Brief Pain Inventory (BPI) (short form) and the Patient Health Questionnaire (PHQ-9)—though you may consider the PHQ-2 as a starting point for the depression screening. Also of interest is a Personal Care Plan for Chronic Pain, which could be another useful tool (although not necessarily related to this effort).

There may be other tools available that are better suited to your practice environment or your patient population, so do not stop searching with first thing you find, and have your team search as well. Then discuss as a group the pros and cons of the tools found. You each will have different perspectives on what might work best, and may find that creating your own form by pulling elements from various tools you found would work best.

Develop and Implement a QI Plan. To develop your QI plan, consider using PDSA (Plan-Do-Study-Act) cycles or another similar process. You can do an Internet search and easily find PDSA worksheets and information about how to use them (the IHI Knowledge Center website[6] can be very helpful with this process).

Plan. What do you want to accomplish? How do you want to implement the intervention? In this case, the care team needs to consistently and effectively use the patient assessment tools for chronic pain patients. But what is the best way to accomplish this goal? First, you may consider training for the staff on the importance of the tools and how to use and score

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them correctly. Do you want the nurse or MA to identify which patients will need the forms each morning? Do you want the receptionist to give the BPI form to patients as they check in, or have the nurse or MA give the form to patients as they are roomed? The form can be collected, reviewed, and scored prior to seeing the patient, but who will be responsible for this task? When you are with the patient, will you incorporate the PHQ-9 (or PHQ-2) as part of reviewing the patient's pain tool? After the patient encounter, who will be responsible for adding the tools to the patient's record so they can be used to monitor progress and treatment success? Whatever process is decided upon, it should be a documented workflow that all impacted are aware of and able to follow.

Do. Now implement the plan. Be sure everyone makes note of issues or problems they encounter with the process or the tools. Have a set time to pause and take a look at your plan. You may be able to tell quickly if a process or intervention is effective or has flaws, or it may take a while.

Study. Collect data for the same measures originally assessed and then come together as a group to reflect on the effort. Was the process/intervention effective? What barriers were encountered? Were there issues with the implementation of the effort? Were there problems with the assessment tools? Did all necessary parties buy into the effort? Did you reach your improvement goal?

Act. This is where you tweak and repeat (if necessary). Based on what you have learned thus far, what changes need to be made to the process or the tools? What should you do differently, and does that change your expectations for the effort? Make any necessary modifications and Do again.

Once you complete a PDSA cycle (or two or three), you have satisfied the ABFM Part IV requirement. We require that you collect baseline and post-intervention data, but your project may be more effective if you collect data multiple times and reevaluate or tweak your plan or interventions. You can create a visual tool, such as a "run chart" in Excel, to help monitor the progress of your effort.

Reflection. Reflect on how the QI effort impacted your practice and the care you provide patients. This should consist more than just a review of data; you should think about how this effort impacted your care team, your work environment, and your patients. Was it an eye-opening experience that you want to expand into other areas of your practice, or was it disappointing? In either case, why? Finally, what QI effort will you consider next? Keep in mind that other models such as Six Sigma and Lean exist, which you can find referenced on the internet.

The ABFM is always looking for new avenues for granting Part IV credit to physicians. We offer the ABFM-developed Performance in Practice Modules (PPMs), and there are many approved alternative activities through various organizations. In addition, the self-directed pathway allows physicians to receive Part IV credit for QI efforts they develop.

For more information on ABFM Part IV modules and alternate activities, please visit https://www.theabfm.org/moc/part4.aspx or call our Support Center at 877-223-7437 or email help@theabfm.org.

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ATTENTION: Diplomates Who Certified in 2004

Diplomates who certified or recertified in 2004 are required to complete three MC-FP modules for Stage Three: one Part II module (SAM), one Part IV module (PPM, MIMM, or approved Part IV alternative), and one additional module of choice (Part II or Part IV).

Diplomates planning to take the MC-FP Exam in April 2014 may open and begin an examination application as of December 6, but until MC-FP requirements are met, the application cannot be cleared and finalized. Test centers and dates may not be chosen until an application is complete.

ATTENTION: Diplomates Who Certified in 2007

Diplomates who certified or recertified in 2007 are required to complete three MC-FP modules for Stage Two by December 31, 2013 in order to remain eligible for the 10-year certification path. For Stage Two requirements, Diplomates are required to complete one Part II module (SAM), one Part IV module (PPM, MIMM, or an approved alternative), and one module of choice (Part II or Part IV).

Diplomates who do not complete Stage Two requirements on schedule will continue on the 7-year certification path. The 7-year cycle requirements include 3 SAMs (Part II), 1 PPM (or approved alternate Part IV activity) and 3 additional modules (your choice of Part II or Part IV), which must be completed either prior to or during the application process for the next exam. To guarantee your eligibility for the 10-year certification, you must successfully complete required MC-FP modules by the end of 2013.

ATTENTION: Diplomates Who Certified in 2010

Diplomates who certified or recertified in 2010 are required to complete three MC-FP modules for Stage One by December 31, 2013 in order to remain eligible for the 10-year certification path. For Stage One requirements, Diplomates are required to complete one Part II module (SAM), one Part IV module (PPM, MIMM, or an approved alternative), and one module of choice (Part II or Part IV).

Diplomates who do not complete Stage One requirements on schedule will continue on the 7-year certification path. The 7-year cycle requirements include 3 SAMs (Part II), 1 PPM (or approved alternate Part IV activity), and 3 additional modules (your choice of Part II or Part IV), which must be completed either prior to or during the application process for the next exam. To guarantee your eligibility for the 10-year certification, you must successfully complete required MC-FP modules by the end of 2013.

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