Schmidt noted that she had thought her further training to become a doctor would be easy because she had already undergone the training to be an NP. It wasn't until she got into the program that she realized how much she did not know about the underlying causes of disease processes.

NPs Are Not Physicians

Most proposals that would allow NPs to practice independently come in response to the ongoing shortage of primary care physicians, according to the AAFP report. However, "Substituting NPs for doctors cannot be the answer. Nurse practitioners are not doctors, and responsible leaders of nursing acknowledge this fact."

In fact, Kathleen Potempa, PhD, RN, dean of the University of Michigan School of Nursing and president of the American Association of Colleges of Nursing, said in a *New York Times* article that, "Nurses are very proud of the fact that they're nurses, and if nurses had wanted to be doctors, they would have gone to medical school."

"Dr Potempa is right—nurse practitioners do not have the substance of doctor training or the length of clinical experience required to be doctors," says the AAFP report.

The AAFP calls for filling the primary care gap by a continued transition to team-based care in medical homes "with all health professionals playing valuable and appropriate roles."

"Studies show the ideal practice ratio of NPs to physicians is approximately 4 to 1," the report says. "With PCMHs built around that ratio, everyone can have a primary care doctor and receive the benefits of team-based care."

Controlling Costs

The report also dismisses claims that substituting NPs for primary care physicians results in lower costs. It cites a study in *Medical Care Research and Review* that says "the evidence that role revision increases health care efficiency or lowers costs is weak and contradictory."

"Health care planners need to be alert to the possibility that, while nonphysicians cost less to employ than physicians, savings on salaries may be offset by lower productivity and less efficient use of nonstaff resources," says that study.

The AAFP report, meanwhile, acknowledges that "the cost of health care continues to be a major hurdle for our nation."

"While there is no silver bullet, there is growing evidence that the PCMH model—which emphasizes improved access to more robust primary care teams—can reduce total costs," says the AAFP, pointing to a recent report by the Patient-centered Primary Care Collaborative that provides "34 examples of private insurance companies, state and federal entities implementing the PCMH model and finding 'outcomes of better health, better care and lower costs are being achieved.'"

The bottom line, according to Goertz, is that the AAFP is saying the PCMH model and its concepts are the right way to move forward with care in this country. Independent practice standards for NPs vary from state to state, but PCMH standards do not, said Goertz, adding that independent practice for NPs is not the right model with which to move into the future of health care.

AAFP News Now staff

From the American Board of Family Medicine

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KNOWLEDGE ASSESSMENT RESPONSES IN THE ABFM SELF-ASSESSMENT MODULES (SAMS)

ABFM introduced self-assessment modules (SAMs) in 2004 with the implementation of Maintenance of Certification for Family Physicians (MC-FP.) The SAMs consist of a 60-item knowledge assessment (KA), including multiple choice, multiple true/false, and fill-in-the-blank formats with references, followed by a clinical simulation keyed to the KA content.[1] The KA items are organized according to competencies (eg, pharmacologic therapy, non-pharmacologic therapy, etc) defined during the SAM development process. ABFM currently offers SAMs covering asthma, care of the vulnerable elderly, cerebrovascular disease, early childhood illness, coronary artery disease, depression, diabetes, health behavior, heart failure, hypertension, maternity care, mental health in the community, pain management, preventive care, and well child care. A SAM covering hospital medicine will be available in September.

During the first few months of use, Diplomates tended to spend substantial time reading and studying the associated reference material prior to engaging the KA items. This approach led to quite lengthy SAM sessions for a number of Diplomates —an average of nearly 10 hours on the hypertension KA[1]—which led ABFM staff to recommend to participants that they take the KA "cold" (ie, without preparation) the first time through. Following this "first pass," Diplomates receive feedback and critiques for the missed items,

Table 1. Knowledge Assessment (KA) Results

Module Name	Percent First Response Correct
Asthma	39
Care of Vulnerable Elders	43
Cerebrovascular Disease	40
Childhood Illness	36
Coronary Artery Disease	40
Depression	40
Diabetes	40
Health Behavior	42
Heart Failure	54
Hypertension	15
Maternity Care	36
Pain Management	41
Preventive Care	35
Well Child Care	38

which facilitates success on subsequent attempts. To successfully complete the knowledge assessment, Diplomates must correctly answer 80% of the items in each competency area.

ABFM purposefully creates the SAMs to present an in-depth and challenging exposure to the content area. The information technology (IT) platform allows the Board to capture and retain success rates on Diplomates' first-pass attempts. IT staff have recently queried these results for all SAMs completed since 2004. The lowest average (15%) occurred with hypertension; the highest (54%) occurred with heart failure. The median for all the SAMs was 40%. The results for all of the KAs appear in Table 1.

The results demonstrate that the KAs do indeed represent challenging material, as intended. Interestingly, in spite of the hypertension module's apparent difficulty, this SAM is the 2nd most popular offering: as of the end of August 2012, Diplomates have completed nearly 42,000 hypertension SAMs (the diabetes SAM tops the list at 44,445 modules completed.)

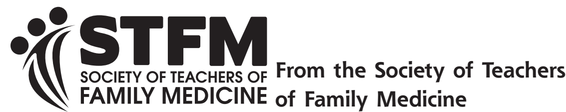
Also, the recommended first-pass approach has anecdotally decreased substantially the time needed to complete the knowledge assessments (Gary Jackson, personal communication 8/31/2012.)

The SAMs represent in-depth coverage of their respective content areas. Over the years since introducing MC-FP, ABFM has created a fairly broad portfolio of topics, but has several additional offerings in the planning stages. In particular, we plan to develop in the coming year modules related to care transitions and medical genomics. Rest assured that these additional offerings will continue the tradition of up-to-date, in-depth, and challenging coverage of the subjects!

Michael D. Hagen, MD

References

1. Hagen MD, Ivins DI, Puffer JC, et al. Maintenance of certification for family physicians (MC-FP) self assessment modules (SAMs): the first year. *JABFM.* 2006;19(4):398-403.



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AT STFM, RESEARCH IS A PRIORITY

STFM is focusing on innovation and research in medical education. So much so that Scholarship and Innovation is 1 of STFM's 5 strategic priorities.

"Fostering an active culture of inquiry, including training a cadre of clinical researchers, is a key task for today's family medicine educator," said CERA Co-chair Major Dean Seehusen, MD, MPH, Fort Belvoir Community Hospital, Fort, Belvoir, Virginia. "STFM is working hard to give educators tools to accomplish that task."

Each year, STFM invests financial resources, along with member and staff time, to advance scholarship through the following initiatives:

Family Medicine

STFM's flagship journal publishes the latest research and commentary on medical education. For more than 30 years, *Family Medicine* has published innovative, quality contributions from authors in a variety of specialties and academic fields.

Annals of Family Medicine

STFM is the third largest financial contributor to *Annals*, which publishes original clinical, biomedical, social, and health services research.

Grant Generating Project

STFM is 1 of 3 financial partners in the Grant Generating Project (GGP). The GGP equips family medicine researchers with skills to successfully develop and submit grants for research funding. With its emphasis on critical thinking, analysis, and writing, GGP provides training that can be generalized to other grant-writing projects and scholarly writing activities.

CAFM Educational Research Alliance (CERA)

STFM, along with the other Council of Academic Family Medicine organizations, developed CERA to set within family medicine a standard for medical education research that is rigorous and generalizable.