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THE EVOLUTION OF MAINTENANCE OF CERTIFICATION FOR FAMILY PHYSICIANS (MC-FP) PART IV, PERFORMANCE IN PRACTICE

With the first recertification examination offered by the American Board of Family Medicine (ABFM) in 1976, the board required a patient record review to assess performance in practice. The initial records reviews required physicians to assess 4 patient records in each of 5 disease categories; these audits were independently scored by the family medicine department at the University of Iowa for the first several years. In 1983, the requirement was changed to assess 3 patient records in each of 2 disease categories. For the reviews, physicians audited individual patient charts and recorded approximately 100 items for each. In turn, the board analyzed these data, then provided their individual performance data and peer comparisons to Diplomates, as well as a reference guide (which was a monograph that comprised a current review of the particular audit categories selected) and feedback with suggestions for improving performance. This process remained largely unchanged for 20 years.

In the late 1990s, the Institute of Medicine (IOM) released 2 seminal reports on patient safety, *To Err is Human*¹ and *Crossing the Quality Chasm*,² that heightened concern among constituencies such as the government, insurance companies, and advocacy groups, over medical errors and quality in care. In response to these concerns, in 2000 the member boards of the American Board of Medical Specialties (ABMS; the parent body for the ABFM) adopted a formal process for continual professional development called Maintenance of Certification (MOC), which includes a performance-in-practice component (Part IV).³

Performance in practice. What does that mean? The board defines it as “assessing a Diplomate’s competence in systematic measurement and improvement in patient care.” Clearly, this means more than simplistic patient record review and feedback process that the board used previously.

When physicians review performance data, awareness of their performance can result in improvement⁴; however, improvements, if not associated with system-

atic changes in practice, likely will diminish over time.⁵ The performance-in-practice component of Maintenance of Certification for Family Physicians (MC-FP) is designed to deliberately support behavior or practice changes that produce sustainable improvements in patient care. By periodically assessing performance, setting an improvement goal, developing a plan for change, and implementing evidence-based improvements into practice (the Plan-Do-Study-Act cycle, or other quality improvement methodology),⁶ physicians can systematically and sustainably improve the care they provide to patients. By completing this process as part of maintaining board certification, the board strives to assure the public that certified Diplomates possess the ability to identify shortcomings in practice and make substantive improvements to patient care.

In accord with the IOM reports’ pleas for improvement in health care processes, not just measurement, the board’s Performance in Practice Modules (PPMs) were designed as a basic introduction to quality improvement, providing the tools and resources necessary to develop and implement a quality improvement plan. Between 2003 and 2009, the board developed 6 topic specific modules (asthma, coronary artery disease, depression, diabetes, heart failure, and hypertension) and 1 comprehensive module (which focused on preventive care measures across all ages and both genders). They were intentionally designed to represent a basic introduction to quality improvement methodology, with the understanding that many health care organizations had already undertaken meaningful quality improvement work—efforts that in many cases represented more sophisticated approaches than those demonstrated in the PPMs—and, going forward, we would need to develop a pathway for physicians to earn MC-FP credit for participating in these valuable activities.

In 2005, we began to develop an external provider pathway. Sponsors (eg, large practices, health systems, hospitals) that had implemented meaningful, structured quality improvement activities could apply to have single efforts considered as alternatives to the PPMs. Currently, between 20 and 25 programs apply each year. And in 2008, we began working with the American Boards of Internal Medicine and Pediatrics to develop a pathway for sponsors that run multiple activities, which might involve multiple medical specialties, to create portfolios of activities that could be accepted as alternatives to the PPMs (the Multi-Specialty MOC Portfolio Approval Program; currently 17 ABMS member boards participate, 31 sponsor organizations have been approved, and 494 activities have been submitted [154 activities with family physician participation]).

These pathways have served as an excellent resource for our Diplomates. Each year, the portfo-

lio of approved activities has grown, and thousands of physicians have been able to satisfy their MC-FP requirements using activities that relate more clearly to their practice contexts than the PPMs.

Even as these pathways took off and thrived, ABFM staff recognized that our current offerings overlooked another avenue for obtaining MC-FP Part IV credit. Many individual physicians participate in or develop quality improvement efforts that are not part of a larger organization or that have not been submitted to the Board for consideration as an approved alternative activity. To accommodate these activities, in 2011 we began to develop a self-directed pathway that would support both clinical and non-clinical activities (depending on the physician's work context) being considered for a Diplomate's Part IV requirement. The self-directed pathway enables physicians to describe specific quality improvement work they have undertaken. The activities must meet the same standards and meaningful participation requirements as any other Part IV activity, but this pathway offers Diplomates the flexibility to develop or participate in activities that relate more clearly to their practice environment. To date, more than 200 Diplomates have chosen this option to satisfy their Part IV requirement.

As the discipline of family medicine evolves, the need for more diverse, innovative avenues to assess performance in practice increases. We currently plan for a second-generation PPM that will provide a more user friendly and robust process, and are exploring

other areas for alternative credit. These changes and new pathways notwithstanding, the Board's fundamental mission remains unchanged: to assure the public that board-certified family physicians possess the knowledge, skills, and professionalism necessary to provide the highest quality of care.

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