part of the solution." He noted that family physicians do, in fact, prescribe a lot of opioids because 1 out of every 5 visits to a medical office is to a family physician's office. "Who better to recognize and treat pain than the family physician who knows the patient in the context of their entire situation?" asked Meigs. "The opioid crisis is a very complex problem with no simple remedy. No legislative mandate is going to correct this problem," he added. The answer, he said, is not to avoid prescribing these drugs, but to prescribe wisely and carefully. "If you are going to prescribe and treat pain, then educate yourself and do it properly and safely," said Meigs. He reminded family physicians of the myriad of learning opportunities on the topic that were available at FMX.

Meigs spoke most passionately about legislative interference into the business of medicine. "I want legislators, bureaucrats, administrators, bean counters, and insurance company executives out of my exam room," he said, drawing sustained applause from his colleagues. He called the exam room a sacred place of trust, empathy, and compassion between a family physician and his or her patients. "Please note," Meigs added, "I still treat patients. I don't have clients. My patients are people with needs and concerns, not business opportunities. The exam room is no place for outside interference about what we ask about, talk about, discuss, or treat."

Meigs also promised an Academy focus on workforce issues. "We will advocate for GME funding reform based on the nation's physician workforce needs. We need to raise the awareness, understanding, and the confidence of medical students to choose a career in family medicine," said Meigs. He also pledged to address the "systemic, structural, and even cultural obstacles" in the current world of health care so that family physicians can once again "enjoy a sustained and fulfilling career in family medicine."

Lastly, he mentioned diversity, health equity, and the social determinants of health—issues that are of critical importance to all patients in all communities across the country. "I have outlined where I think our energy, effort, and engagement will be needed this coming year. Our work is important, our patients are depending on us, our country needs us," said Meigs. The AAFP must repeat that message again and again until everyone hears it.

"I'm going to give you my honest, best effort to make things better," said Meigs. "I am a family physician."

Sheri Porter
AAFP News *Department*

From the American Board of Family Medicine

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A MESSAGE FROM THE ABFM PRESIDENT

Feedback is critically important in helping the American Board of Family Medicine (ABFM) continuously improve the assessment tools that we use in our certification process. We used data from the evaluations provided after Diplomates complete self-assessment activities to determine that the clinical simulations were not as useful as the knowledge assessments in helping family physicians improve their practices. This information led to our decision to no longer make the clinical simulations a mandatory part of the self-assessment and lifelong learning component of continuous certification. Accordingly, we uncoupled the clinical simulations from the knowledge assessments this past July.

This uncoupling required several months of recoding the programs that drive self-assessment activity on our website. Because we were making these major changes, we thought it time to make several other important changes in response to feedback as well. We have consistently heard since we introduced maintenance of certification almost 15 years ago that we have made the certification process too complicated and unwieldy. Prior to the initiation of this new paradigm, the certification process was rather straightforward. A family physician took the initial certification examination, and after passing it, he or she maintained a full, valid, and unrestricted medical license, accumulated 300 continuing medical education credits, and completed the computerized office record review—retrospectively auditing 2 charts each for 1 acute and 1 chronic medical condition—before taking the exam again 6 or 7 years later.

Although the new maintenance of certification process replaced the computerized office record review with online modules to facilitate more efficient completion of quality improvement activities and added new self-assessment modules, our overarching, integrated approach to continuing certification changed little. We complicated it, however, with all sorts of new terminology and acronyms—Parts I, II, III, and IV, SAMS, PPMs, MIMMs, and the like. As if that were not enough, we had multiple payment plans that changed several times over the past 15 years resulting in multiple permutations of payment methodology that are dependent on when a Diplomate transitioned into this new process!

That all changed in July 2016. When Diplomates logged on to our website after July 21st, they would have noticed all of this confusing terminology had gone away. We have replaced it with language that we think more accurately reflects our continuing integrative approach to the certification process. The activities that Diplomates will complete to continue their certification have been renamed to accurately describe what they are. To increase flexibility to meet requirements for continuous certification, all of these activities will be assigned a point value. Diplomates simply need to accumulate 50 points every 3 years with the completion of at least 1 knowledge self-assessment, at least 1 performance improvement activity, and any other activities of their choosing to reach this point total. Although about one-half of our Diplomates are familiar with this point system, the other half are not because they have not yet transitioned into the continuous certification process. We have provided a detailed crosswalk for those not familiar with the process to help them effortlessly move into the new point system.

Payment has been simplified as well. The previous methodology was confusing, because it seemed that payment was associated with paying for a module. In fact, Diplomates were paying a process fee that amortized the total cost of certification (including the examination) over their entire certification cycle and depended on whether they chose a 7- or 10-year option. Now everyone will simply pay that same amount on an annual basis. Once the annual fee has been paid, Diplomates can undertake and complete as many activities as they like. If they find that they don't like a particular module, they can quit and try another module that may be more to their liking at no additional cost. Because many like to prepay their fees, we have reinstated the ability to do that as well. As previously announced, we have also implemented the 50% discount for Diplomates aged over 70 years that will be retroactive to the beginning of this calendar year.

We hope that these changes will simplify and make the certification process more efficient, but more importantly, we hope it underscores that certification is a continuous process that begins in residency training and continues throughout a family physician's professional career. This was the original intent of those that founded the Board in 1969, and we hope to make that more explicit as we move forward. As many know, we have other initiatives underway to further simplify and reinforce this principle. This includes the recent rollout of our registry, PRIME, that many have already begun to utilize, as well as our recent announcement to release in early 2017 the continuous knowledge self-assessment activity and the new performance improvement platform integrated with PRIME. We will also be announcing changes to the format of the examination and describing the data that our Board of Directors used to mandate those changes at the end of this year.

We realize that these changes will necessitate "unlearning" old terminology and acquainting oneself with new language, but we believe that the ultimate goal of simplifying the certification process will justify these changes. As always, we welcome the feedback of our Diplomates; it has been critical in allowing us to continue to improve the certification process so that it is both meaningful and efficient.

James C. Puffer, MD
President and Chief Executive Officer
American Board of Family Medicine

From the Society of Teachers of Family Medicine

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STFM RESPONDS TO COMMUNITY PRECEPTOR SHORTAGE

Primary care clerkship directors are finding it increasingly difficult to obtain clinical training sites.[1]

To begin to address this challenge, STFM is implementing new initiatives to:

- Decrease the percentage of primary care clerkship directors who report difficulty finding clinical preceptor sites
- Increase the percentage of students completing clerkships at high-functioning sites

Quantifying the Quality Issue

In order to determine the quality of current clerkship experiences, STFM developed research questions for a Council of Academic Family Medicine Educational Research Alliance (CERA) survey. The survey asked family medicine clerkship directors:

- Using either actual data or your best estimate, what percentage of your students complete their family medicine clerkships at preceptor sites that:
  - Have patient-centered medical home (PCMH) or similar practice transformation recognition?
  - Provide comprehensive care, including obstetrical care (OB)? Comprehensive care is defined as inclusion of both acute and chronic care, preventive services, end-of-life care, care at all stages of life, and obstetrics.
  - Provide comprehensive care, without obstetrical care (OB)? Comprehensive care is defined as