A Message from the President

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It is hard to believe that I have completed my 16th year at the American Board of Family Medicine (ABFM). Time has passed quickly as I and our incredible staff became immersed in the task of transforming this organization from one that simply delivered an examination on the second Friday of July each year to one that has become heavily invested in helping family physicians provide the very best care to their patients. The journey has been an exciting one, and I have come to work each day enthused about the continuing transformation of our organization into one which not only helps family physicians provide high-quality care, but also gathers data to better inform others about the important work that they do on behalf of their patients.

We gather these data from several sources. One of the most important has traditionally been the demographic survey that is completed when family physicians apply to take one of our examinations. These data have been invaluable in helping us better understand what they actually do in practice so that we can continuously improve the assessment tools that we use to help them provide better care. However, the data serve other useful purposes as well. Perhaps the best example of this was the use of the data by the American Academy of Family Physician's (AAFP) Robert Graham Center to inform rule making after passage of the Affordable Care Act in 2010 for the Primary Care Incentive Payment. Graham Center research using ABFM data convinced the Centers for Medicare and Medicaid Services to include most rural-based family physicians who otherwise would have been penalized for providing broad, full-scope care to their patients. That is, they would have been precluded from receiving the primary care bonus written into the Act based on the limited CPT code methodology on which eligibility for the bonus was being determined.

We have rapidly expanded the data sets that we are gathering to provide additional information about the specialty. These have included the Milestones data that we receive from the Accreditation Council for Graduate Medical Education (ACGME) for every family medicine resident in training, and data from the Resident Graduate Survey, developed and administered in collaboration with the Association of Family Medicine Residency Directors (AFMRD), that characterizes the work of recently graduated family medicine residents. Important examples of the use of these data sets include recently published reports on burnout among family physicians, the changing nature of the scope of practice of recently graduated family physicians, and the powerful and long-lasting imprinting that occurs as a function of the environment in which family medicine residents train.

These data are also used to document the effectiveness and utility of assessment tools that we have created for use in the Family Medicine Certification process. We have reported on the data shared with us in the evaluations of the Performance in Practice Modules describing the relevance and clinical utility of these modules in practice, and we have also published similar data for the Clinical and Knowledge Self-Assessment modules, showing how all these tools have improved quality of care. However, we have just begun to harness the power of these data.

The PRIME registry now has nearly 4 million patients and these data, under approved research protocols, are extremely powerful for research, such as helping develop better case-mix adjustments for primary care payment. As a Qualified Clinical Data Registry, we can also develop, test, and propose better primary care quality measures. We strongly believe that the quality measures that are currently in use are sorely insufficient in accurately and effectively measuring the quality of care that family physicians deliver to their patients. They provide little information on how the cornerstones of family medicine—comprehensiveness, continuity, first contact care, and care coordination—improve the quality and reduce the cost of

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care that family physicians provide to their patients. The data described above will be used to validate the importance of these measures and the influence they have on helping all us to achieve the "Quadruple Aim." We have proposed a new measure for continuity of care for use in the PRIME registry in 2018 and will propose a comprehensiveness measure for 2019.

To use these data effectively, we must catalog them, archive them, know how to readily access them, and guarantee their integrity. This has required significant investment in the development of a new enterprise data management strategy that we embarked on 18 months ago. Using outside expert consultants, we underwent rigorous self study and assessment of our current data management strategies and are now embarking on the second phase of the project that will restructure and streamline our data management operations.

The management of these data and their prudent use require considerable resources; we have our Diplomates to thank for allowing us the ability to do so. When we first envisioned the transition from our old recertification paradigm to the current model of continuous certification, we utilized historic data about participation in the recertification process to develop our business plan. That data demonstrated that approximately 75% to 80% of family physicians that either initially certified or recertified in a given year returned 7 years later to recertify. We expected considerable pushback in the transition to our new model and conservatively budgeted revenue based on the lower 75% return rate in our historic data sets for continuing cohorts.

Since the inception of our new continuous certification paradigm in 2003, every single cohort has participated at a rate greater than 80%! We have used the additional unexpected revenue to invest in enhanced infrastructure, create the PRIME registry, and most importantly to keep the cost of participating in continuing certification stable over the past 15 years. This is quite remarkable, because we have increased the total number of Diplomates that we are serving by more than 20,000 while managing slightly more Diplomates participating in the continuous certification process at approximately the same cost that was in effect in 2003. In fact, in 2011, we *reduced* the annual fee for those entering the continuous certification process to $200 per year.

Considerable discussion has taken place within the physician communities of all specialties with respect to the cost, effectiveness, relevance, and burden related to participation in the continuous certification process developed by each of the 24 member boards of the American Board of Medical Specialties (ABMS). The ABFM has had considerably less difficulty transitioning to this new paradigm because one of our founding principles was that we would only issue time-limited certificates. Furthermore, the 4 components of our old recertification paradigm were strikingly similar to the major elements of the mandated ABMS paradigm approved in 2000. Many other older member boards that have large numbers of lifetime certificate holders have had a much more difficult time implementing their programs.

Robust participation in continuing certification has provided the resources to allow us to continuously improve our process with a constant eye on keeping cost low, making the process more efficient, reducing burden and redundancy, and creating synergy by allowing participation to meet other reporting requirements and needs. We remain convinced that the overwhelming majority of family physicians gain considerable satisfaction in meeting the high standards that we have established for certification and are intrinsically motivated to do so. Nevertheless, we are becoming increasingly concerned about the ways in which some are using our certification inappropriately.

ABFM certification was created to allow family physicians to voluntarily demonstrate their professionalism by meeting the high standards necessary for certification in our specialty; it was never intended to be used as the sole criterion or an absolute requirement for licensure, privileging, credentialing, Employment, or reimbursement. We are disheartened by the way some hospitals, payors, and groups are using the lack of certification to deny credentials or privileges or influence reimbursement to otherwise-qualified family physicians. Although we fully support the use of certification to obviate the need for family physicians to meet burdensome privileging and credentialing requirements, no family physician that is not board certified should be denied privileging or credentialing if they can otherwise demonstrate that they provide, and can continue to provide, high-quality care. We have begun to speak forcefully on this issue, and we

are fully supportive of the advocacy efforts of the AAFP to attempt to rectify this problem. We want family physicians to participate in our continuous certification process because they want to do so, not because they must.

As many of you know, I began my final year of work at the ABFM in January of this year. Much important work remains to be done on many of the initiatives mentioned above. We will be announcing additional improvements to the continuous certification process after the first quarter of the year, and we have several other new initiatives that we will get underway in the second quarter. I remain excited about the work that we do and look forward to helping complete much of it before I depart at the end of 2018.

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