Improving Performance Improvement

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What is the future of performance improvement (PI)? Over the past 2 years, the American Board of Medical Specialty Certification Boards have implemented many changes to increase the value and decrease the burden of Board Certification and to decrease burden of what they are asking from Diplomates. American Board of Family Medicine (ABFM) has implemented the Family Medicine Certification Longitudinal Assessment, launched an outreach campaign with the American Academy of Family Physicians (AAFP), its chapters, and the other organizations of Family Medicine, and is now systematically revising its knowledge self assessments and starting a national journal article activity. In no other area of ABFM's certification activities, however, has there been greater effort to improve value than the PI requirement—with a focus on increasing the options to ensure alignment and relevance with Diplomates' practice types and areas of interest; providing ways to help them easily choose relevant activities; and creating mechanisms for Diplomates to simply report on the quality improvement efforts in which they are already engaged within their practice.

Diplomates often ask about PI activities: what are they? Why do I have to do them? The history is important. Since the 1950s, there has been formal research on the quality of care, both in general and in Family Medicine[1]. At its founding in 1969, the American Board of Family Medicine (originally ABFP) insisted that knowledge alone, as measured by an examination, was not sufficient for Board Certification: performance was also essential. In fact, the first recertification included a chart audit to assess the quality of practice of Diplomates. As many longstanding Diplomates remember, this evolved into computerized chart reviews.

The publication of the Institute of Medicine (IOM) reports, *To Err is Human*[2] and *Crossing the Quality Chasm*[3] along with McGlynn's national study of the quality of care across the continuum of care[4], changed public and policy discourse across the country permanently. Poor quality was common, both across the continuum of care and across the country, and a major cause of death. In response, the American Board of Internal Medicine (ABIM) Foundation charter of professionalism[5] highlighted improving quality as a key component of professionalism, the American Board of Medical Specialties included "Improving Performance in Practice" as a part of Maintenance of Certification system[6] and the Accreditation Council of Graduate Medical Education (ACGME) built Systems-Based Practice into the Next Accreditation System.[7]

The ABFM Perspective and Rationale

ABFM believes that there is an ongoing and compelling need for improving health and health care. Participation in PI activities demonstrates that board-certified family physicians know how to examine their practice (whatever and wherever those may be), identify an area in which care delivery or outcomes could be improved, implement a process change, and then assess whether that change resulted in an improvement. Starting about 15 years ago and working with the AAFP and other partners, ABFM put together a variety of options for family physicians working in a range of practices from solo and small groups to large multispecialty settings.

ABFM is now revising its PI activities, as laid out in our new strategic plan.[8] A first step has been to reduce burden of reporting, beginning with creation of the Self-Directed Activity process, which provides

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a simple submission process for Diplomates to report on what they are already doing in practice. Those in large groups, Accountable Care Organizations (ACOs), clinically integrated networks, and other organizationally sponsored quality improvement initiatives can do the same through another new pathway: the Organizational PI Activity. We also greatly simplified the administrative process and shortened the turnaround time on approving these activities from 36 days to 1 to 5 days. Alternatively, participants in our PRIME registry[9] benefit from automatic extraction of the data from their Electronic Health Records (EHR), greatly facilitating quality improvement. To support the integration of PI into education, additional focused and flexible PI options are now available for residents and faculty as well as community preceptors.

ABFM has also begun adding new activities to better fit the varied scope of practicing family physicians. In response to Diplomate feedback, we have added a number of new PI activity modules on broader topics over the last year, such as Emergency Department/Urgent Care; Efficiency and Cost Reduction; Hospice and Palliative Medicine; Sports Medicine; Hospital Medicine; and more—in an effort to ensure that family physicians of all practice types have something relevant. While adding many new options is appropriate given the diversity of family medicine, it also creates potential for decision paralysis—something we heard often from Diplomates. In response to that, last summer ABFM implemented the PI Locator in the Physician Portfolio. Much like Amazon shopping preferences, the PI locator asks each Diplomate a few simple questions about their practice and clinical interests and scans the catalog of options to present them with a smaller, focused list of options that would be best suited to their needs and preferences. Finally, how these activities are delivered was revamped into a new platform that has proved to provide a much better user experience for those selecting ABFM-developed modules. Approximately 30,000 family physicians submit PI activities every year and evaluations report overall satisfaction and improvement in practice. 88% feel that the activities are extremely or very relevant to their practice, and 85% stated that they will change their care of patients as the result of completing the PI activity.

More recently, ABFM has focused on creating new activity options to address critical and emerging events in our world: the COVID-19 pandemic and the sequelae of the murder of George Floyd, which refocused our attention to the serious efforts needed to address health inequities. Modeled after the Self-Directed PI activity, 2 new PI activity options allow for reporting on what family physicians have done to respond to the changes needed in practice as a result of the pandemic and the changes that many Diplomates expressed wishing to do to improve health equity in their practices or communities. Over 2000 physicians completed the COVID PI activity from April to June, making it one of our most popular activities. In June, the AAFP added Continuing Medical Education (CME) credit to this effort, recognizing the learning that family physicians are doing in response to the pandemic. The health equity module was launched as this editorial was being written. Both are available on our Web site: www.theabfm.org/continue-certification/performance-improvement.

Another key part of our strategy is promoting education about quality/PI, working residencies and with the AAFP and other partners. Since 2008, all Family Medicine residents have been trained in some way in quality improvement. This means that approximately 40% of practicing family physicians have had some initial formal training in Quality Improvement (QI). Quality improvement has been incorporated into 2 large regional collaboratives[10–14] and the Association of Family Medicine Residency Directors Residency Performance Index (AFMRD RPI) initiative.[15] We are hopeful that this QI training in residency will be imprinted on residents over their future careers. Importantly, however, approximately 60% of family physicians have not had residency training in QI. The AAFP and other partners are playing an important role in supporting further training for family physicians.

Finally, ABFM has made a major commitment to changing the ways in which family medicine is measured. As recommended by the Institute of Medicine in 2015,[16] quality measures need to be fewer and more impactful: a partial count reveals a Tower of Babel, with thousands of measures mandated or encouraged by many different stakeholders! For family physicians and other primary care providers, disease-specific measures often do not capture the core of what we do. We therefore have begun to identify, test, and disseminate new quality measures—measures that capture the core functions of primary care that drive population health—continuity, comprehensiveness, patient reported outcomes and value of care.[17]

Improving PI

Our long-term agenda is to improve PI in fundamental ways. First on the list is to work with the AAFP, health systems and payers to develop an agenda for improving care delivery and quality in family medicine and primary care. Akin to the national quality strategy,[18] we will work to convene stakeholders to identify gaps and priorities in both health care and in education about quality. The challenge, of course, is the tremendous breadth of what family physicians do, along with the current rapid rate of change in health care. Important parts of this agenda must also be the consideration of defining different measures of quality and maintaining focus on mitigating health disparities.

How else can ABFM add value for our Diplomates and for the public? We will study Diplomate feedback as we evolve our offerings and work to document the degree of improvement across a range of activities. We also look forward to input from the broader community. Leaders of large health systems have suggested both a desire for an "on ramp" for working in quality improvement for practicing doctors and a need for curating successful change packages in large systems across conditions. This is particularly important as we as a nation and as health care providers look at complicated issues like health equity, transitions of care and population health. We will also look to other Certification Boards for ideas, including credit for family physicians who lead care improvement within large practices and systems, community initiatives to improve health or systematic improvement of educational outcomes. And, finally, we will continue to develop and test new quality measures and look for partners among large systems and payers to test new measures at scale.

We want to engage with all who are interested in improving the outcomes of our care. Now, more than ever, we need to focus on improving the care we provide—and to do this, we need to build a learning community.

To see this article online, please go to: http://jabfm.org/content/33/5/819.full.

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