FAMILY MEDICINE UPDATES

The American Board of Family Medicine (ABFM) introduced Maintenance of Certification for Family Physicians (MC-FP) in 2004 in response to policy adopted by the American Board of Medical Specialties (ABMS).1 ABFM reported in 2006 the initial Diplomate experiences with MC-FP.2 At that time, ABFM had Self-Assessment Modules (SAMs), consisting of a 60-item knowledge assessment followed by a virtual patient clinical simulation available only for hypertension, type 2 diabetes mellitus, asthma, and depression. Since that time, ABFM has deployed modules for coronary artery disease, chronic heart failure, well child care, maternity care, preventive care, care of the vulnerable elderly, pain management, early childhood illness, cerebrovascular disease, and health behavior. Each of the SAMs includes a Diplomate assessment of both the knowledge assessment followed by a virtual patient clinical simulation available only for hypertension, type 2 diabetes mellitus, asthma, and depression. Since that time, ABFM has deployed modules for coronary artery disease, chronic heart failure, well child care, maternity care, preventive care, care of the vulnerable elderly, pain management, early childhood illness, cerebrovascular disease, and health behavior. Each of the SAMs includes a Diplomate assessment of both the knowledge assessment and the simulation components.

In addition to the Diplomates’ subjective assessments of the SAMs, ABFM captures the actions taken during each simulation, including the action itself, the simulated date and time of the action, and the simulated patient’s current health state. This information is available to the Diplomates for their self-assessment.

In an interview after the press event, Stream stressed the need to develop a solid, secure, physician-patient relationship so meaningful patient conversations can take place.

“People really do need a doctor who knows them and can help them navigate the medical system if they have a serious medical problem,” he said. “It is also important to note that it is one thing to get a ‘Choosing Wisely’ decision from a doctor who knows you, but that to do that, you have to build trust up over time.

“I think that as family physicians, our role is unique, because we are not only managing the care that we give, but it is also just as critical that we coordinate care for our patients using our subspecialty colleagues.”

Matt Brown
AAFP News Now

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captured in an action log, which serves as a persistent record of the Diplomate’s traversal through the simulation scenario.

ABFM introduced the chronic heart failure (CHF) SAM and associated simulation in 2006. We present in Figure 1 a graphical summary of simulation actions taken in the CHF SAM, as extracted from the simulation action logs from 2006 to 2011. We present the results as percentage of simulations in which given actions occurred.

The results indicate overall high use of angiotensin converting inhibitors (ACEInhibitors), ACE inhibitors and/or angiotensin receptor blockers (ACEInhibitorsARBS), but surprisingly low use of beta-adrenergic blocking agents (BetaBlockers.) Digitalis preparations (DigitalisPrep) demonstrated very low use. The majority of Diplomates also did a formal assessment of left ventricular function (Echocardiogram.)

The CHF simulations generally present scenarios representing patients with stage C heart failure, as defined in the 2009 ACCF/AHA heart failure guideline. According to that guideline, ACE inhibitors and beta-adrenergic blockers should routinely be used in these patients. This discrepancy between recommended therapy and the low percentage of beta-adrenergic blocker prescriptions in the simulations suggests that the knowledge assessments should perhaps place greater emphasis on the use of these agents in class C heart failure. The current CHF knowledge assessment contains only 7 items that reference beta-blockers, and nearly all of these present a beta-adrenergic agent only as historical information in the clinical stem of the item, rather than as a focus of decision-making in the item.

These results suggest that the simulations, although clearly presenting a virtual patient environment, can serve as a useful probe for identifying possible management gaps that should be emphasized in the SAM knowledge assessments.

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References
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