Family Medicine Updates

From the American Academy of Family Physicians

MAKING CARE SAFE

A look at progress in studying medical errors seems fitting for the inaugural *Annals of Family Medicine* – and AAFP patient safety activities this spring in Washington, DC, provided plenty of grist for that mill.

"During the first few months after I came to this country from New Zealand in late 1999, I heard people saying things about health care that astonished me, and some of those things were about medical errors," said Susan Dovey, PhD. She spoke March 18 at a primary care forum sponsored by the Robert Graham Center in Washington.

"Lots of things have changed in the last 3 years to make primary care safer," Dovey said. She should know. She was principal investigator for the first US study of errors in family practice and was a coauthor of the first international study on errors in family practice/general practice.

Some things that astonished Dovey in early 2000:

• The United States has "the best health system in the world," said a participant in a briefing on Capitol Hill. Yet the World Health Organization listed healthy life expectancy at birth in the United States in 2000 as 67.4 years, a shorter healthy life span than experienced by people in 26 other countries.

• At a meeting in Washington, Dovey heard, "Most health care is provided in hospitals." But in 2001, the Robert Graham Center's paper on the ecology of medical care showed that, for any 1000 people in the United States in a given month, 8 receive care in hospitals, and 217 visit physicians' offices (of those, 113 visit primary care physicians' offices).

• As the Academy began to focus on medical errors, family physicians mentioned misplaced lab reports and messages left unanswered. Those, said Dovey, were regarded as "just trivial, everyday things – not what we mean by medical errors."

The Institute of Medicine report *To Err Is Human*, issued in late 1999, focused on hospital settings and grabbed headlines with its estimate of 44,000 to 98,000 deaths per year from medical errors. In 2000, said Dovey, there was a leap in interest in studying threats to patient safety – with most of the studies in hospitals, but some in primary care.

By 2003, she said, "The scope of patient safety mistakes is better understood. Things that were considered trivial are now regarded as things to be corrected."

She added, "Patient safety is recognized as an issue to be addressed at all levels of the health system."

What have the Academy and the Robert Graham Center had to do with that? Lots. They've met these challenges:

• **Build an error reporting system**. Family physicians in the AAFP National Network for Family Practice and Primary Care Research used a new system to record mistakes in their practices for the US study and are using it in other studies. Australia, Canada, Germany, New Zealand, the Netherlands, the United Kingdom and the United States are using the reporting system in their study group, called Learning in an International Network About Errors and Understanding Safety (LINNAEUS). The German team in the LINNAEUS group won the Berlin Health Medal this year for innovations in research. "That's incredibly important to me, that a non-English-speaking country has won accolades for the work it's done with us," said Dovey.

• **Develop a description/categorization of the errors**. Finding ways to label and count medical errors is a work in progress. Errors reported by the AAFP national research network and the LINNAEUS group led to a preliminary taxonomy. It lists process errors, such as mistakes in office administration, treatment, and communication, as well as knowledge and skills errors, such as errors in diagnosis and execution of a clinical task. "The categorization is now in use not only throughout the United States, but throughout the world," said Dovey.

• **Test whether physicians could better use a paper reporting system or a computerized system**. "We found that family physicians, even those unaccustomed to using computers in their daily practice, will use computers to report errors they see in their practice," said Dovey.

• **Establish the Developmental Center for Research and Evaluation in Patient Safety in Primary Care.** The center, a program of AAFP's national research network, aims to improve the safety and quality of primary care through research, evaluation, education, and dissemination of research findings.

• **Put resources into developing effective, usable information technology systems for primary care offices.** The Academy is exploring ways to develop, distribute and support an open-source electronic

health record. The open-source model would lower physicians' information technology costs by eliminating licensing fees and would allow users to contribute to the software's evolution. The whole project would boost the quality of care, efficiency, and patient safety.

• **Receive recognition from funding agencies**. For example, the AAFP national research network is conducting research through 2 grants from the Agency for Healthcare Research and Quality. One grant supports the study of laboratory and diagnostic imaging errors; the other funds research in medical errors reported by patients, physicians, and other staff in primary care.

"The AAFP is way ahead of the curve," David Hsia, JD, MD, an analyst at AHRQ, said in response to Dovey's talk. "You're actually trying to collect data on patient safety. Most other specialties are not."

The need for voluntary, confidential reporting systems for medical errors came under discussion March 13 during AAFP presentations for legislative aides and reporters on Capitol Hill.

The day before, the House of Representatives, by a vote of 418-6, passed HR 663, a bill that would give the green light to creating voluntary, confidential reporting systems for medical errors, including those in physicians' offices. The entities collecting the data would be called patient safety organizations. (At press time, it was not known when the Senate might consider related legislation.)

The Academy held its 2 briefings to reinforce key elements of HR 663 and stress the importance of error reporting in primary care.

"This is not a new concept. Confidential, voluntary reporting is used by the Federal Aviation Administration for aviation safety, and it seems to work very well," said AAFP President-elect Michael Fleming, MD, of Shreveport, La.

AAFP President James Martin, MD, of San Antonio, Tex, discussed medication mistakes and misfiled lab reports – mistakes often made and often discovered before a patient is harmed. "How many near misses take place in doctors' offices that we never know about?" asked Martin. "This is not a time for fault-finding and finger-pointing. It is a time to try to identify where the errors occur and what it is that we require to make changes."

Bob Phillips, MD, assistant director of the Robert Graham Center, explained, "We need organizations like the Academy to be able to become patient safety organizations and use their full engine – their full capacity for education, for tools for physicians' practices – to improve patient care."

Jane Stoever
AAFP News Department

From the American Board of Family Practice

REFINING THE PARADIGM: THE TRANSITION FROM RECERTIFICATION TO MAINTENANCE OF CERTIFICATION

Introduction

Family practice has long been a leader in recertification. In 1969, the American Board of Family Practice (ABFP) was the first specialty board to issue time-limited certificates and to require mandatory recertification every 7 years. The founders of the ABFP had the foresight to create a process that has served the specialty well for the past 34 years. Recently, the American Board of Medical Specialties (ABMS), sensing growing and repeated outside threats to medicine, developed a strategic plan that would assure the American public that all medical specialists would meet the highest standards of competency. They defined competency and mandated that "maintenance of competence should be demonstrated throughout the physician's career by evidence of lifelong learning and ongoing improvement of practice." More important, they designed a process called Maintenance of Certification (MOC), in which every board-certified specialist in the United States would be expected to participate.

The ABFP has been developing a unique program for family physicians within the framework specified by the ABMS. I talked with James C. Puffer, MD, Executive Director of the ABFP, to learn more about how family practice will approach these new requirements. For a full transcript of this discussion, go to www.abfp.org.

Q. What is the "Maintenance of Certification" program?

A. Maintenance of Certification is intended to measure continuously the ongoing competencies of practicing physicians in every specialty. These competencies are medical knowledge, patient care, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice.

The ABMS has developed a framework of 4 components that will measure the 6 competencies continuously: evidence of professionalism, evidence of self-assessment and lifelong learning, evidence of cognitive expertise, and evidence of assessment of performance in practice. Each member board of the ABMS will be required to develop specific mechanisms for assessing diplomates in each of these 4 areas.

Q. When will the ABFP launch its Maintenance of Certification program?

A. The ABFP will phase in its MOC program beginning January 1, 2004 and extending to 2010. The first group who enter the MOC program will be those who certify or recertify in family practice in 2003.

Q. What is meant by the phrase, 'Refining the Paradigm - the Transition from Recertification to Maintenance of Certification'?

A. The components of our recertification process that have been used for close to 30 years are strikingly similar to the 4 components of the MOC process. Therefore, unlike other specialists, our diplomates will at least have had some experience with the basic aspects of the process. By way of example, we have required a full and unrestricted license in every state in which the diplomate practices, 300 hours of Continuing Medical Education (CME), a recertification examination, and the Computerized Office Record Review (CORR). Each of these 4 recertification components needs only to be modified slightly to meet the new requirements for MOC established by the ABMS. That's why we are calling this "refining the paradigm" rather than making a paradigm shift to an entirely new and different model.

Q. What does the successful launch of the MOC program mean for family practice diplomates and the specialty?

A. The MOC program will provide the mechanism by which we can continuously assess the competencies of the practicing family physician and do so in a scientifically reliable and valid manner. Our hope is that the federal government, third party payers, and state licensing boards will recognize this and use the information to replace current or future requirements that impose tremendously burdensome tasks on the busy, practicing family physician. By taking the lead in this area, we envision the MOC process as a value-added component of the physician's practice. Not only could this program potentially avoid time-consuming tasks, such as quality assurance audits by third-party payers and relicensing exams by state licensing agencies, it will also assure that family physicians stay abreast of the state of the art in our specialty and, more important, apply it to the care of their patients.

Q. Whom does it affect?

A. This will affect every single diplomate of the ABFP, although the program will be phased in, so it won't affect everyone at once. From this point forward, those who will either certify or recertify under the old process will immediately enter into the MOC program. They will be issued a certificate good for 7 years, as has always been done, and enter the 7-year MOC cycle. In order to maintain their certificate, they need to successfully complete all 4 components of the MOC process during that 7-year period.

Q. What will diplomates need to do to satisfactorily complete those components?

A. **Evidence of professionalism.** They will need to continue to possess a full, unrestricted license in all states in which they practice. Additionally, the ABMS is currently developing patient satisfaction and peer assessment instruments that it envisions will be used by boards to measure another aspect of professionalism. These will be available in 2004 or 2005.

Evidence of self-assessment and lifelong learning. We will offer a variety of clinical self-assessment modules from which a diplomate will be able to select 1 to perform per year for a total of 6. The first 2 that will be developed by the ABFP and available next year will be Diabetes and Hypertension. We are working closely with the American Academy of Family Physicians (AAFP) and others to coordinate the rollout of our self-assessment modules with their continuing medical education initiatives. Some of these initiatives, if approved by the ABFP, may be used to substitute for up to 2 of the 6 modules. Each ABFP clinical self-assessment module will consist of 2 parts. Part A will be an assessment of the diplomate's knowledge with respect to the disease domain. Part B will be an assessment of the diplomate's ability to apply that knowledge in a clinical setting. We will use our patient simulation technology to assess this. Both Parts A and B of the clinical self-assessment modules will be Web delivered. Diplomates will be able to take them at any time and at any place where they have computer access. They can take these as many times as necessary to pass each part. Part A must be successfully completed before moving on to Part B. Candidates must successfully complete 6 clinical self-assessment modules during the MOC cycle.

If diplomates have a Certificate of Added Qualification (CAQ) in Adolescent Medicine, Geriatric Medicine or Sports Medicine, 1 of the 6 clinical self-assessment modules must be taken within the discipline of their CAQ.

Evidence of cognitive expertise. This will be measured by examination. The examination will be offered in the sixth or seventh year of the MOC cycle. We are making the transition into delivering the examination entirely on the computer. Next year we will offer the examination at a number of paper-and-pencil sites as well as 200 computer-based testing centers throughout the United States. It is estimated that 80% of our diplomates will be within a 1-hour drive of one of these testing centers.

Evidence of assessment of performance in practice. We will introduce this in 2004. Initially, this will be done by modifying our current computerized record review process. The diplomate will choose a specific disease domain and will select 10 patient charts for audit. This audit will be done via the Web at the physician's convenience. The physician will abstract information from the chart, which will be transmitted to us. This information will be measured against evidence-based quality indicators, and the physician will be given feedback. Based on his or her performance, the physician will then go to a section on our Web site for assistance with developing a quality improvement plan which will be individually tailored. At some point during the MOC cycle, the diplomate will be asked to repeat the audit so that we can determine whether, in fact, the quality improvement program that they have developed has resulted in improvement in this aspect of their practice. One assessment-of-performance-in-practice module must be completed during the 7-year MOC cycle. We are working with the AAFP to make certain that the quality improvement initiatives that they are currently designing for their members will be suitable for satisfying this component of MOC.

Q. How do I prepare for the MOC?

A. We are collaborating with all stakeholders in our specialty to ensure that they are fully aware of how we plan to proceed with the MOC process. We would expect that they will develop unique CME programs which will be targeted at helping family physicians.

Q. Do I have more than one opportunity to take various components of MOC?

A. Of course, as in the past, one will need to maintain a current and unrestricted license throughout the MOC cycle. With respect to Part 2, self-assessment and lifelong learning, the clinical self-assessment modules may be taken as many times as necessary to pass. The cognitive examination will be given multiple times per year, and therefore, there is the possibility that if the exam was failed early in the sixth year, after satisfying all other components of MOC, it could be taken again later in the year. If the repeat exam was failed, it could be taken again early in the seventh year with the possibility of taking the exam yet again later in the seventh year if failed. So theoretically, the exam could be taken as many as 4 times in an attempt to pass within the MOC cycle.

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From the Society of Teachers of Family Medicine

RESEARCH AND THE SOCIETY OF TEACHERS OF FAMILY MEDICINE

This inaugural issue of the *Annals of Family Medicine* should be viewed with a great sense of pride by the members of the sponsoring organizations, including the Society of Teachers of Family Medicine (STFM). It represents a major investment and a historic level of cooperation among the organizations.

STFM has increasingly recognized and accepted the importance of research as a core part of family medicine and the Society's mission. In our roles as STFM research committee chair (PD) and communications committee chair (MR), we've seen firsthand the growth of research as a core component of the society's activities. It is gratifying to be able to report that research has a prominent place within STFM's programs and strategic planning. Issues regarding family medicine research are regularly and actively discussed at STFM Board meetings, and there is a striking level of research interest and expertise among the current members of the Board of Directors.

The STFM Research Committee is an extremely active group, coordinating a large block of dedicated time at the Annual Spring Conference for research papers, posters, and skill-building presentations; monitoring the family medicine research literature to select the annual STFM Best Paper Award winners; and coordinating a Resident and Student Research Forum that provides residents and students the opportunity to present original research to their peers. The STFM Annual Spring Conference trails only the North American Primary Care Research Group's (NAPCRG) Annual Meeting among all of our discipline's conferences in the number of research presentations, with a large majority of those presentations representing clinical research.

Over the past several years, the fellow representatives of the STFM Research Committee and NAPCRG have closely collaborated to sponsor a fellows' e-mail discussion list and multiple support activities at our annual meetings, including fellows' works-in-progress sessions. As a result, family medicine research fellows have 2 family medicine organizational meetings where they can be assured of a welcome and a place to get feedback on their developing research efforts.

The Research Committee monitors current research issues that might be of interest to and important for our members and facilitates 2 to 3 research

skill-building seminars at each STFM Annual Spring Conference. Research Committee members also help facilitate the research workshop of the STFM Faculty Development Series, which is periodically offered in conjunction with STFM conferences. This workshop orients novice faculty researchers to the basics of research design, planning, implementation, and communication.

STFM also supports active liaison relationships with the NAPCRG Board, the NAPCRG Committee on Building Research Capacity, the American Academy of Family Physician's Commission on Clinical Policies and Research, and the Academic Family Medicine Organizations Research Subcommittee, with the STFM representative (usually the chair of the Research Committee) often being the only person overlapping these various groups.

When the initial discussions arose regarding the possible formation of a new research journal for our discipline, the leadership of STFM stepped forward to take an active role. When these negotiations became more concrete to the point of asking for a large investment of STFM resources to help make the journal become a reality, the STFM Board discussed the critical issues and agreed to take its share of the risk. In particular, Roger Sherwood, the executive director of STFM, has been extremely supportive of this endeavor, recognizing the potential importance of the new journal to our research community. STFM also will continue to support the publication of our long-standing journal *Family Medicine,* with a particular focus on educational and program-oriented research, but a willingness to publish other types of research as well. We foresee that both journals will complement each other, flourish, and serve as important avenues for publication. Combined, they will be important voices in our continuing efforts to establish and elucidate the research base of our discipline and to improve the health of the public.

STFM is extremely proud to collaborate with the family of family medicine organizations in the production of the Annals. In this first issue, we recognize the many efforts of all who have contributed to its birth and look forward to its growth and success.

For more information on STFM Research activities, visit the STFM Web site at www.stfm.org, or contact Dr. Dickinson at perry.dickinson@uchsc.edu.

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From the Association of Departments of Family Practice

'SWOTTING' DEPARTMENTS: ISSUES AND CHALLENGES IN ACADEMIC FAMILY MEDICINE

The SWOT analysis, commonly used in business management, is a process for delineating the **S**trengths, **W**eaknesses, **O**pportunities, and **T**hreats to an organization. Just as business has used the SWOT approach, academic programs can develop their own systems and organizations for effective support and analysis, since the health of academic family medicine has a major impact on the future of the discipline as a whole.

To this end, the Association of Departments of Family Medicine (ADFM) represents the academic organization of family medicine in the medical schools throughout the United States. The ADFM, formed in 1977, has more than 125 organizational members, which in turn represent several thousand faculty. The purpose of ADFM, as defined in its mission statement, is to "promote the philosophy and interests of family medicine in medical schools in the United States …". To accomplish this goal, ADFM provides a forum for informing and training members on innovative approaches to the missions of academic departments. It has recently developed a departmental consultation service to assist departments in identifying strengths and weaknesses and recommending solutions.

It is difficult to describe a typical family medicine department. If you have not visited a family medicine department in a while, you may be in for a surprise. Departments vary considerably in size, scope, and design, and have become increasingly complex entities in the last decade. What has not changed is the threefold mission of research, teaching, and clinical care. Most departments have responsibility for medical student clerkships in the third or early fourth year, offer residency training (often at several sites), promote scholarly activity, and play a significant role in the provision of primary care for their institutions.

In addition, a recent study indicated that a majority of departments also have major responsibility for the teaching of interdisciplinary courses in the first 2 years of medical school, and typically rely on more than 100 volunteer faculty in each program to accomplish the teaching load.[1]

The majority of departments are also involved in training programs beyond the residency. More than half of departments provide fellowships in faculty

development, geriatrics, sports medicine, or obstetrics in addition to an assortment of other fellowship offerings.[1] Many family medicine departments have a more complex academic mission, which may include academic community and preventive medicine activities.

The clinical role of departments varies as well. In addition to the core provision of primary care, it may include involvement in or management of primary care networks, university student health services, employee services, contractual activities with government entities (such as public health departments, correctional institutions, or mental health services); and special clinical services such as women's health, HIV care, or sports medicine. Most academic departments also continue to have significant clinical activity in inpatient settings.

Along with medical student education, research is one of the core responsibilities of academic departments. There is some evidence that the productivity of research has increased in the past few decades, though in the opinion of some, not at the desired rate. Limitations have been attributed to a lack of trained researchers, insufficient support for areas of interest to family physicians, and insufficient opportunities for collaboration in smaller departments with competing missions. The recent emphasis on academic support of research by US Public Health Service grants may indicate a step towards improving this record in the future. In addition, departments have been active in the development of a number of practice-based research networks, which may facilitate greater collaboration and more opportunities to address relevant research questions.

There are several areas of concern. A recent study[2] of academic family medicine departments indicated that only 40% have financial reserves, down 14% from a similar study reported 3 years earlier.[1] The number of departments with an excess of debt remained the same (24%), but the number with neither debt nor reserves has increased (34% from 19%). Threats to the financial stability of departments include continuing financial difficulties of academic health centers, poor reimbursement for primary care, a disproportionate share of underserved and Medicaid patients, and the possibility of diminishing support for federal primary care educational funding.

Another related concern has been the apparent discordance between the perception of priorities of academic family medicine department chairs and the medical schools, universities, and academic health centers in which they reside. For example, while graduate education was the top priority cited by the chairs in one study (53%), only a small percentage of them believe this to be the highest priority of the other academic entities.[1] On the other hand, family medicine departments often find themselves as bridges between the academic and practice world, and in the best situations, as developers of new systems of care and of education that benefit both, and the patients most of all.

In the upcoming issues of *Annals*, ADFM will explore the areas of strength, delineate the inherent weaknesses, outline the opportunities, and exchange ideas on the threats facing academic family medicine in education, clinical care, and research. By highlighting programs that have developed innovative approaches and lasting solutions, we hope that we will stimulate positive discussion and dialogue.

Samuel C. Matheny, MD, MPH
President of ADFM, 2001-2003

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NORTH AMERICAN PRIMARY CARE RESEARCH GROUP

From the North American Primary Care Research Group

HEALTH SERVICES RESEARCHER LU ANN ADAY: PRIMARY CARE AND HEALTH SERVICES RESEARCHERS AS PARTNERS

Lu Ann Aday, PhD, Lorne Bain Distinguished Professor in Public Health and Medicine at the University of Texas School of Public Health, shared her thoughts on the synergy of health services research and primary care research in an interview with NAPCRG Newsletter Editor John G. Ryan, DrPH. The complete interview is published in the February 2003 NAPCRG Newsletter, available online at www.napcrg.org.

Dr. Aday's comments were apropos the theme of the 2002 Annual Meeting of the North American Primary Care Research Group, "Building Research Infrastructure." Many primary care researchers recognize the urgency of establishing a nonparochial, transdisciplinary approach to health care research, as suggested by Dr. Aday. But more important, Dr. Aday was addressing the underlying subtheme of the 2002 Annual Meeting, "Health and Health Care Disparities: Geographic, Racial, Economic, and International." Kurt Stange, MD, PhD, NAPCRG

president, called disparities in health care "an indisputable problem that has defied quick-fix solutions. …" NAPCRG's 2003 Meeting, Oct 25-28, at the Fairmont Banff Springs, in Banff, Alberta, builds on these twin themes by addressing the benefits of linking researchers, communities, and funders.

JR: What motivated you to pursue the study of health care access and equity?

LA: I was inspired by John F. Kennedy's invitation to, "Ask not what your country can do for you, but what you can do for your country." After completing my masters, I joined Volunteers in Service to America. This experience provided a strong experiential base for undertaking my doctoral studies in health services research on access to care for vulnerable populations. Upon receiving my doctorate in 1973, I joined the Center for Health Administration Studies of the University of Chicago. At CHAS, I was privileged to work with Odin Anderson and Ronald Andersen, who had done much of the foundational conceptual and empirical work at that time on the predictors and indicators of equity of access to health care.

JR: How do you see disparities at the primary-health-care level increasing as a result of the current malpractice insurance crisis in the United States?

LA: Whether the malpractice crisis has increased in intensity; and, if so, why, and who is most likely to bring suit – middle class or socioeconomically disadvantaged clients – are questions that have been pursued by health services researchers over the last several decades. One perspective, however, is that the perceived crisis is probably best viewed as a sentinel indicator of deeper problems with the US health care system. Health services research has documented that patient adherence and satisfaction are enhanced by effective patient-provider communication, continuity in the doctor-patient relationship, time spent in the clinical encounter, and associated trust of medical care providers. The increasing "corporatization" of medical care and associated transformations in the systems of organizing and financing services have presented major challenges to maintaining these qualitative dimensions of the patient-provider encounter. These aspects of care may be particularly compromised, because of either system or interpersonal factors, in health care for minorities and socially disadvantaged populations. The question then becomes, How should more fundamental system problems, which may be signaled by malpractice insurance rates and claims, be addressed?

JR: How do you see health services research and primary care research linking more closely and effectively in the next 5 to 10 years?

LA: Primary care research brings a unique and important perspective to illuminating timely and important health services research questions. This IOM definition of primary care aptly reflects the essential elements of primary care that also present the biggest challenges in addressing many of the issues of health and health care disparities discussed earlier: the quality and characteristics of the doctor-patient partnership and the role of family and related cultural and community context in health care. Primary care researchers can be full and insightful partners in the design and conduct of research to identify the role of these factors in influencing the quality and outcomes of care.

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