ARTICLE

The American Board of Family Medicine: Celebrating 50 Years of Continuing Transformation

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The history of the American Board of Family Medicine (ABFM) is briefly recounted by focusing on 4 major touchstones that can be considered instrumental in shaping its development as the third largest specialty board in the United States. These include the board's founding, its implementation of maintenance of certification, the creation of its research enterprise, and its culture. The importance of each of these touchstones to the unique contributions that the ABFM has made to the specialty board community is explored. (J Am Board Fam Med 2020;33:S69–S74.)

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Any attempt to briefly recount the 50-year history of the American Board of Family Medicine (ABFM) in the space allotted for this commentary would be woefully inadequate, and would neglect the significant contributions made by many of the members of its board of directors and staff in defining its unique place among the member boards within the American Board of Medical Specialties (ABMS). Accordingly, it would seem appropriate to focus on 4 important touchstones that most would agree have shaped the evolution of the ABFM and have impacted the specialty of family medicine: our founding, the advent of maintenance of certification, the creation of the ABFM research enterprise, and its intraorganizational culture. With the exception of a few of our founders, an attempt has been made to purposely avoid naming those who have significantly contributed to the growth and success of the ABFM for fear of leaving anyone out; instead, specific attribution will not be ascribed to the events that have shaped the ABFM into the organization that it currently has become. However, those who have been intimately involved in impacting the ABFM's future will recognize their fingerprints all over this recounting of the important milestones that have resulted in the evolution of the ABFM into the organization that it has become.

Our Founding

After better than 5 years of overcoming nearly insurmountable odds, the then American Board of Family Practice (ABFP) was approved by the Liaison Commission for Specialty Boards in February 1969.[1] Nicholas J. Pisacano became the Founding Executive Director of the ABFP; and John Walsh, MD was elected as the ABFP's first President. The rapid growth and approval of residency training programs followed—almost 200 programs had been created within the first 5 years, and the first certifying examination was given in 2 separate administrations in 1970 and 1971. As mentioned on the occasion of the celebration of the 40th anniversary of the ABFM, "the forces that influenced the eventual establishment of the ABFM were intimately tied to the expectations that the public had for the physicians who provided their care. To a large degree, these expectations were not being met, and the answer to this dilemma was a new specialty that would train family physicians to become the personal physicians of a wanting public."[2]

To guarantee that the family physicians who were trained and eventually certified would be of the highest caliber to serve this wanting public, the ABFM established a set of standards that were unequalled among medical specialty boards at the

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time of the founding. Namely, the founders decided that the ABFM would be distinguished from other certifying boards in 3 major ways:

1. The ABFM would have no grandfathers—every family physician certified by the ABFM would need to successfully pass the initial certification examination.
2. Those initially certified by the ABFM would need to successfully recertify every 7 years. Successful recertification would require a full, valid, and unrestricted medical license; accumulation of 300 hours of continuing medical education (in alignment with the American Academy of General Practice—the forerunner of the American Academy of Family Physicians—membership requirement); successful completion of an office record review of the management of acute and chronic conditions selected from a list provided by the ABFM; and finally, passing the recertification examination.
3. All certificates administered by the ABFM were time limited and could only be renewed by successfully meeting the requirements for recertification described above.

As will be seen, these rigorous requirements were instrumental in not only guaranteeing that board-certified family physicians had met the highest standards established by any medical specialty board, but also would be critically important in easing family physicians into a new recertification paradigm with the advent of maintenance of certification at the beginning of the 21st century.

The Advent of Maintenance of Certification

Maintenance of Certification (MOC) was adopted by the ABMS in March 2000 as a program for the assessment of the continuing competence of board-certified specialists. This program had 4 basic components that required evaluation by each ABMS medical specialty board before their board-certified diplomates could successfully continue to be designated as board certified. These components included professionalism, life-long learning and self-assessment, cognitive expertise, and performance in practice. ABFM's founders were incredibly prescient, as it is obvious that the 4 elements that they established for recertification were identical to those established by the ABMS for MOC more than 30 years later! Given that the basic elements of ABFM's existing recertification process were embraced by the new ABMS process, it could embark on modernizing each of the elements in the recertification process to make them relevant for the practicing family physician within a rapidly changing health care landscape. A concomitant project on which the specialty of family medicine and each of its major organizations would embark provided the perfect platform for doing so.

This of course was the Future of Family Medicine project, which provided an opportunity for the specialty to reimagine itself within the context of keeping pace with the continuing evolution of the health care system. Specifically, of the 6 task forces that were created to effect the changes needed for the specialty to adapt to this evolution, Task Force 3 was created to address key issues with respect to the continuous personal, professional, and practice development in family medicine. The major goal of this task force was to ensure that family physicians delivered core attributes and system services throughout their careers, and the expected outcome of its work was to identify strategic directions that would improve the quality of health care delivered to patients by family physicians.[3]

Given this opportunity, the ABFM immediately began to redesign its longstanding recertification paradigm to assist family physicians with the task of continuously improving the quality of care they delivered to their patients. The ABFM became an organization continuously focused on the delivery of high-quality care rather than the role it had assumed for the previous thirty years—that of an organization that simply delivered a yearly examination to certify or recertify family physicians. In the process of transforming the organization to deliver on this new strategic direction, a tag line was created to underscore ABFM's new vision: "Quality health care, public trust. . .setting the standards for family medicine." The ABFM launched its newly designed continuous certification process in 2003 with the goal of transitioning every family physician into this process over the ensuing 7 years. New elements of the redesigned paradigm (Table 1) included Self-Assessment Modules (SAMs) that challenged family physicians to keep current with state-of-the-art knowledge in the top 20 areas deemed by the then Institute of Medicine to be critical to the improvement of care in the United States, and Performance in Practice Modules, which streamlined and replaced the Computerized Office Record Review—a process

Table 1. Comparison of Original American Board of Family Medicine Recertification Process with Maintenance of Certification Paradigm

Recertification	Maintenance of Certification
I. Valid and unrestricted license	I. Professional standing
	Valid and unrestricted license
II. 300 hours of CME	II. Self-assessment and lifelong learning
	300 CME credits
	Self-assessment modules
III. Recertification examination	III. Assessment of cognitive expertise
	Maintenance of certification examination
IV. Computerized office record review	IV. Performance in practice
	Performance in practice modules

CME, continuing medical education.

that had served its purpose for more than 25 years. These modules were delivered online and provided the opportunity for diplomates to complete them at a time and location of their own choosing. In addition, the examination was transformed from a paper-and-pencil format delivered once yearly to computer-based delivery at testing centers located throughout the United States and internationally during a 3-week testing window twice yearly. Implementation of these changes required the rapid expansion of ABFM's information technology infrastructure to asynchronously manage the participation of 90,000 diplomates in this new paradigm.

By 2010, every ABFM diplomate had transitioned into MOC and participation in the process was robust.[4] During the transition, several additional milestones designed to improve the quality of care were accomplished. This included collaboration with the American Boards of Pediatrics (ABP) and Internal Medicine (ABIM) on the Improving Performance in Practice initiative in 2003 to introduce diplomates to the processes of quality improvement; public reporting of diplomate participation in MOC in 2006, which continues to this day; creation of a Physician Quality Reporting Initiative registry in 2008 to provide the opportunity for diplomates to meet the MOC performance in practice requirement while receiving enhanced Center for Medicare and Medicaid (CMS) reimbursement for reporting through the registry—the forerunner of our PRIME registry (described later); collaboration with the National Heart, Lung and Blood Institute as a strategic partner to use the SAMs to disseminate new asthma guidelines as part of the National Asthma Education Program in 2009;[5] and creation of the Mayo Clinic Institutional Pilot with ABIM and ABP in 2009 to allow diplomates working at Mayo Clinic institutions and practices to receive MOC credit for quality improvement work done within the Mayo Health Care System. This eventually would grow into a multi-institutional program that we handed off to ABMS in 2013 for administration across all its specialty boards.

While 2010 marked the end of the transition of all ABFM diplomates into MOC, it also was significant in that it signaled the beginning of our meaningful interaction with the Office of the National Coordinator for Health Information Technology (ONCHIT) to link ONCHIT initiatives with MOC. We successfully competed for grant funding with our Improving Performance in Practice collaborators that was awarded by ONCHIT in accordance with the HITECH Act passed by Congress. This funding allowed us to assist diplomates with meeting newly mandated meaningful use of HIT (health information technology) criteria while receiving MOC credit for doing so.

In an effort to continue to provide opportunities for family physicians to improve the care that they delivered, in 2013 the ABFM began to explore the feasibility of creating a clinical registry that would simplify reporting requirements under the CMS Physician Quality Reporting System, enhance reimbursement and also facilitate credit for meeting the practice performance requirements for MOC. Using an outside consultant, the ABFM vetted several potential registry vendors before finally selecting FIGmd (Schaumburg, IL) as our registry partner. Our desire was to create a registry that could continuously extract crucial quality data from the practicing physician's electronic health record and format it in a way that would provide real-time feedback to family physicians on the quality of care that they were delivering within their practices. The ABFM PRIME Registry was launched in 2015, and the ABFM immediately sought and subsequently received approval as a CMS-certified Qualified Clinical Data Registry. This status not only allowed the ABFM to do quality reporting on behalf of diplomates who wished to do so, but also provided the opportunity to create and test new

quality measures. Given the paucity of measures that accurately measured the important work that family physicians perform, the ABFM was excited to be able to propose and test new measures that described the critical characteristics of primary care such as continuity, comprehensiveness, and coordination of care.

On the journey to becoming an organization designed to help family physicians deliver higher-quality care, the ABFM realized that strategic investment in the next generation of family physicians was critical, and it embarked on a number of initiatives to help family medicine training programs prepare their trainees for the rapidly changing environment in which they would soon practice. The first of these initiatives, launched in 2006, was P^4, Preparing the Personal Physician for Practice, and participating programs were granted wide latitude from the ABFM with respect to innovating around the Accreditation Council for Graduate Medical Education (ACGME) program requirements.[6] While this project resulted in a number of novel innovations, perhaps one of the most important was innovation around the length of training, with several P^4 programs exploring the benefit of expanding training from 3 years to 4. To further explore the impact of an additional year of training on residency training outcomes, the ABFM in collaboration with the ACGME launched the Length of Training Pilot in 2012.[7] These 2 pilots signaled the beginning of a new relationship with the ACGME and the Family Medicine Review Committee. Specifically, the outcomes of these 2 pivotal projects along with ABFM data routinely collected on family physicians and residency graduates could be used by both organizations to measure training program outcomses.[8] Most importantly, this information could be used by both organizations to inform changes in training program requirements to benefit the preparation of family physician trainees to practice in a rapidly evolving health care environment.

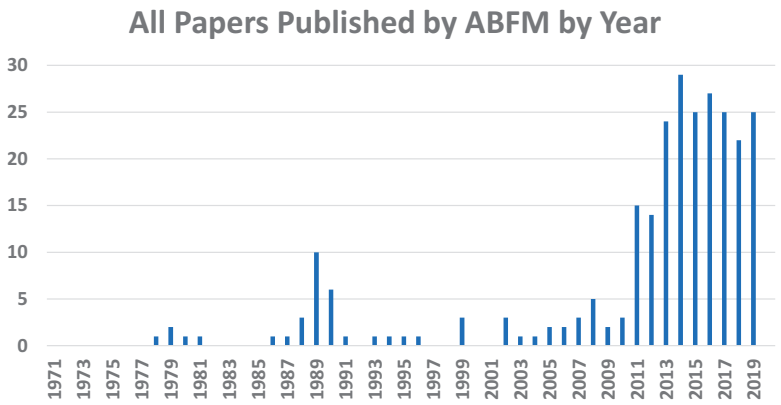
Creation of the ABFM Research Enterprise

During its strategic planning process in 2007, the ABFM board of directors identified assessment of the impact of MOC as its first and most important priority. An initial effort to recruit a research director to undertake this endeavor was unsuccessful, and so the ABFM decided to partner with the Robert Graham Center to begin this task in 2008. This partnership created the foundation for the ABFM's fledgling research enterprise and provided access to resources that the ABFM did not have at that time. These included access to the American Medical Association (AMA) Master File, geospatial analysis, and large data set expertise. While much of the early work done with the Graham Center looked at participation in MOC and evaluated the efficacy of its various elements,[9,10] the researchers at the Graham Center also found utility in the wealth of data that the ABFM possessed about board-certified family physicians. These data had been collected over years at the time that diplomates applied for the continuing certification examination and provided a rich and deep data source that traced the changing nature of the specialty of family medicine.[11] This led to several studies assessing the evolution of the practice of family medicine by our diplomates.[12–14]

As the research portfolio expanded and the research community became aware of the ABFM's research capabilities, another search for a research director ensued, which concluded with the onboarding of a new, inhouse research director in 2012. Concurrently, a new Vice President of Research and Policy was also recruited, who also came onboard in 2012 to oversee the expansion of the ABFM research endeavor and the use of ABFM data to create sound policy. In short order, a qualitative researcher, a large data set researcher, and a research assistant were hired to create the critical mass necessary to meet the expectations of the board of directors, who again had identified exploration of the value of the ABFM certification program and its various elements as the top strategic priority during their 2012 strategic planning process. Accordingly, the research department began the critical analysis of each of the components of the certification process, including the examination, SAMs, and Performance in Practice Modules, as well as the in-training examination taken by residents, and the scope of practice of family physicians. This has resulted in the publication of over 150 peer-reviewed manuscripts to date (Figure 1), and this body of work has verified the efficacy of the ABFM certification paradigm and demonstrated its ability to improve the quality of care that ABFM certified family physicians deliver to their patients.

As the research enterprise grew, the realization that it was important to be able to categorize, store, and retrieve all the data that was being collected

Figure 1. Number of American Board of Family Medicine research publications by year.



became increasingly apparent. This led to a detailed analysis of data management processes and the implementation of an enterprise data management strategy. The ABFM created a data warehouse where it began to store uniquely characterized data from diplomate demographic surveys, the national graduate surveys, ACGME Milestones data, as well as data from continuing certification assessments, including examination performance, self-assessment activities, and performance in practice activities. While not completely built out yet, the data warehouse is expected to eventually hold over 20 million discrete data elements, becoming the single largest data repository for the specialty.

It is important to note that the significant accomplishments realized by the research enterprise would not have been possible without the ABFM's decision in 2003 to transform itself into a digital organization with the advent of MOC. The rapid evolution of its information technology infrastructure, which has now become virtualized, set the stage for it to become an organization whose decisions are directed by data, and whose information technology expertise and resources has allowed it to rapidly innovate. The recent accelerated launch of a longitudinal assessment pilot as an alternative option to the high stakes continuing certification examination is a perfect example of this.

Culture Trumps Strategy

While attempting to briefly convey critical aspects of the evolution of the ABFM over the past 50 years, it should be apparent that the repeated ability of the organization to transform itself to meet the challenges of an ever-changing health care environment has been a key element in the successful implementation of its certification programs. In large part, this culture can be attributed to the bold vision for the specialty that the founders created when they introduced the revolutionary concepts of time-limited certification and recertification at the inception of the specialty. In the ensuing 50 years, the ABFM has been fortunate to have a staff dedicated to keeping the organization on the forefront of professional certification, and this has been aided by the enabling function of a board of directors equally dedicated to the mission of the organization. No challenge has been too great and no obstacle insurmountable for an organization continuously committed to excellence in all that it does. Based on the recent strategic plan developed by the current board of directors this year, we can be confident that the ABFM will continue to challenge itself to remain on the leading edge of physician certification and self regulation.

To see this article online, please go to: http://jabfm.org/content/33/Supplement/S69.full.

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