New Recertification Is Not So Bad, Expert Says

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

NEW YORK — The new recertification process developed by the American Board of Family Medicine is not as onerous as some are making it out to be, L. Thomas Wolff, M.D., said at a meeting of the New York County Chapter of the American Academy of Family Physicians.

"We're doing many of the things we were doing in the past, but we're doing them better," he said. "We're helping ourselves as a discipline."

Dr. Wolff formerly served on the American Board of Medical Specialties and its Committee on Certification and Recertification. He noted that it was the ABMS that initiated changes to the recertification process, which apply to all ABMS member boards. "It's really an issue that all of medicine is struggling with," he said.

He also pointed out that the ABFM was the first specialty board ever to require recertification. "Nicholas Pisacano, M.D. [the ABFM's first executive director], said, 'How can we put our imprimatur on someone and know that 7 years later, they've kept up?'" explained Dr. Wolff. "We were also the only board at the time to require continuing medical education."

The ABFM, formerly known as the American Board of Family Practice, was renamed effective Jan. 1 following the unanimous recommendation by its board of directors. The name change was associated with AAFP's Future of Family Medicine project, which recommended more use of the term "family medicine" to avoid the confusion generated by the term "family practice."

ABFM also required family physicians to send in charts for chart review. "That really made me look at my practice and change things," said Dr. Wolff, who still sees patients and is also director emeritus of the Rural Medical Education Program at the State University of New York, Syracuse. He noted that the ABMS is currently working on refining its peer review process for the specialties.

Dr. Wolff gave high praise to the interactive patient simulator, in which physicians get to "examine" and ask questions of a simulated patient on the computer. The program requires the test taker to manage the patient until he or she is stabilized for either three visits or 2 years' time, whichever comes first.

But Wendy Barr, M.D., a family practice resident at Beth Israel Medical Center, New York, who recently used the simulator, said it has kinks that need to be worked out. For example, there were no instructions about how to use a pull-down menu that would "officially" tell the patient to go home. "So if you didn't know you needed to send the patient home, the patient sat in the waiting room all night, and you got dinged for it," she said.

Another point of contention is the self-assessment modules (SAMs). To recertify, family physicians must complete at least one annually. Critics say the modules take too long and don't have intuitive answers. In fact, the American Academy of Family Physicians House of Delegates voted at their meeting last October to ask the ABFM to delay implementation of the SAMs (FAMILY PRACTICE NEWS, Nov. 1, 2004, p. 1).

But Dr. Wolff said that the SAMs were useful teaching tools; he noted that the plan is to update them with the latest evidence-based medicine every 6 months. And in response to a question from an audience member, he said he would not be surprised to see the SAMs replace recertification exams—another part of the process—altogether.

'Physicians in general seem to get so stuck in the way things are. It's amazing how disappointing people's response has been.'

"It may be that at some point the ongoing [SAM] process will suffice," he said, adding that such a change would be a long way off. "I don't know that, but it wouldn't surprise me." Dr. Wolff noted that for all the angst among family physicians about the changes, there is even more consternation among other specialties such as thoracic surgery, in which physicians had been given what they assumed would be a "lifetime" certification, only to find out they now have to recertify.

Neil Calman, M.D., president of the Institute for Urban Family Health, New York, said he thought the reaction of family physicians to the new process has been "absolutely absurd."

"Physicians in general seem to get so stuck in the way things are," he said. "It's amazing how disappointing people's response has been."

One of the little known advantages of the new process, noted Steve Tamarin, M.D., chief of family medicine at St. Luke's-Roosevelt Hospital Center, New York, is that physicians can receive up to 15 hours' CME credit for each SAM they complete.

"One of the problems in medicine is that the quality of CME available really stinks, and much of it is corrupt [because] it's financed by the pharmaceutical companies," he said. "It's a serious problem, the corruption of medical education by business. This solves that problem."

Dr. Wolff urged audience members to contact the board if they have questions or concerns about recertification.

One change the board made to the SAMs involved the process used to educate the physician if he or she got a question wrong. "It [used to] send you to an article, where you had to read the whole bloody article to find one thing," he said. "But now they're going to have [specific] critiques with the information because the idea is to teach, not to try to fool anybody." ■

POLICY & PRACTICE

Portable Health Plans

Patients can take their health insurance coverage with them when they change or lose a job, under the final regulations that implement the last piece of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). According to a statement by the Health and Human Services Department, it is important that American workers, who often change jobs several times in the course of their lives are able to respond to the modern workplace without having to fear for their health insurance. The regulations allow greater portability and availability of group health coverage during a time of job transition, setting limits on preexisting condition exclusions that could be imposed, and requiring group health plans and insurance issuers to offer "special enrollment" to certain patients who lose eligibility for other group health coverage or health insurance, or to otherwise eligible new dependents. The regulation goes into effect for plan years starting on or after July 1.

Computer Entries Lead to Errors

Automation isn't necessarily a foolproof way to improve patient safety and reduce medical errors, a report from the United States Pharmacopeia (USP) found. Computer entry errors were the fourth leading cause of medication errors according to MEDMARX, USP's national medication error reporting system. These errors have steadily increased and represent about 12% of all MEDMARX records from 1999 through 2003. Performance deficits—where an otherwise qualified physicians makes a mistake—were the most frequently reported cause of errors. Distractions were the leading contributing factor, accounting for almost 57% of errors associated with computer entry. The report provided an analysis of 235,159 medication errors voluntarily reported by 570 hospitals and health care facilities nationwide.

Reduced Benefits for Retirees

Businesses are asking retirees to pay more for their health coverage as they struggle to control rising costs, the Kaiser Family Foundation reported. In the past year, 79% of firms increased their retirees' contributions for premiums, and 85% expect to do so in the coming year. In addition, 8% of employers surveyed eliminated subsidized health benefits for future retirees in 2004. For 2005, 11% said they are likely to terminate coverage for future retirees; however, 58% of said they were likely to continue offering prescription drug benefits and accept the tax-free subsidy created by the new Medicare law. The survey included responses from 333 large private-sector firms that offer retiree health benefits.

Spending for Power Wheelchairs

Federal safeguards did not go far enough to curb out-of-control spending growth for power wheelchairs under the Medicare program, the Government Accountability Office found. Medicare spending for the wheelchairs rose more than fourfold from 1999 through 2003, raising concerns that some of the payments may have been improper. Following the indictment of several power wheelchair suppliers in Texas who fraudulently billed Medicare, GAO was asked to examine earlier steps taken by the Centers for Medicare and Medicaid Services to respond to improper payments. CMS' contractors started informing the agency in 1997 about escalating spending for wheelchairs, and some started taking steps to respond to improper payments, yet the agency didn't assume an active role until 2003. Since then, CMS has worked to prevent fraudulent suppliers from entering the Medicare program, although it has not implemented a revised form to collect better information for power wheelchair claims reviews, the GAO found.

Medicaid's Benefits to the States

An annual fiscal survey of the states failed to examine the benefit of Medicaid to the states' economies, according to Families USA. The report released by the National Governors Association (NGA) and the National Association of State Budget Officers indicated that state spending for Medicaid, including federal funds, has surpassed state spending on primary and secondary education. Yet, state general fund expenditures show that states spent more than twice as much on education than they did on Medicaid. "When analyzing the NGA survey's findings on Medicaid, it is important to count the economic benefit that Medicaid holds for states," said Families USA Executive Director Ron Pollack. "A recent Families USA study found that on average every $1 million invested in Medicaid by states generates nearly 34 jobs, $1.2 million in wages, and $3.3 million in business activity," he added. During fiscal 2005, Medicaid is estimated to grow as much as 12% due in part to expiring federal fiscal relief. Long-term growth is expected to be 8%-9%, well above expected state revenue growth, the NGA's report said.

Global Smallpox Stockpile

The United States has pledged 20 million doses of smallpox vaccine toward the global stockpile managed by the World Health Organization (WHO). The vaccine doses will physically remain in the U.S. Strategic National Stockpile, but will be available for WHO use in an emergency. The global stockpile is designed to help countries, especially developing ones, that have no vaccine and are not prepared to respond to a smallpox outbreak. The global stockpile will only be used if at least one human case of smallpox is confirmed. U.S. officials have been urging the creation of a WHO Smallpox Vaccine Bank, which would create a physical vaccine stockpile in Geneva and a virtual global stockpile around the world.

—Jennifer Silverman