ACHIEVING THE MULTIPLIER EFFECT USING PART IV MOC
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INTRODUCTION
ABMS PERFORMANCE IMPROVEMENT
• Health care systems and their physicians continuously strive to improve care to patients through QI/PI initiatives
• Family Medicine residents and faculty are required to complete a performance improvement activity for board (re) certification

HEALTH CARE DISPARITIES – ACCREDITATION REQUIREMENTS
• Physicians across the continuum of medical education need to learn and incorporate an understanding of health care disparities into their care of patients
  o MEDICAL STUDENTS
    • LCME Standard 7.6: Curricular Content/Cultural Competence and Health Care Disparities
  o RESIDENTS/FELLOWS
    • CLER Pathway #5 Quality: Reducing Health Care Disparities
  o PRACTICING PHYSICIANS
    • CME must be a strategic asset to QI/patient safety imperatives including health care disparities

PHYSICIAN WELL BEING & BURNOUT
• PI, QI & Health Care Disparities initiatives can be perceived as just another requirement
• Studies on well-being and burnout plus medical education accreditation standards, highlight the importance of:
  o Engaging in team-based activities
  o Aligning/integrating education to meet multiple needs

PROJECT AIM: MAKE IT COUNT 3X
Utilize a single QI initiative to meet and seamlessly complete multiple requirements using a disparities focused learning/PI activity in a family medicine residency program:
1. Accreditation
2. Board Certification
3. ↑ Patient Outcomes

METHODS
IDENTIFIED CURRENT PROJECT / ACTIVITY THAT COULD COUNT 3X
Family Medicine Resident Program was an Alliance of Independent Medical Center (AIAMC) National Initiative V participant required:
• Project focused on health care disparities from identification of actionable clinical disparity gap in patients’ care then education and subsequent PDSA cycles to address the gap:
  o COLORECTAL CANCER SCREENING (CRC) is clinical quality metric
    • CRC screening population records sampled for eligible patients ≥ age 50
    • Age = largest disparity gap for CRC
    • 13-15% screening gaps between populations aged 50-54 and ≥ 65 vs age
• Project met ACGME CLER + Common Program Requirements for:
  o Health Care Disparities
  o Quality Improvement
  o Scholarly Activities
  o Board Certification
  o Project participation = Performance Improvement

PART IV BOARD CERTIFICATION
• Application submitted and approved through Aurora Health Care’s Continuing Professional Development Portfolio Program
  o Maintenance of Certification (MOC) Part IV for ABFM
  o 2 PDSA cycles with 3 data points: baseline, midpoint, end

RESULTS X 3
#1: PART IV BOARD CERTIFICATION
• 23 Family Medicine participants
  o 11 residents
  o 12 faculty
• Key participant lessons learned:
  o I learned that patients are amenable to discussion of CRC screening
  o “Normalizing” the screening for the patient seems to make them more agreeable
  o I think the largest barrier our patients face is health literacy – in following the very complex instructions for the (at home) screening test...

#2: ACGME CLER – COMMON PROG REQUIREMENTS
  • HEALTH CARE DISPARITIES & TEAMWORK
    • Application to patient care
  • QUALITY IMPROVEMENT PARTICIPATION
  • SCHOLARLY ACTIVITIES
    • 7 presentations at regional/national meetings
    • 1 published abstract

#3: IMPROVED PATIENT CARE – CRC SCREENING
• DECREASED AGE DISPARITY GAP by 5% for CRC screening in our family medicine residency clinics
• INCREASED CRC SCREENING in 50-54 yo patients by up to 6% depending on clinic

SUMMARY & NEXT STEPS
• We CAN meet ACGME reqs, ABMS board certification reqs and improve patient care with one activity!
• Minimized check-box burdens (burnout) + supported well being (team, shared activity)

References
2. LCME Functions and Structure of a Medical School. Sept 2017.