



The American Board of Family Medicine

ABFM's Required Part IV (PPM, MIMM) – The Best Approach for the Best Results

*Joseph W. Tollison, M.D.
Senior Advisor to the ABFM President*

DISCLOSURE: Dr. Tollison has nothing to disclose related to his presentation.

ABFM Goal:





Foundation of Maintenance of Certification for Family Physicians (MC-FP)

- **Six Core Competencies are the foundation of MC-FP and are assessed during medical training and throughout a physician's career.**
- **They have been endorsed by the Accreditation Council for Graduate Education (ACGME) and the twenty-four members boards of the American Board of Medical Specialties (ABMS).**





Core Competencies

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
2. **Medical Knowledge** about established and evolving biomedical, clinical, and cognitive sciences and the application of the knowledge to patient care.
3. **Practice-based Learning and Improvement** that involve investigation and self-evaluation, appraisal and assimilation of scientific evidence, and improvements in patient care.



Core Competencies

4. Interpersonal and Communication Skills that result in effective information exchange and collaboration with patients, their families, and other health professionals.
5. Professionalism as manifested through a commitment to perform professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
6. Systems-based Practice as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to use system resources to provide optimal care.



Core Competencies

Each of the four parts of MC-FP assesses one or more of the Core Competencies.

Core Competencies	1 Professional Standing	2 Lifelong Learning	3 Cognitive Expertise	4 Performance In Practice
Patient Care				
Medical Knowledge				
Practice-based Learning & Improvement				
Interpersonal & Communication Skills				
Professionalism				
Systems-based Practice				



ABFM Maintenance of Certification for Family Physicians (MC-FP)

- Part I:** Evidence of professional standing
- Part II:** Evidence of a commitment to lifelong learning and involvement in a periodic self-assessment process
- Part III:** Evidence of cognitive expertise
- Part IV:** Evidence of evaluation of performance in practice

Since Our Inception in 1969



What Exactly are the MC-FP Requirements?

7 Year Cycle

7 Modules Total

Certified/Recertified
2003-2010

7 Year Certificate

10 Year Cycle

9 Modules Total

Certified/Recertified
2003-2010

10 Year Certificate

Continuous

**50 Points
Per 3-Year Stage**

Certified/Recertified
2011 and Beyond

Certificate without
End Date



NEW

Continuous MC-FP

Changes Effective with Continuous MC-FP

- 10-year examination requirement
- 7-year certification plan no longer available
- Point system in place - 50 points required per 3-year Stage
 - SAMs= 15 points
 - PPMs= 20 points
 - MIMMs = 15-20 points
- Certification status contingent on meeting MC-FP requirement **WITHIN** each 3-year Stage (deadline December 31st of year 3 of Stage)
- Simplified financial plan
- CME requirement per 3-year Stage – 150 credits (*Unchanged*)



MC-FP Deadline

Deadline:
December 31, 2014

2011 Diplomates:
Complete Continuous
Stage MC-FP
Components

2007 Diplomates:
Complete Stage II
MC-FP Components

2004 Diplomates:
Complete Stage III
MC-FP Components



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- **Website**
 - www.theabfm.org
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 - Phone: 888-995-5700
 - Fax: 859-335-5701

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Extended Hours Available!

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(eastern)

Monday - Friday

&

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(eastern)

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- Manned by ABFM Staff located **IN** the ABFM home office
- Able to answer questions regarding all phases of ABFM business

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2 Minute Rule

Have a Question after 2 minutes?
Contact our Support Center!!



ABFM Maintenance of Certification for Family Physicians (MC-FP)

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- Part III:** Evidence of cognitive expertise
- Part IV:** Evidence of evaluation of performance in practice

Since Our Inception in 1969



**Take
the
Leap**



PQRS

Physician Quality Reporting System Diabetes Only



ABFM MC-FP Part IV

PPM
PPM Alternative
MIMM

MC-FP Part IV



ABFM MC-FP Part IV

**Do you have
Continuing Patient Care?**

YES

**ABFM
Approved Part
IV Activities**

NO

**MIMM
ABFM Approved
Part IV**

**Hand Hygiene
with Simulated
Patient Data**

**Self Directed
Activity without
Patient Data**



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Demographics

The pathway in which you will complete the Part IV requirement for MC-FP is dependent upon your continuing care responsibilities for family medicine patients and the availability of patient data. You will be provided the modules which you can complete to fulfill the Part IV requirement by answering the following question.

Do you have direct, continuing care responsibilities for family medicine patients? ☐ Yes ☐ No

[Submit](#)

If you have direct,
continuing patient care,
click Yes.

If you have NO direct,
continuing patient care
responsibilities, click NO.

Related Pages

[Track Your Progress](#)

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Tools

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ABFM MC-FP Part IV

MIMM

MC-FP Part IV



ABFM MC-FP Part IV

**Do you have
Continuing Patient Care?**

YES

**ABFM
Approved Part
IV Activities**

NO

**MIMM
ABFM Approved
Part IV**

**Hand Hygiene
with Simulated
Patient Data**

**Self Directed
Activity without
Patient Data**



ABFM MC-FP Part IV

NO Access to Continuing Patient Care?



Methods in Medicine Modules (MIMMs)

ABFM Products

no additional charge beyond the cost of MC-FP

Current Topics:

Clinical Information Management MIMM

Cultural Competency MIMM

Hand Hygiene PPM (with simulated patient data)

ABFM Self-Directed Activity



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Medical Licensure



MC-FP Modules



MC-FP Exam

My MC-FP

- ▶ [My Requirements](#)
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Payments

- ▶ [Payment Receipts](#)

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- ▶ [Request Verification Letter](#)
- ▶ [Diplomate Status:](#) Certified
- ▶ [MCFP Status:](#) Meeting Requirements
- ▶ [Current Cycle:](#) 7 Year Certificate with Option to extend to 10 years

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MC-FP Modules

Current Stage
Activity

Self-Assessment
Modules (Part II)

Part IV
Modules

External Part IV
Modules

Performance in Practice Modules

Performance in Practice Modules (PPMs) consist of introductory materials, detailed instructions, and an interactive quality improvement (QI) development process. The QI implementation period is a minimum of 1 days with the exception of the Hand Hygiene PPM which has a minimum of 14 days (two 7-day periods) for the QI implementation period. Please keep these timeframes in mind when completing your MC-FP requirements.

Introduction ▼

Roadmap ▼

Available Topics	Access Module
Hypertension PPM	REVIEW

Alternative Part IV Modules

Available Topics	Access Module
Cultural Competency MIMM	START
Hand Hygiene PPM	START
Information Management MIMM	RESUME

Available
resources to assist
you in completing
the **MIMM**:
Introduction
Roadmap

- ▶ [MC-FP User's Guide](#)
- ▶ [Support Center](#)
- ▶ [Change Part IV Pathway](#)



MC-FP Modules

Current Stage
Activity

Self-Assessment
Modules (Part II)

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Performance in Practice Modules

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Introduction ▼

Roadmap

Available Topics

Hypertension PPM

Alternative Part IV Modules

Available Topics	Access Module
Cultural Competency MIMM	START
Hand Hygiene PPM	START
Information Management MIMM	RESUME

Related Pages

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Tools

To begin a MIMM click on the
“START” link next to the MIMM topic
of your choice.



ABFM MC-FP Part IV

PPM Alternatives MC-FP Part IV



ABFM MC-FP Part IV

Approved Part IV Alternatives

(Examples of Approved Part IV Alternatives)

- American Academy of Family Physicians (METRIC)
- Multi-Specialty Portfolio Approval Program (MSPP) Sponsor organization activities
- National Committee for Quality Assurance (NCQA)
 - Physician Recognition Programs
 - Approved programs: Diabetes, Heart/Stroke, Back Pain, Patient Centered Medical Home
 - Individual-level certificates of recognition in Heart/Stroke, Diabetes, Back Pain, or PCMH (only 2011, Level 3) can be submitted for Part IV credit
 - Organization-level certificates of recognition require additional physician attestation to be considered for Part IV credit

(Bridges to Excellence programs can be considered through the Self-Directed pathway)



ABFM MC-FP Part IV

Visit the ABFM website for the
complete current list of

Approved Outside Vendor Activities

www.theabfm.org

*(listed under the Maintenance of Certification Section—
click the Part IV Performance in Practice)*



Part IV Alternatives Support

- **Nichole Lainhart, Program Manager MC-FP Alternatives Activities**
 - Phone: 877-223-7437, ext 1230
 - Email: NLainhart@theabfm.org
- **Support Center**
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 - Live Chat



ABFM MC-FP Part IV

PPM

MC-FP Part IV



ABFM MC-FP Part IV

**Do you have
Continuing Patient Care?**

NO

**ABFM
Approved Part
IV Activities**

Yes

**PPM ABFM
Approved Part
IV with Patient
Data**

**PPM Alternatives
Part IV Modules
with Patient Data**

**Self Directed
Activity with
Patient Data**



ABFM MC-FP Part IV

Access to Continuing Patient Care?

YES

Complete a Performance in Practice Module (PPM)



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ABFM MC-FP Part IV

Important Benefits of the PPM

- 1) Applied to your practice and your patients
- 2) Provides performance-based overview of your practice
- 3) Directed and controlled by you
- 4) Data available only to you (non-discovery)

★ Physician Quality Reporting System (Diabetes) with potential additional financial benefits available



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MC-FP Modules



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My MC-FP

- ▶ [My Requirements](#)
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Spotlight Programs

- ▶ [Physician Quality Reporting](#)
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Payments

- ▶ [Payment Receipts](#)

Current Status

- ▶ [Request Verification Letter](#)
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MC-FP Modules

Current Stage
ActivitySelf-Assessment
Modules (Part II)Part IV
ModulesExternal Part IV
Modules

Related Pages

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My Calendar

Tools

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- ▶ [Support Center](#)
- ▶ [Change Part IV Pathway](#)

Performance in Practice Modules

Performance in Practice Modules (PPMs) consist of introductory materials, detailed instructions, and an interactive quality improvement (QI) development process. The QI implementation period is a minimum of 0 days with the exception of the Hand Hygiene PPM which has a minimum of 14 days (two 7-day periods) for the QI implementation period. Please keep these timeframes in mind when completing your MC-FP requirements.

Introduction

Roadmap

Available Topics	Access Module
Asthma PPM	START
Comprehensive PPM	START
Coronary Artery Disease PPM	START
Depression PPM	START
Diabetes PPM	START
Hand Hygiene PPM	START
Heart Failure PPM	START
Hypertension PPM	REVIEW

Alternative Part IV Modules

Available Topics	Access Module
Information Management MIMM	RESUME

Available
resources to assist
you in completing
the **PPM**:
Roadmap
Introduction



ABFM MC-FP Part IV

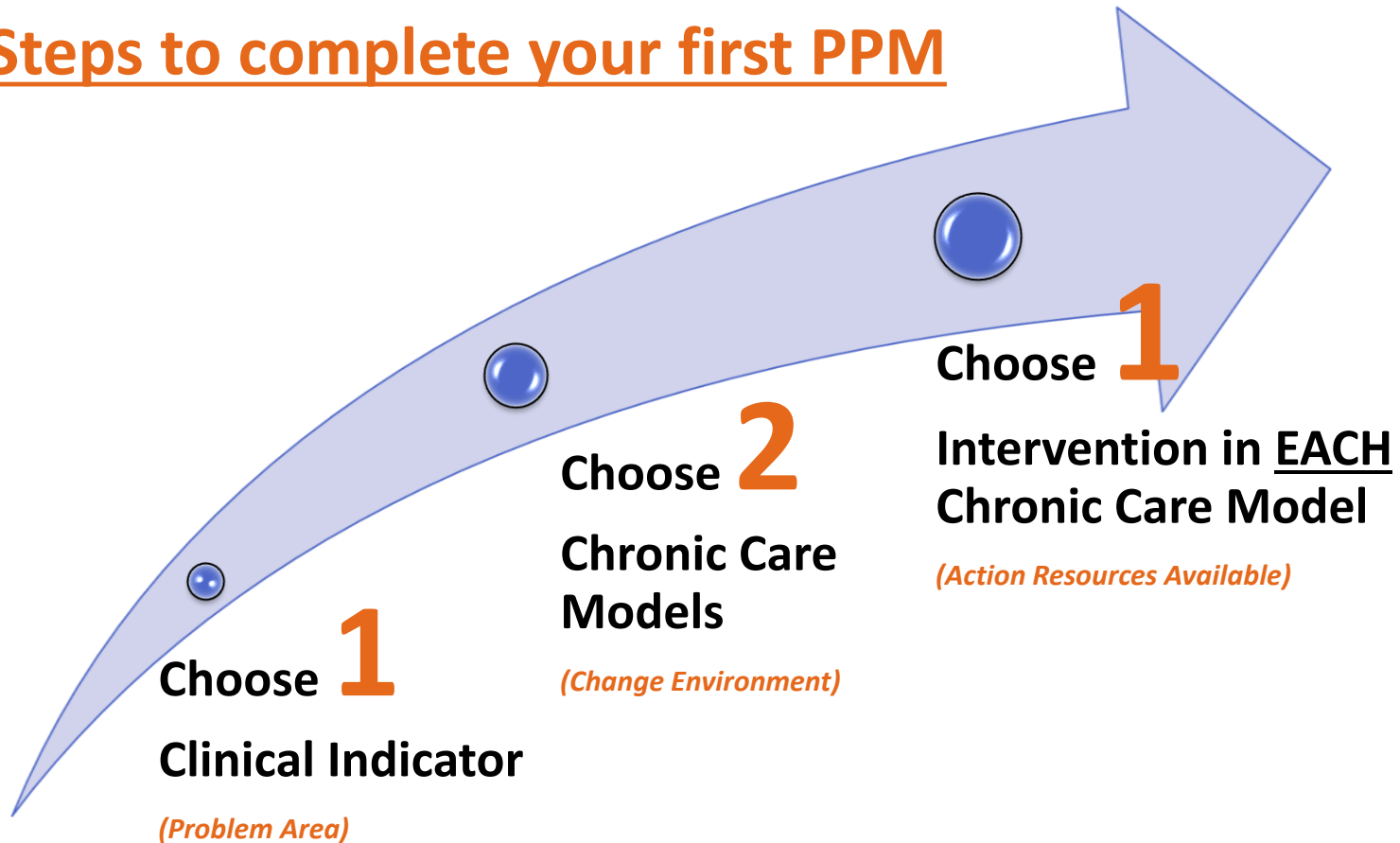
PPM Choices currently available online:

- Asthma
- Comprehensive
- Coronary Artery Disease
- Depression
- Diabetes
- Hand Hygiene
- Heart Failure
- Hypertension
- Self-Directed



ABFM MC-FP Part IV

Steps to complete your first PPM





ABFM MC-FP Part IV

Let Your Staff Help
IMPORTANT!!!



Print Forms



Hand Out Forms
(Individual Entry Mode Only)



Input Data



ABFM MC-FP Part IV

1 Week Minimum

**QI Implementation Period Between
Pre and Post Data Collection**





ABFM MC-FP Part IV





ABFM MC-FP Part IV

There are 2 ways to submit patient data in a PPM

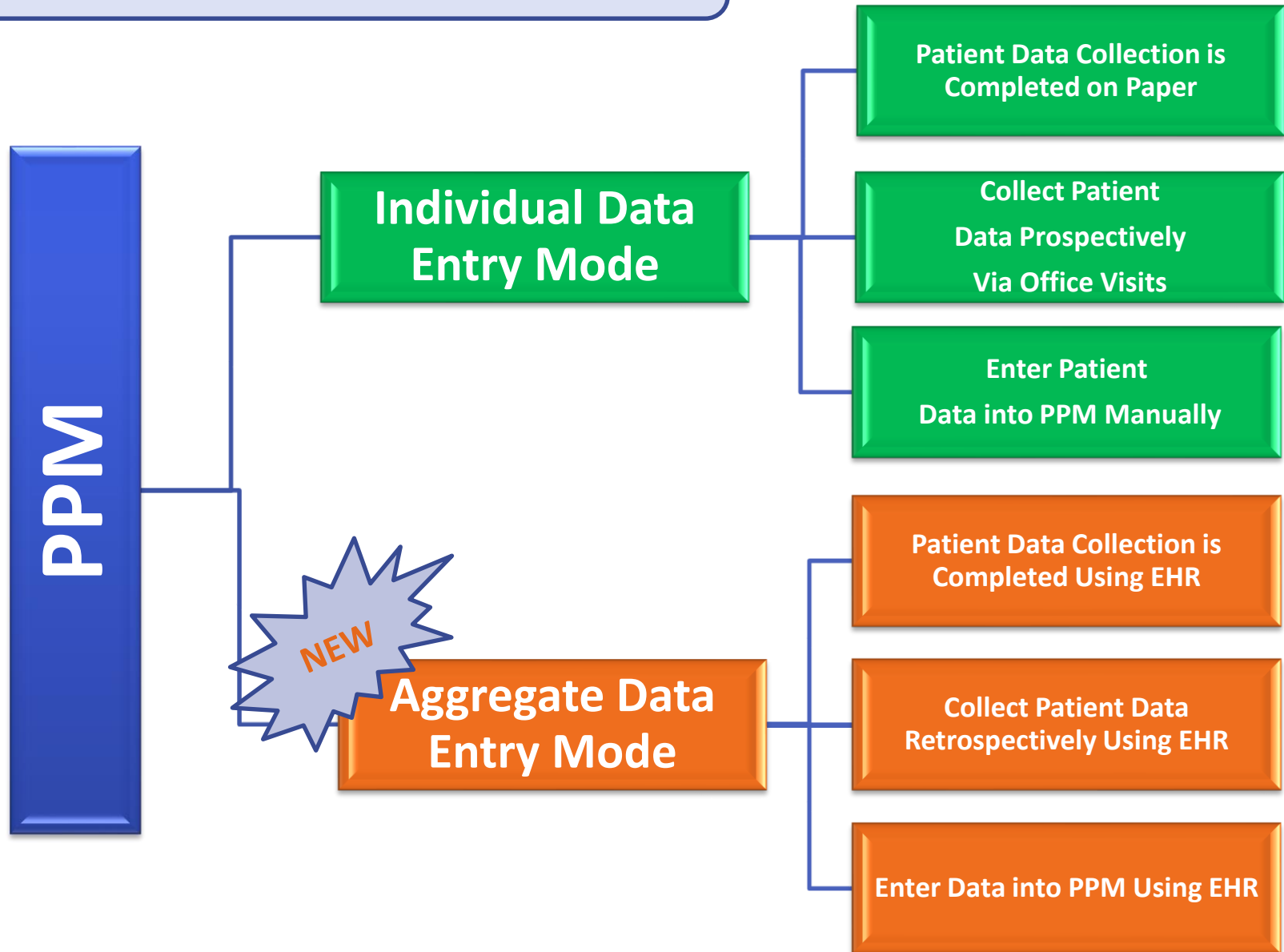
Individual Entry Mode

- Enter your data prospectively based on individual patients

Aggregate Entry Mode

- Enter data retrospectively for multiple patients
- Most commonly used for physicians who have Electronic Health Records (EHR)

What is the Difference Between Individual and Aggregate Data Entry Mode?





Performance In Practice

Performance in Practice

Indicators Instrument

Indicators

CM Categories

Interventions

Plan

Respond

Withdraw

Quit

PPM Status

Expand All

Initiated the PPM Process

First set of patient data submitted

Created a plan for improvement

Second set of patient data submitted

Completed PPM successfully

Status Legend

Completed

Current

Pending



Current PPM Module

Diabetes



Introduction
[HTML](#) | [PDF](#)



Navigational Tutorial
[View Tutorial](#)

Download PPM Indicators Instrument

Please download the PPM Indicator Instrument. This instrument is based on important indicators of Diabetes care; each question represents one of these indicators and corresponding questions for the physician to answer. The responses on this form will gauge your performance on the indicators. You should download and you then may enter the results by returning to the Diabetes PPM module in the ABFM Web portal.

The instrument is available in two layouts: (1) a two-page version, with one page containing the patient questions and one containing the physician questions listed side by side.

If you have not submitted the patient data within 3 months, you will receive an email notification reminding you to do so.

Download Diabetes Indicator Instrument

Instrument Layout

Separate Questionnaires

Each indicator instrument will be printed on a separate page.

- [English \(PDF\)](#)
- [Spanish Patient/English Physician \(PDF\)](#)
- [English Patient/Spanish Physician \(PDF\)](#)
- [Spanish \(PDF\)](#)

- Windows - Right-click and select "Save"
- Macintosh - Control + Click and Select

Combined Questionnaire

Each indicator instrument will be printed side-by-side on a single page.

- [English \(PDF\)](#)
- [Spanish Patient/English Physician \(PDF\)](#)
- [English Patient/Spanish Physician \(PDF\)](#)
- [Spanish \(PDF\)](#)

- Windows - Right-click and select "Save"
- Macintosh - Control + Click and Select

Proceed

Physician Questionnaire

This form is being used to evaluate and improve the care you receive from your doctor. It is also meant to help you talk with your doctor about your health. Please take a few minutes to answer the first set of questions on this form and then hand it to your doctor or a member of his or her staff. Your doctor will answer the second set of questions. Please answer honestly. Your responses will be kept completely confidential.

Diabetes Patient Indicators Instrument

1. Have you had your hemoglobin A1c (a test of how much sugar is in your blood) checked in the last 6 months? Select Yes or No.
☐ Yes
☐ No

Diabetes Physician Indicators Instrument

1. Have you tested the patient's hemoglobin A1c in the last 6 months? Select Yes or No.
☐ Yes
☐ No

If you selected yes, what is the patient's hemoglobin A1c value?
Hemoglobin A1c _____

2. Have you examined the patient's feet today? Select Yes or No.
☐ Yes
☐ No

Patient Questionnaire

Diabetes Physician Indicators Instrument

4. Have you tested the patient's hemoglobin A1c in the last 6 months? Select Yes or No.
☐ Yes
☐ No

If you selected yes, what is the patient's hemoglobin A1c value?
Hemoglobin A1c _____

5. Have you examined the patient's feet today? Select Yes or No.
☐ Yes
☐ No

If you selected yes, select each aspect of the examination that you have performed.

- ☐ Inspection
- ☐ Monofilament Examination
- ☐ Vascular Integrity

6. Have you tested the patient's urine for microalbuminuria this year? Select Yes or No.
☐ Yes
☐ No
☐ Not Applicable

If you selected yes, was it positive or negative? Select the appropriate response.

- ☐ Positive
- ☐ Negative

7. Have you counseled the patient for smoking cessation? Select the appropriate response.
☐ Yes
☐ No
☐ Not Applicable

8. Do you have documentation that the patient had an eye exam performed by an eye care professional in the past year?
☐ Yes
☐ No

9. Have you checked the patient's LDL value in the past year? Select Yes or No.
☐ Yes
☐ No

If you selected yes, what is the patient's most current level?

LDL Level _____

10. Have you measured the patient's systolic and diastolic blood pressure today? Select Yes or No.
☐ Yes
☐ No

If you selected yes, what is the patient's blood pressure?

Systolic _____

Diastolic _____

Individual Entry Mode
Download PPM Indicator Instruments (Questionnaires)

Individual Entry Mode:

Diabetes PPM Example Questions:

Physician Questionnaire

Diabetes Physician Indicators Instrument

1. Have you tested the patient's hemoglobin A1c in the last 6 months? Select Yes or No.

- ☐ Yes
☐ No

If you selected yes, what is the patient's hemoglobin A1c value?

Hemoglobin A1c _____

2. Have you examined the patient's feet today? Select Yes or No.

- ☐ Yes
☐ No

If you selected yes, select each aspect of the examination that you have performed.

- ☐ Inspection
☐ Monofilament Examination
☐ Vascular Integrity

3. Have you tested the patient's urine for microalbuminuria this year? Select Yes or No.

- ☐ Yes
☐ No
☐ Not Applicable

If you selected yes, was it positive or negative? Select the appropriate response.

- ☐ Positive

Individual Entry Mode:

Diabetes PPM Example Questions:

Patient Questionnaire

staff. Your doctor will answer the second set of questions. Please answer honestly. Your responses will be kept completely confidential.

Diabetes Patient Indicators Instrument

1. Have you had your hemoglobin A1c (a test of how much sugar is in your blood) checked in the last 6 months? Select Yes or No.
 - ☐ Yes
 - ☐ No
2. Has your doctor checked your feet in the last 6 months? Select Yes or No.
 - ☐ Yes
 - ☐ No
3. Has your doctor tested your urine for signs of diabetic kidney disease this year? Select Yes or No.
 - ☐ Yes
 - ☐ No
4. Do you smoke? Select Yes or No.
 - ☐ Yes
 - ☐ No

If you selected yes, has your doctor talked to you about quitting? Select the appropriate answer.

- ☐ Yes
- ☐ No

Diabetes Physician Indicators Instrument

Have you tested the patient's hemoglobin A1c in the last 6 months? Select Yes or No.

- ☐ Yes
- ☐ No

If you selected yes, what is the patient's hemoglobin A1c value?

Hemoglobin A1c _____

2. Have you examined the patient's feet today? Select Yes or No.
 - ☐ Yes
 - ☐ No

If you selected yes, select each aspect of the examination that you have performed.

- ☐ Inspection
- ☐ Monofilament Examination
- ☐ Vascular Integrity

3. Have you tested the patient's urine for microalbuminuria this year? Select Yes or No.
 - ☐ Yes
 - ☐ No
 - ☐ Not Applicable

If you selected yes, was it positive or negative? Select the appropriate response.

- ☐ Positive

Please Note: All patient and physician data must be completed in the Grid mode before the data can be submitted. If you would like to submit single instrument data, please use one of the other available View Preferences.

Diabetes Patient Indicators Instrument

(Select Language) ▼

Patient Responses >

	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10
1. Have you had your hemoglobin A1c (a test of how much sugar is in your blood) checked in the last 6 months? Select Yes or No.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Has your doctor checked your feet in the last 6 months? Select Yes or No.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Has your doctor tested your urine for signs of diabetic kidney disease this year? Select Yes or No.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Do you smoke? Select Yes or No.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If you selected yes, has your doctor talked to you about quitting? Select the appropriate answer.	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable	☐ Yes ☐ No ☐ Not Applicable

Individual Entry Mode

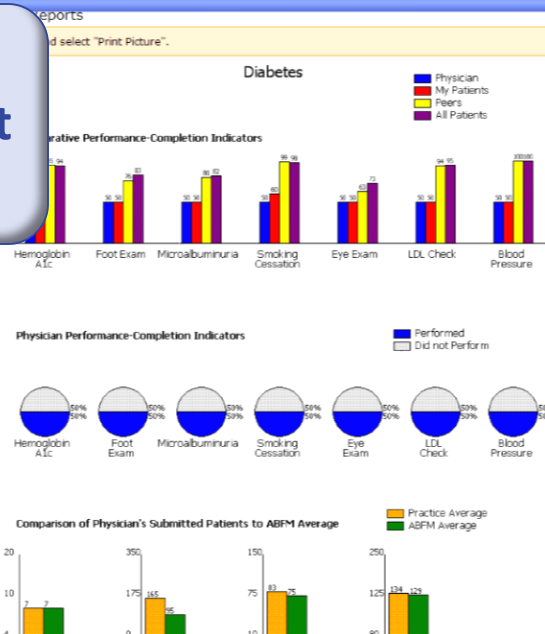
As you and each of your patients complete the Patient Indicator Instrument, you or a member of your staff should enter the data into the online template of your PPM.

Individual Entry Mode: Diabetes PPM Example Questions

Patient Responses	Patient 1	Patient 2	Patient 3
1. Have you had your hemoglobin A1c (a test of how much sugar is in your blood) checked in the last 6 months? Select Yes or No.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Has your doctor checked your feet in the last 6 months? Select Yes or No.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Has your doctor tested your urine for signs of diabetic kidney disease this year? Select Yes or No.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Do you smoke? Select Yes or No.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Individual Entry Mode

Review the Pre-Quality Improvement Comparison Reports



Individual Entry Mode

Select at least **1** clinical indicator as an area for improvement.

Select clinical indicators as an area for improvement.	Click to Select
Hemoglobin A1c	☐
Foot Exam	☒
Microalbuminuria	☐
Smoking Cessation	☐
Eye Exam	☐
Lipids	☐
Blood Pressure	☐

Begin Quality Improvement

Quit



Performance in Practice



Current PPM Module
Diabetes



Introduction
[HTML](#) | [PDF](#)



Navigational Tutorial
[View Tutorial](#)



References
[HTML](#) | [PDF](#)



Roadmap
[HTML](#) | [PDF](#)

Indicators Instrument

Indicators

CCM Categories

QI Interventions

QI Plan

Suspend

Withdraw

Quit

PPM Status

Expand All

Initiated the PPM Process

First set of patient data submitted

Created a plan for improvement

Second set of patient data submitted

Completed PPM successfully

Please select Chronic Care Model (CCM) Categories

You have already chosen a clinical indicator. You will now choose at least 2 components of the Chronic Care Model (CCM) to guide you in selecting effective interventions for improvement. For more information on the CCM, visit the [PPM Roadmap](#) or [Improving Chronic Care](#).

- ☐ **Community Resources and Policies** - Change concepts and interventions that utilize community resources to meet the needs of patients (NCQA Physician Practice Connections category-Patient Education and Support)
- ☐ **Health System** - Change concepts and interventions that create a culture, organization, and mechanisms that promote safe, high-quality healthcare
- ☐ **Self-Management Support** - Change concepts and interventions that empower and prepare patients to manage their health and healthcare (NCQA Physician Practice Connections category-Patient Education and Support)
- ☐ **Delivery System Design** - Change concepts and interventions that assure the delivery of effective, efficient clinical care and self-management support (NCQA Physician Practice Connections category-Care Management)
- ☐ **Decision Support** - Change concepts and interventions that promote clinical care consistent with scientific evidence and patient preferences (NCQA Physician Practice Connections category-Clinical Information Systems/Evidence-Based Medicine)
- ☐ **Clinical Information Systems** - Change concepts and interventions that promote clinical care consistent with scientific evidence and patient preferences (NCQA Physician Practice Connections category-Clinical Information Systems/Evidence-Based Medicine)

Information from Improving Chronic Illness Care (ICIC)

ICIC is a national program supported by The Robert Wood Johnson Foundation

- ☒ **Community Resources and Policies** - Change concepts and interventions that utilize community resources to meet the needs of patients (NCQA Physician Practice Connections category-Patient Education and Support)
- ☒ **Health System** - Change concepts and interventions that create a culture, organization, and mechanisms that promote safe, high-quality healthcare
- ☐ **Self-Management Support** - Change concepts and interventions that empower and prepare patients to manage their health and healthcare (NCQA Physician Practice Connections category-Patient Education and Support)
- ☐ **Delivery System Design** - Change concepts and interventions that assure the delivery of effective, efficient clinical care and self-management support (NCQA Physician Practice Connections category-Care Management)
- ☐ **Decision Support** - Change concepts and interventions that promote clinical care consistent with scientific evidence and patient preferences (NCQA Physician Practice Connections category-Clinical Information Systems/Evidence-Based Medicine)
- ☐ **Clinical Information Systems** - Change concepts and interventions that promote clinical care consistent with scientific evidence and patient preferences (NCQA Physician Practice Connections category-Clinical Information Systems/Evidence-Based Medicine)

Individual Entry Mode

Select at Least **2** Chronic Care Models (CCM) to guide you in selecting interventions for improvement

Choose 2 of 6 Chronic Care Model (CCM) Categories

1. Community Resources and Policies

- Change concepts and interventions that utilize community resources to meet the needs of patients (NCQA Physician Practice Connections category-Patient Education and Support)

2. Health System

- Change concepts and interventions that create a culture, organization, and mechanisms that promote safe, high-quality healthcare

3. Self-Management Support

- Change concepts and interventions that empower and prepare patients to manage their health and healthcare (NCQA Physician Practice Connections category-Patient Education and Support)

Choose 2 of 6 Chronic Care Model (CCM) Categories

4. Delivery System Design

- Change concepts and interventions that assure the delivery of effective, efficient clinical care and self-management support (NCQA Physician Practice Connections category-Care Management)

5. Decision Support

- Change concepts and interventions that promote clinical care consistent with scientific evidence and patient preferences (NCQA Physician Practice Connections category- Clinical Information Systems/Evidence-Based Medicine)

6. Clinical Information Systems

- Change concepts and interventions that organize patient and population data to facilitate efficient and effective care (NCQA Physician Practice Connections category- Clinical Information Systems/Evidence-Based Medicine)



Performance in
Practice

Indicators
Instrument
Indicators
CCM Categories
QI Interventions
QI Plan
Suspend
Withdraw
Quit

PPM Status

Expand All
Initiated the PPM Process
First set of patient data submitted
Created a plan for improvement
Second set of patient data submitted
Completed PPM successfully

Status Legend
Completed
Current
Pending



Current PPM Module
Diabetes

Quality Improvement Intervention

You've chosen your Chronic Care Model, chosen Community Resources and Policies that you've chosen.
From the menu for these intervention categories, choose from the list of choices under the poster to use from the list of choices under the poster.
There are directions under each CCM category.
You may return to the QI Interventions menu.

Diabetes - Foot Exam

Community Resources and Policies

Change concepts and interventions that utilize community resources to meet the needs of patients.

1. Choose at least 1 Intervention Category.
2. Choose at least 1 Intervention from each Intervention Category selected.
3. Choose at least 1 Intervention Item from each Intervention selected.

- ☐ Referral to Services
- ☐ Community Services and Organizations
- ☐ Medication/Treatment Assistance
- ☐ Support Groups

Self-Management Support

Change concepts and interventions that empower and prepare patients to manage their condition.

1. Choose at least 1 Intervention Category.
2. Choose at least 1 Intervention from each Intervention Category selected.
3. Choose at least 1 Intervention Item from each Intervention selected.

- ☐ Patient Care Card
- ☐ Posters
- ☐ Patient Education

Individual Entry Mode

Choose **ONE** intervention category within each Chronic Care Category previously chosen.

Change concepts and interventions that utilize community resources to meet the needs of patients.

1. Choose at least 1 Intervention Category.
2. Choose at least 1 Intervention from each Intervention Category selected.
3. Choose at least 1 Intervention Item from each Intervention selected.

☒ Referral to Services

☒ 1. Referral to Services (Links)

☐ ADA: Diabetes Camps for Children

☒ ADA: ADA Live Online Patient Resource

☐ CDC: Index of State-Based Diabetes Prevention and Control Programs

☐ AADE: American Association of Diabetes Educators Foundation

☐ Community Services and Organizations

☐ Medication/Treatment Assistance

Individual Entry Mode

- Choose **1** Intervention.
- Choose **1** Intervention Item.

Individual Entry Mode

Design your Quality Improvement (QI) Plan

Note: "Add Custom Step" is an *optional* step.

Indicator -- Foot Exam

Intervention Category -- Patient Care Card -- (CCM Category - Self-Management Su

Possible Steps in Intervention Implementation Plan

- ☐ Print patient care card.
- ☐ Order patient care card.
- ☐ After training staff on using care cards, make copies if necessary, and distribute to patients by mail or in the office during visits.

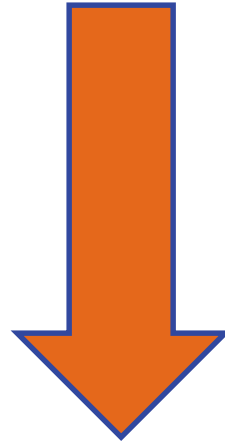
Add Custom Step

- ☐ Print patient care chart.
- ☐ Order patient care chart.
- ☐ After training staff on using care charts, make copies if necessary, and distribute to patients by mail or in the office during visits.

Add Custom Step



**Implement your
QI Program for
at least 1 week**



**Repeat Physician and Patient
Questionnaires**

Individual Entry Mode

Once the questionnaires are complete and the data is entered in the PPM,

2. Has your doctor checked your feet in the last 6 months? Select Yes or No.

☐ Yes
☐ No

3. Has your doctor tested your urine for signs of diabetic kidney disease this year? Select Yes or No.

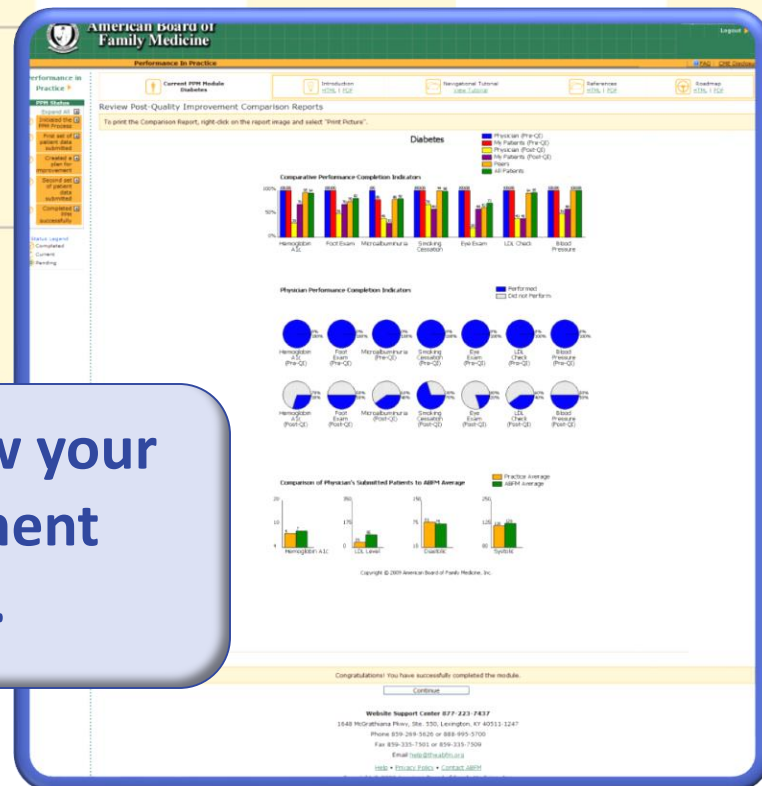
☐ Yes
☐ No

4. Do you smoke? Select Yes or No.

☐ Yes
☐ No

	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5
1. Has your doctor checked your feet in the last 6 months? Select Yes or No.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Has your doctor checked your feet in the last 6 months? Select Yes or No.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Has your doctor tested your urine for signs of diabetic kidney disease this year? Select Yes or No.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Do you smoke? Select Yes or No.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

You will be able to review your Post Quality Improvement Comparison charts.



Congratulations!

You have completed your PPM.

 **American Board of Family Medicine**

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Enter CME Credits Information

CONGRATULATIONS on the successful completion of your Performance in Practice Module (PPM)!

Please insert below the total number of hours you spent on the PPM module. Include the time spent completed the questions and reading the online references for the PPM.

Total number of hours spent in completing the PPM:

Total CME credits awarded:

Please make sure your AAFP ID number is listed correctly below. It is very important the AAFP ID number you list is accurate, otherwise we cannot successfully communicate your CME information with the American Academy of Family Physicians.

AAFP ID: (7 digits)

Your CME credit information for this module has not been uploaded to the AAFP.

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Certificate of Successful Completion

Dr. Edward Charles Demo
Diabetes Performance in Practice Module

November 06, 2009 20 Credits

This activity has been reviewed and is acceptable for up to 20 Prescribed credits by the American Academy of Family Physicians. AAFP accreditation begins March 31, 2008. Term of approval is for two years from this date. This activity has been approved from March 31, 2008 to March 30, 2010.

AAFP Prescribed credit is accepted by the American Medical Association as equivalent to AMA PRA category 1 credit toward the AMA Physician's Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed credit, not as category 1.



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Don't forget to record the number of hours you spent completing the PPM and to print your CME certificate.

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 **American Board of Family Medicine**

Performance In Practice

Performance in Practice ▶

Welcome Screen

Data Entry

Indicator Instrument

Indicators

CCM Categories

QI Interventions

QI Plan

Suspend

Withdraw

Quit

PPM Status

Expand All

Initiated the PPM Process

Current PPM Module **Diabetes**

Introduction [HTML](#) | [PDF](#)

Navigation Tutorial (coming soon)

Please Select a Data Entry Mode for the Pre-Quality Improvement Patient Data Entry

There are two (2) ways to submit your patient data: (1) individual entry mode which will require you to enter your data based on individual patients or; (2) an option is most commonly used by physicians who have a type of Electronic Health Records (EHR) system in their office.

Data Entry Mode (select an option below)

☐ Individual Data Entry

☒ Aggregate Data Entry

☐ Electronic Health Records

☐ Payor/ Health Plan Records

☐ Medical Group Records

☐ Centers for Medicare and Medicaid Services (CMS) Services

☐ Other

Aggregate Entry Mode
Select the type of EHR you use in your practice

https://portfolio.abfp.org/ppm/Reports/IndicatorsInstrumentDownload.aspx

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American Board of Family Medicine

Performance In Practice

Performance in Practice ▶

Current PPM Module **Diabetes**

Introduction HTML PDF

Navigational Tutorial (coming soon)

Download PPM Indicators Instrument

Please download the Indicator Instrument. This instrument is based on important indicators that you select. Download the instrument and complete it for at least ten (10) patients' data; you then may enter the results.

The instrument is available only in English.

If you have not submitted the patient data within 1 month, you will receive an email notification reminding you to do so.

Download Diabetes Indicator Instrument

Instrument Layout

Indicator Instrument

Each indicator instrument will be printed on a separate page.

PPM Status

Expand All

Initiated the PPM Process

First set of patient data submitted

Created a plan for improvement

Physician Indicators Instrument

You will use this form to collect the patient data needed to complete your Performance in Practice activities. Please answer all the questions on this form. For each question, please provide the total number of patients from which you gathered your data (the "denominator" for determining your performance). For each question, also provide either the number of patients who meet the criterion in the question (the "numerator" for determining your performance), or the percentage of patients who meet the criteria.

Diabetes PPM Physician Indicators Instrument (Aggregate Data)

- What percentage of your diabetic patients had a hemoglobin A1c test in the last 6 months?
 Percentage of Patients _____ | Number of Patients _____
 Total Number of Patients _____ | Total Number of Patients _____
 1(a) What percentage of these patients have a hemoglobin A1c value > 9%?
 Percentage of Patients _____ | Number of Patients _____
- What percentage of your diabetic patients had a foot examination at their last appointment?
 Percentage of Patients _____ | Number of Patients _____
 Total Number of Patients _____ | Total Number of Patients _____
 2(a) What percentage of these patients received inspection of the foot examination?
 Percentage of Patients _____ | Number of Patients _____
 2(b) What percentage of these patients received Monofilament examination of the foot examination?
 Percentage of Patients _____ | Number of Patients _____
 2(c) What percentage of these patients received Vascular integrity of the foot examination?
 Percentage of Patients _____ | Number of Patients _____
- What percentage of your diabetic patients were tested for microalbuminuria in the last year?
 Percentage of Patients _____ | Number of Patients _____
 Total Number of Patients _____ | Total Number of Patients _____
- What percentage of your diabetic patients have been counseled in smoking cessation?
 Percentage of Patients _____ | Number of Patients _____
 Total Number of Patients _____ | Total Number of Patients _____
- What percentage of your diabetic patients had a documented eye examination performed by an eye care professional in the last 12 months?
 Percentage of Patients _____ | Number of Patients _____
 Total Number of Patients _____ | Total Number of Patients _____

Aggregate Entry Mode
Download PPM
Indicator Instrument

Aggregate Entry Mode:

Diabetes Physician Indicators Instrument Example Questions

performance in Practice activities. Please provide the total number of patients from which you answered each question, also provide either the

number of patients who meet the criterion in the question (the "numerator" for determining your performance), or the percentage of patients who meet the criteria

Diabetes PPM Physician Indicators Instrument (Aggregate Data)

1. What percentage of your diabetic patients had a hemoglobin A1c test in the last 6 months?

Percentage of Patients _____

|

Number of Patients _____

or

Total Number of Patients _____

|

Total Number of Patients _____

- 1(a) What percentage of these patients have a hemoglobin A1c value > 9%?

Percentage of Patients _____

|

Number of Patients _____

or

2. What percentage of your diabetic patients had a foot examination at their last appointment?

Percentage of Patients _____

|

Number of Patients _____

or

Total Number of Patients _____

|

Total Number of Patients _____

- 2(a) What percentage of these patients received Inspection of the foot examination?

Percentage of Patients _____

|

Number of Patients _____

or

- 2(b) What percentage of these patients received Monofilament examination of the foot examination?

Percentage of Patients _____

|

Number of Patients _____

or

- 2(c) What percentage of these patients received Vascular integrity of the foot examination?

Percentage of Patients _____

|

Number of Patients _____

Performance in Practice

Performance in Practice

Welcome Screen

Data Entry

Indicators Instrument

Indicators

CCM Categories

QI Interventions

QI Plan

Suspend

Withdraw

Quit

PPM Status

Expand All

Initiated the PPM Process

First set of patient data submitted

Created a plan for improvement

Second set of patient data submitted

Completed PPM

Current PPM Module

Diabetes

Introduction

HTML | PDF

Enter Pre-Improvement Patient Data

Diabetes

1. What percentage of your diabetic patients had a hemoglobin A1c test in the last 6 months?

Percentage of Patients

%

OR

Number of Patients

Total Number of Patients

1a. What percentage of these patients have a hemoglobin A1c value > 9%?

Percentage of Patients

%

OR

Number of Patients

Total Number of Patients

2. What percentage of your diabetic patients had a foot examination at their last appointment?

Percentage of Patients

%

OR

Number of Patients

Total Number of Patients

2a. What percentage of these patients received inspection of the foot examination?

Aggregate Entry Mode

As you complete the Patient Indicator Instrument, you or a member of your staff should enter the data into the online Aggregate Data template of your PPM.

Aggregate Entry Mode: Diabetes PPM Example Questions

1. What percentage of your diabetic patients had a hemoglobin A1c test in the last 6 months?

☒

Percentage of Patients %
Total Number of Patients

OR

☐

Number of Patients
Total Number of Patients

1a. What percentage of these patients have a hemoglobin A1c value > 9%?

☒

Percentage of Patients %
Total Number of Patients

OR

☐

Number of Patients
Total Number of Patients

2. What percentage of your diabetic patients had a foot examination at their last appointment?

☒

Percentage of Patients %
Total Number of Patients

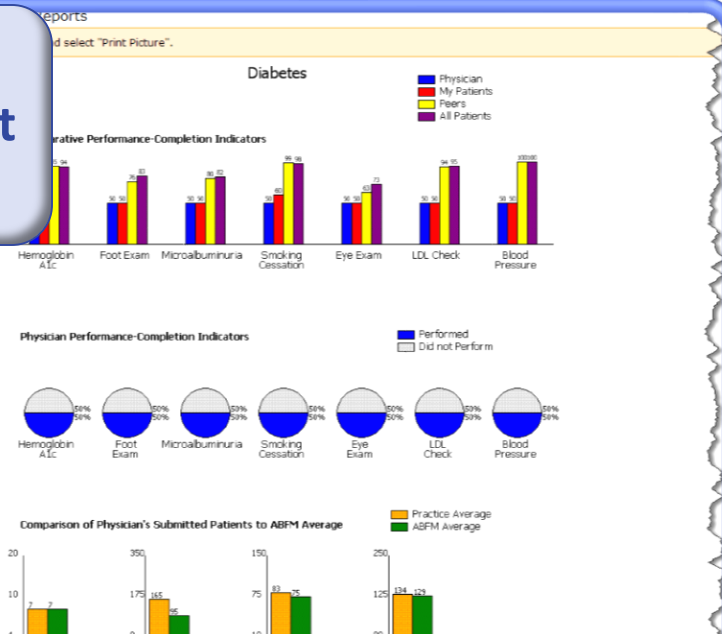
OR

☐

Number of Patients
Total Number of Patients

Aggregate Entry Mode

Review the Pre-Quality Improvement Comparison Reports



Aggregate Entry Mode

Select at least **1** clinical indicator as an area for improvement.

Clinical indicators as an area for improvement.	Click to Select
Hemoglobin A1c	☐
Foot Exam	☒
Microalbuminuria	☐
Smoking Cessation	☐
Eye Exam	☐
Lipids	☐
Blood Pressure	☐

Begin Quality Improvement

Quit



Performance in Practice



Current PPM Module
Diabetes



Introduction
[HTML](#) | [PDF](#)



Navigational Tutorial
[View Tutorial](#)



References
[HTML](#) | [PDF](#)



Roadmap
[HTML](#) | [PDF](#)

Indicators Instrument

Indicators

CCM Categories

QI Interventions

QI Plan

Suspend

Withdraw

Quit

PPM Status

Expand All

Initiated the PPM Process

First set of patient data submitted

Created a plan for improvement

Second set of patient data submitted

Completed PPM successfully

Please select Chronic Care Model (CCM) Categories

You have already chosen a clinical indicator. You will now choose at least 2 components of the Chronic Care Model (CCM) to guide you in selecting effective interventions for improvement. For more information on the CCM, visit the [PPM Roadmap](#) or [Improving Chronic Care](#).

- ☐ **Community Resources and Policies** - Change concepts and interventions that utilize community resources to meet the needs of patients (NCQA Physician Practice Connections category-Patient Education and Support)
- ☐ **Health System** - Change concepts and interventions that create a culture, organization, and mechanisms that promote safe, high-quality healthcare
- ☐ **Self-Management Support** - Change concepts and interventions that empower and prepare patients to manage their health and healthcare (NCQA Physician Practice Connections category-Patient Education and Support)
- ☐ **Delivery System Design** - Change concepts and interventions that assure the delivery of effective, efficient clinical care and self-management support (NCQA Physician Practice Connections category-Care Management)
- ☐ **Decision Support** - Change concepts and interventions that promote clinical care consistent with scientific evidence and patient preferences (NCQA Physician Practice Connections category-Clinical Information Systems/Evidence-Based Medicine)
- ☐ **Clinical Information Systems** - Change concepts and interventions that promote clinical care consistent with scientific evidence and patient preferences (NCQA Physician Practice Connections category-Clinical Information Systems/Evidence-Based Medicine)

Information from Improving Chronic Illness Care (ICIC)

ICIC is a national program supported by The Robert Wood Johnson Foundation

- ☒ **Community Resources and Policies** - Change concepts and interventions that utilize community resources to meet the needs of patients (NCQA Physician Practice Connections category-Patient Education and Support)
- ☒ **Health System** - Change concepts and interventions that create a culture, organization, and mechanisms that promote safe, high-quality healthcare
- ☐ **Self-Management Support** - Change concepts and interventions that empower and prepare patients to manage their health and healthcare (NCQA Physician Practice Connections category-Patient Education and Support)
- ☐ **Delivery System Design** - Change concepts and interventions that assure the delivery of effective, efficient clinical care and self-management support (NCQA Physician Practice Connections category-Care Management)
- ☐ **Decision Support** - Change concepts and interventions that promote clinical care consistent with scientific evidence and patient preferences (NCQA Physician Practice Connections category-Clinical Information Systems/Evidence-Based Medicine)
- ☐ **Clinical Information Systems** - Change concepts and interventions that promote clinical care consistent with scientific evidence and patient preferences (NCQA Physician Practice Connections category-Clinical Information Systems/Evidence-Based Medicine)

Aggregate Entry Mode

Select at Least **2**
Chronic Care Models
(CCM) to guide you in
selecting interventions for
improvement

Choose 2 of 6 Chronic Care Model (CCM) Categories

1. Community Resources and Policies

- Change concepts and interventions that utilize community resources to meet the needs of patients (NCQA Physician Practice Connections category-Patient Education and Support)

2. Health System

- Change concepts and interventions that create a culture, organization, and mechanisms that promote safe, high-quality healthcare

3. Self-Management Support

- Change concepts and interventions that empower and prepare patients to manage their health and healthcare (NCQA Physician Practice Connections category-Patient Education and Support)

Choose 2 of 6 Chronic Care Model (CCM) Categories

4. Delivery System Design

- Change concepts and interventions that assure the delivery of effective, efficient clinical care and self-management support (NCQA Physician Practice Connections category-Care Management)

5. Decision Support

- Change concepts and interventions that promote clinical care consistent with scientific evidence and patient preferences (NCQA Physician Practice Connections category- Clinical Information Systems/Evidence-Based Medicine)

6. Clinical Information Systems

- Change concepts and interventions that organize patient and population data to facilitate efficient and effective care (NCQA Physician Practice Connections category- Clinical Information Systems/Evidence-Based Medicine)



Performance In Practice

Performance In
Practice

Indicators
Instrument
Indicators
CCM Categories
QI Interventions
QI Plan
Suspend
Withdraw
Quit

PPM Status

Expand All
Initiated the PPM Process
First set of patient data submitted
Created a plan for improvement
Second set of patient data submitted
Completed PPM successfully

Status Legend
Completed
Current
Pending



Current PPM Module
Diabetes

Quality Improvement Intervention

You've chosen your Chronic Care Model, chosen Community Resources and Policies that you've chosen.

From the menu for these intervention categories, choose from the list of choices under each category.

There are directions under each CCM category.

You may return to the QI Interventions anytime during the PPM process by clicking the 'Back' button.

Diabetes - Foot Exam

Community Resources and Policies

Change concepts and interventions that utilize community resources to meet the needs of patients.

1. Choose at least 1 Intervention Category.
2. Choose at least 1 Intervention from each Intervention Category selected.
3. Choose at least 1 Intervention Item from each Intervention selected.

- ☐ Referral to Services
- ☐ Community Services and Organizations
- ☐ Medication/Treatment Assistance
- ☐ Support Groups

Self-Management Support

Change concepts and interventions that empower and prepare patients to manage their health.

1. Choose at least 1 Intervention Category.
2. Choose at least 1 Intervention from each Intervention Category selected.
3. Choose at least 1 Intervention Item from each Intervention selected.

- ☐ Patient Care Card
- ☐ Posters
- ☐ Patient Education

Aggregate Entry Mode

Choose **ONE** intervention category within each Chronic Care Category previously chosen.

Community Resources and Policies

Change concepts and interventions that utilize community resources to meet the needs of patients.

1. Choose at least 1 Intervention Category.
2. Choose at least 1 Intervention from each Intervention Category selected.
3. Choose at least 1 Intervention Item from each Intervention selected.

☒ Referral to Services

☒ 1. Referral to Services (Links)

☐ ADA: Diabetes Camps for Children

☒ ADA: ADA Live Online Patient Resource

☐ CDC: Index of State-Based Diabetes Prevention and Control Programs

☐ AADE: American Association of Diabetes Educators Foundation

☐ Community Services and Organizations

☐ Medication/Treatment Assistance

Aggregate Entry Mode

- Choose **1** Intervention.
- Choose **1** Intervention Item.

Aggregate Entry Mode

Design your Quality Improvement (QI) Plan

Note: “Add Custom Step” is an optional step.

Indicator -- Foot Exam

Intervention Category -- Patient Care Card -- (CCM Category - Self-Management Su

Possible Steps in Intervention Implementation Plan

- ☐ Print patient care card.
- ☐ Order patient care card.
- ☐ After training staff on using care cards, make copies if necessary, and distribute to patients by mail or in the office during visits.

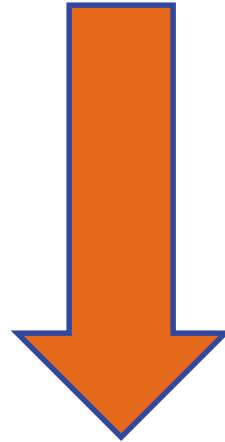
Add Custom Step

- ☐ Print patient care chart.
- ☐ Order patient care chart.
- ☐ After training staff on using care charts, make copies if necessary, and distribute to patients by mail or in the office during visits.

Add Custom Step



**Implement your
QI Program for
at least 1 week**



**Repeat Physician
Indicator Instrument**

Aggregate Entry Mode

Once the physician indicator instrument is complete and the data is entered into your PPM,

3. Has your doctor tested your urine for signs of diabetic kidney disease this year? Select Yes or No.

☐ Yes

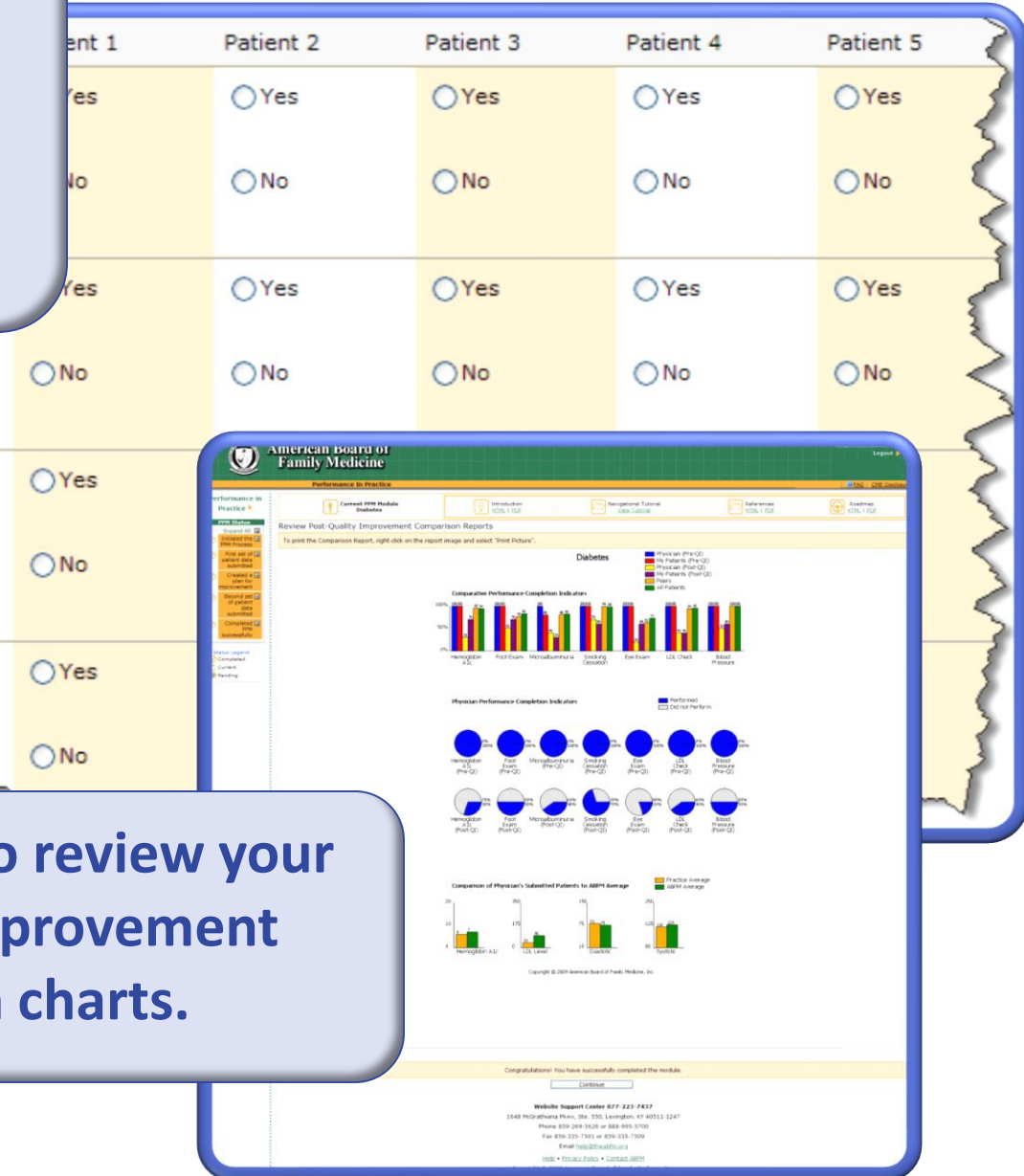
☐ No

4. Do you smoke? Select Yes or No.

☐ Yes

☐ No

You will be able to review your Post Quality Improvement Comparison charts.



Congratulations!

You have completed your PPM.

American Board of Family Medicine

Physician Portfolio
Logout
Welcome Dr. Demo
Not Dr. Demo? Click here.

certification/Recertification Exam • Maintenance of Certification • Certificates of Added Qualifications • Residency Training • Find a Physician • About

Home > Physician Portfolio > CME Credits Information

Enter CME Credits Information

CONGRATULATIONS on the successful completion of your Performance in Practice Module (PPM)!

Please insert below the total number of hours you spent on the PPM module. Include the time spent completed the questions and reading the online references for the PPM.

Total number of hours spent in completing the PPM:

Total CME credits awarded:

Please make sure your AAFP ID number is listed correctly below. It is very important the AAFP ID number you list is accurate, otherwise we cannot successfully communicate your CME information with the American Academy of Family Physicians.

AAFP ID: (7 digits)

Your CME credit information for this module has not been uploaded to the AAFP.

ABFM Support Center 877-23-7437
1648 McGrathiana Parkway, Ste. 550, Lexington, KY 40511-1247
Phone 859-269-5626 or 888-995-5700
Fax 859-269-7501 or 859-35-7509
Email help@theabfm.org

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The American Board of Family Medicine
Certificate of Successful Completion

Dr. Edward Charles Demo
Diabetes Performance in Practice Module

November 06, 2009 20 Credits

This activity has been reviewed and is acceptable for up to 20 Prescribed credits by the American Academy of Family Physicians. AAFP accreditation begins March 31, 2008. Term of approval is for two years from this date. This activity has been approved from March 31, 2008 to March 30, 2010.

AAFP Prescribed credit is accepted by the American Medical Association as equivalent to AMA PRA category 1 credit toward the AMA Physician's Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed credit, not as category 1.

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Don't forget to record the number of hours you spent completing the PPM and to print your CME certificate.



ABFM MC-FP Part IV

Self-Directed PPM

All activities must:

- Be developed using evidence-based criteria and national standards
- Ensure the physician is meaningfully involved
- Incorporate pre- and post-intervention evaluation of the physician's performance using evidence-based quality indicators
- Include the development and implementation of an individualized plan for improvement



ABFM MC-FP Part IV

Self-Directed PPM

- The required attestation form can be accessed through the physician portfolio
- Submission of an attestation form does not guarantee Part IV credit
- Approval occurs on a case-by-case basis
- Allow up to 8 weeks for the review process



Specific Information about the Self-Directed activity can be found in your Physician Portfolio



Part IV Alternatives Support

- **Nichole Lainhart, Program Manager MC-FP Alternatives Activities**
 - Phone: 877-223-7437, ext 1230
 - Email: NLainhart@theabfm.org
- **Support Center**
 - Phone: 877-223-7437
 - Email: help@theabfm.org
 - Live Chat



Opportunities Involving Your Board Certification

- **CME** – a minimum of 1/4 of your AAFP/ABFM required CME
- **Flexibility/Control** – increasing number of choices of on-line programs so that you may select and individualize your overall program – among these are many choices of Part IV alternatives, which may save duplication of effort and time
- **Exam Locations** – greatly increased availability of locations and dates for proximity and travel cost savings
- **PQRS** – a CMS-sponsored significant financial benefit available through ABFM— may be paired with a PPM quality improvement activity for a “two for”
 - National reporting system for quality of care
 - A one time “snapshot” of current practice
 - A significant financial reward for early adopters
 - Avoid 2015 proposed penalty from CMS



CME

Awarded by the American Academy of Family Physicians

SAM = **12**
CME Credits

PPM = **20**
CME Credits

MIMM = **20**
CME Credits

Cultural
Competency
MIMM = **9**
CME Credits



American Board
of Family Medicine

Initial Certification / Residency

Maintenance

Track Your Progress
Update Your License
Access MC-FP Modules

Welcome to your Physician Portfolio

Welcome!

Welcome to the new website

Update Your Contact Information

Make sure your information is up to date.

- ▶ [About the MC-FP Process](#)
- ▶ [What is a Part II Module](#)
- ▶ [What is a Part IV Module](#)

[Get Started](#)

Track Your Progress

- ☒ [Medical Licensure](#)
- ☒ [MC-FP Modules](#)
- ☒ [MC-FP Exam](#)

Payments

[Payment Receipts](#)

Current Status

[Request Verification Letter](#)

- ▶ **Diplomate Status:** Certified
- ▶ **MCFP Status:** Meeting Requirements
- ▶ **Current Cycle:** 7 Year Certificate with Option to extend to 10 years

- ▶ [Physician Quality Reporting](#)
- ▶ [Recognition of Focused Practice](#)

My Profile

- [Update my Contact Information](#)
- ▶ [Manage Username & Password](#)
- ▶ [Email Settings](#)
- ▶ [Update National Provider Identifier \(NPI\)](#)
- ▶ [Update Name](#)
- ▶ [Training & Certification History](#)
- ▶ [Affiliate ID Numbers](#)
- ▶ [Demographics](#)
- ▶ [In-Training Examination](#)
- ▶ [Support Center & Tutorials](#)

Update Your Contact Info
Get a Receipt
Get a Verification Letter

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Website Resources

- **General Website**
 - Website Site Map
 - Navigation Tutorial
 - Flash Tutorial
- **Self-Assessment Modules (SAM)**
 - Jing Videos
 - Webinars
 - Flash Tutorial
- **Performance in Practice Modules (PPM)**
 - Flash Tutorial
- **Support Center**
 - Live Chat Opportunity



Continuous MC-FP

Set a Goal of 1 Module Per Year!

Year 1:
Complete 1
Module

Year 2:
Complete 1
Module

Year 3:
Complete 1
Module





Exam Deadlines

2014 Fall Exam Deadlines

Fall 2014 Exam Deadline	Date
Registration Begins	July 25, 2014
Deadline to submit application without a late fee	August 25, 2014
Final Deadline to submit application with a \$200 late fee	September 15, 2014
Exam Dates	November 10,11,12,13,14,15
Exam Results	December 19, 2014



Avoid Late Fees

BEGIN the formal application prior to the deadline to avoid late filing fees

- to be able to access the application, all required modules must be paid for/and or started
(completion of the modules is not required to start the application but all modules must be complete by the deadline for clearing deficiencies)
- IMPORTANT!!! Advance beyond the payment page of the application
- go back to the application to choose a test date and test center as soon as all deficiencies are cleared (including completion of all modules)

ABFM Goal:



