Meetings with ADFM

Board of Directors, February 13

Town Hall Meeting, February 14

1. ABFM Update (see attached; I will highlight a couple of issues and am glad to answer questions)

2. Opportunities for Working Together: 2019 (for discussion)
    - A Specialty Wide Journal Club
    - Can Departments and their faculty help with Knowledge Self-Assessments?
    - Aligning with Clinically Integrated Systems

3. Strategic Issues (for Discussion Throughout the Meeting):
    - The Future of Annals of Family Medicine
    - Planning for Major Residency Expansion
    - The Future of Quality Improvement
    - Whither Professionalism?
    - How should the Working Party of Family Medicine Organizations Evolve?

MEMORANDUM

TO: ADFM Board of Directors

FROM: Warren Newton, MD, MPH
President & CEO
American Board of Family Medicine

RE: ABFM Annual Update

DATE: February 1, 2019

Colleagues, I look forward to meeting with you soon. My hope is to talk you about ways ABFM might collaborate with your and individual departments in 2019.

I've written this update to give you some context about what we do. I apologize in advance that I will need to leave your Board meeting early to help interview the finalist candidates for editor of Annals of Family Medicine.

Over the longer term, I would like to arrange annual meetings between ABFM and the ADFM Board. I believe that Departments should play a key role in the evolution of the specialty and I want to support this in any way possible.

Here is the update:

1. **ABFM Strategic Planning**—As I mentioned to you a year ago, ABFM is conducting a strategic planning process. Impressed by both the amplitude and the uncertainty of changes in health care, we used an intensive scenario planning process modelled on the process used by the ACGME. Our initial retreat was last September—thanks to Steve Zweig for his participation! – and we are now finalizing the 5 year plan in preparation for our Board Meeting at the end of April.

   The question that drove our strategic planning process was: how can the Board support the personal physician of the future? While final details are pending, it is very clear that our five year plan envisions major changes in many aspects of our board certification portfolio, and robust engagement of Diplomates, other

Family Medicine organizations, other specialties and other professions. In the short term, we look to exploring with you and others a specialty wide journal club initiative, creation of new enduring materials, and outreach to large clinically integrated systems. In the longer term, we plan work in professionalism, a rethinking of quality improvement and collaboration in research, and will want your input and partnership.

2. What does ABFM do on an ongoing basis? ABFM has about 93,000 Diplomates; the number continues to increase steadily. Annually, we have the work of **developing materials for, testing and reviewing stage requirements for Board Certification for all of our Diplomates**. Every year, we certify about 9000 in the spring (including about 3500 residents) and about 3400 in the fall. In addition, we are the administrative board responsible for Sports Medicine (along with Internal Medicine, Pediatrics and PM&R) and participate in CAQ/subspecialties within Sports Medicine, Geriatrics, Hospice and Palliative Medicine, Adolescent Medicine, Pain Medicine, Sleep Medicine and a Focused Practice Designation in Hospital Care with Internal Medicine. The multiple choice questions we write undergo a lot of review and development, as they set the standard of cognitive expertise for the specialty. We are always looking for item-writers with broad scope and an excellent knowledge base!

   In addition to the examinations, we provide self-assessment materials for about 60,000 Diplomates annually, as well as online continuous self assessment (CKSA) for about 20,000 people. All modules are updated annually; evaluations of those modules have been very strong. One area of possible collaboration is for departments or individuals to contract for the development and updating of specific modules.

3. Board eligibility—and its sunsetting--became a major issue this fall. It is important for you to be aware of the changing rules about who can call themselves "board eligible". Seven years ago, ABMS appropriately required all boards to put a limit on how long an individual could remain "board eligible." ABFM set that limit at seven years from the time a resident is certified to graduate by their program director. Additionally, ABFM set a one-time, seven-year period for all family medicine residency graduates prior to 2012 to become board-certified under this process. This time period expired 12/31/18.

   Interestingly, over the last seven years, of approximately 4,000 in this group, about one half have become board certified, 25% started the process but did not successfully finish, and 25% did not start. By the time you read this, time

has run out, and individuals who have lost board eligibility must complete 12 full months of supervised retraining before applying for board certification again. But exactly what is "supervised retraining?" and how can interested individuals get it? We are now considering what policy to set—and how we can help these individuals. We welcome your ideas.

4. An early priority of our new strategic plan has been to develop another option for assessment of cognitive expertise. As you may know, the **Family Medicine Certification Longitudinal (FMCLA)** pilot rolled out January 4. Demand is high—about 84% are choosing FMCLA. Technically, it is working well so far and early feedback is very positive. The pilot will run two years. We have planned an extensive evaluation.

   Longitudinal assessment is exciting for us because it offers the opportunity of setting the standard for cognitive expertise—which is one of the four core components of our certification portfolio—while also providing a foundation for learning in the form of questions calibrated in difficulty against what all other family physicians know, delivered at a time and place convenient for the Diplomate. Participants will get answers, a critique and an open source reference in real time; annually they will get more detailed information about their performance and knowledge gaps compared to other family physicians. I believe that it is this focus on supporting learning, along with reducing time and expense and increasing convenience, which has led to the rapid growth of longitudinal assessment in other specialties.

   A question we are being asked often is: how can Diplomates prepare for the longitudinal assessment? We look to working with the AAFP and other partners such as Departments to develop answers. The broader issue is, of course, how to rethink the continuing medical education enterprise, given the bankruptcy of the pedagogical model and the challenging economics. I look for Departments to help with new ideas and business models.

   We also look for ideas on how to engage Family Medicine residents in the longitudinal assessment process. At issue is building the habits of life-long learning, particularly when residents graduate from the learning rich environment of residencies. Our continuous knowledge self assessment (CKSA) is available to them, of course, We will discuss this issue with program directors and the AFMRD Board at the PDW in April.

5. **Engagement of ABFM Diplomates and Partner Family Medicine Organizations** – A priority of our strategic plan is to change the nature of our

relationship with Diplomates. To this end, I have tasked Libby Baxley, our Executive Vice President, to lead a Diplomatee engagement initiative. She is leading our efforts to reach out to Diplomates and to reorganize our communications. State AFP chapters have reached out to get more information about what we are doing, and we have started a process to meet with chapter leaders and attend chapter and regional meetings. We will visit about half of the state chapters this year. Our new website will debut in the first part of this year. We have made a concerted effort to reduce the density of information, use more direct language and change the tone to one of collaboration. We are also engaging with a group of residents to give us feedback on that component of the website.

We are committed to engagement with the Family of Family Medicine—hence our outreach to you. We also present every year at AFMRD, and have changed our annual meetings so they will not conflict with STFM n the future. Finally, we will be meeting regularly rwith the organizations supporting our Diplomates with added qualifications, such as Sports Medicine and Hospice and Palliative Care

In addition to coming to meetings, we are committed to work on specific projects with our partner academic organizations. We are supporting the ADFM Physcian Scientest Residency Pathway, the AFMRD Clinic First and FM-NICCE initiatives, and the STFM preceptor improvement projects. We look forward to talking with you about supporting teaching and quality improvement in your Departments.

6. ABFM is responsible for coordinating the **Working Party meetings in January and August this year**—this is the meeting of the staff and volunteer leadership of all 8 Family Medicine organizations in the country. In the second week of January, a major focus of the discussion was planning for the **major expansion of family medicine residencies** implicit in Family Medicine for America's Health setting the goal of 25% of American medical students choosing. family medicine by 2030. I look forward to ADFM's contributions and thought partnership in this area.

   Our broader goal is developing the Working Party into something more than passive information sharing. We believe the challenges facing the specialty are substantial, and require on going and concerted effort and attention to strategic priorities.. We ask for your help in reaching this goal.

7. **ABFM's research enterprise** continues to be robust. A core of our work is tracking what is happening in the discipline through our Diplomates and their practices. While it is difficult to summarize simply the breadth of our work, highlights from the last year include our ongoing work to develop quality measures that capture the essence of the contributions of family medicine; explore the relationship between family physician burnout, employment model and declining scope of practice; and systematic efforts to track the outcomes of residency training.

   A key emphasis of our research work is preparing the ground for primary care friendly policy. In the summer, the ABFM Foundation funded a planning meeting for a possible new National Academies study of primary care. The national academies have now approved that effort and fundraising is underway.

   We see ABFM data as a national resource for the discipline. We highly value the collaborations we have with the AAFP Graham Center, other members of the family of family medicine and many other external collaborators. A key part of our strategic plan will be consideration of how best to support the research infrastructure of our discipline.

   We are now conducting a national search for a new Senior Vice President of Research and Policy. This individual will be a member of our senior leadership team, providing strategic direction to our research initiatives and playing a leadership role in the Center for Professionalism and Value in Health Care. The SVP will also begin to coordinate our various fellowship programs—the Pisacano and Puffer scholars as well as our many research fellows in Lexington or Washington. We have excellent candidates for the position and hope to conclude the search by the spring.

8. **PRIME, the ABFM registry**, continues to mature. As you know, it is free for ABFM Diplomates and Residents, translates EHR data into a quality measure dashboard, and supports a variety of reporting needs including MIPS. In the last year, we have added Population Health Assessment Engine (PHATE), our set of tools to help family physicians to map and address social drivers of health in their practice. As you know, we have a launched a pilot of residency and department participation in PRIME. A component of the role of the Senior Vice President of Research and Policy is to develop a strategic plan for the next phase of development of PRIME.

9. The **Center for Professionalism & Value in Health Care,** led by Bob Phillips, launched in the fall of 20018 and is now engaging future partners

across the country. The Center will have a physical presence in Washington DC and will take over Primary Care Measures that Matter, the development of the PRIME registry, and the Population Health Assessment Engine (PHATE). Dr. Phillips is now identifying a Board of Advisors and launching a research agenda.

10. ABFM remains committed to supporting **international family medicine**. For a number of years, the ABFM Foundation has supported the Montegut Fellowship which funds trips to WONCA global meetings by regional family medicine leaders around the world. In the fall of 2018, ABFM was invited to attend the 40th anniversary of the Alma Ata Declaration—unfortunately, due to politics, the American government chose not to go. An emerging issue is the potential policy tension between primary care and primary health care, which we will be highlighting in working with WHO, Gates and other funders. We are now considering becoming a WHO collaborative research center.

11. The **ABMS Vision Committee** has published a draft of its report and has collected public feedback. The goal of the committee is ambitious—to transform the entire board certification enterprise. In general, we are pleased with the draft proposal, which affirms the importance of consequential judgements, and quality improvement, while underscoring consistency and public members on the Boards. We believe that the report will give ABFM the flexibility to evolve substantially. The final report will come out mid-February.

12. **Data for your consideration**. What jobs are we training our residents for? As you know, we conduct annual surveys of all family medicine residency graduates in the country. The response rate has been about 67%. The data demonstrate a dramatic gap between resident preparation/desires and practice three years after graduation. Representative findings from 2017 include:

	Residency Prepared	Currently Practicing
Newborn Hospital Care	88%	24%
Maternity Care	90%	27%
ICU/CCU Care	65%	22%
Endometrial Biopsy	63%	26%
IUD Insertion	79%	40%

We look forward to working with you on this.

Warren

.

WPN:CS