DRAFT 6.18.23

ABMS/ACGME Competency Summit (June 15/16, 2023)
Family Medicine Meeting Notes and Recommendations

Attendees: RCFM – Eileen Anthony (THU), Colleen Cagno, Grant Hoekzema; AFMRD – Kristina Diaz, ADFM – Dave Schneider, AOBFP – Joan Grzybowski, DIO – Raul Ayala, STFM – Randy Pearson, ABFM – Warren Newton (FRI)

Background review for the group – August CBME summit with initial steps towards strategic plan, ABFM/RCFM work on core outcomes and input/vetting by stakeholders, publication in Annals, with ABFM competency based board eligibility to follow this week. Discussion around general acceptance of the 12(15) core outcomes – how these are interpreted will vary by program/community (e.g. care of pregnant patients). Points made that high stakes exam will remain a key piece of certification. Recap of outcomes of stakeholder meetings – ACGME competency assessment workshop sponsored by ABFM-F has produced 49 CBME "champions" (including RPS members) and the need to capitalize on their energy. Learnings from STFM CBME taskforce are multitude – ILP's are key factor for success, heavy emphasis in "authoritative" CBME guidelines.

A DIO panel highlighted challenges in operationalizing CBME institutionally; importantly, Dr. Ayala, a family physician DIO from Adventist Health described adapting curriculum and competencies to meet community needs, not just ILP's – rural mobile health clinics in central CA valley focused on SUD, mental health and maternity care: community need driven, resident/faculty champions, DIO support, advocacy at health system level. He emphasized that trumpeting improvements in QI/patient safety and patient outcomes will help enlist institutional buy-in and financing. The summit also gave us a chance to hear the perspective of other DIOs, the ACGME CIO and, very importantly, engage with RC/Board representatives from other specialties including Surgery, Pediatrics, Pathology and Ob/Gyn.

Priorities and Recommendations for the Specialty

1. Communication to program directors, faculty and residents is a urgent priority.

   We've started this over the last six months at the leadership level (including the summit, FMLC, ADFM, RLS, STFM, the ACOFP Executive Committee) as well as the RC and ABFM over the last six months; the core outcomes and competency based ABFM Board eligibility policy have been announced at the RLS mainstage

and sent to every program director/coordinator in addition to faculty and residents.

We recommend now that the specialty develop now, as soon as possible, a common message: why CBME, why now—and sent by all of the organizations. This communication should include first steps, identify resources, including assessments, and underscore that it is an evolving progress.

Inclusion of program directors at formerly DO only residencies will be important. Leaders of the ABOFP have sat on the RC and attended the residency summit; the ACOFP has been involved in every aspect of the residency rdesign process—but reaching out to residency directors and faculty of formerly DO programs will be important.

2. <u>The FM RC has developed a data strategy for what they will need for accreditation of family medicine residencies.</u> This involves detailed review of current required WebAds submissions from residencies—focusing on specific data needed for individual standards. Their intent is also to consider the resident and faculty surveys. They have engaged the CIO of the ACGME, who is embarking on an ambitious ACGME-wide "digital transformation". They have been told that what they want is possible, but that it will take time—and ongoing focus from the ACGME.

3. <u>The ABFM, working closely with AFMRD leadership, program directors and others has developed its policy for implementing "competency based Board eligibility".</u> This was posted ahead of print on 6/15/23 and has been distributed to all program directors and program coordinators on 6/19. AFMRD will work with ABFM to set up a follow up webinar and other plans as needed.

4. <u>National Assessment Strategy</u> – The STFM Assessment Task Force has developed a draft listing of recommendations. We believe that this is a great start. Our group suggests:

    a. Tools are critical. The STFM assessment group should develop and curate a list which should be dynamic and available to all family medicine faculty and residents. .
    b. The ACGME and other sources have open source materials that are good quality and relevance. The assessment task force should review and include as appropriate.
    c. They emphasize direct observation among a variety of assessments. Multisource feedback should also be called out, as should metrics that

related to the Starfield principles—continuity, referral rate and appropriateness and quality of care—which are listed in the new residency standards.

d. There should be more detailed recommendations regarding equity in assessment. Reference the Macy conference and the recent NBME conference.
e. Increasing volume of assessments without increasing burden is critical—the recommendations should address. A handheld digital app is necessary (see below)
f. Sampling of assessment is also critical—there need to be assessments across the continuum of care.
g. Consider an explicit focus on improving the function of CCCs. The ACGME has excellent materials available.
h. Consider more attention to a "learning strategy" and the growth mindset—the importance of formative feedback and tracking how well residents are learning.

We recommend that FMLC meeting includes review of the next current draft of this proposal. We are sending detailed peer review of the document.

5. National Strategy for Faculty Development. The STFM Assessment Committee gave us an excellent initial draft. By way of peer review, our group ask the Assessment Committee to consider the following additions:
    a. As the Task Force understands, tools are necessary but not sufficient. Jas as important is a shared mental model among faculty and teaching faculty how to give feedback. This should be emphasized.
    b. Similarly, good functioning of the CCC is critical. Consider including a focus on this.
    c. Include mention the initial roll out of information this summer/early fall—a key first step in the spread of this work across the specialty.
    d. Important to use multiple methods, including push announcements, existing national conferences, especially RLS and STFM.
    e. STFM plans to update their certificates for residency faculty and other resources. Given the reach and resources of the STFM, this is a critical component of a national strategy. STFM should also consider making CBME a focus for the 2024 annual meeting, including a plenary and an invitation for presentations.
    f. Coordination of agenda across the meetings of Family Medicine organizations over the next year would be valuable: this winter, the AAFP COE, ADFM, RLS, ACOFP focused on different aspects of the issue. What can we do going forward?

g. It is important to stress in faculty development that residency redesign is not just CBME. CBME is an educational strategy to the end of training family physicians who will provide robust primary care in communities—and help heal health care. At every stage, we must be careful to keep our CBME efforts aligned with the rest of residency redesign (the practice is the curriculum, engagement in communities about disparities, development of areas of focus)
h. Other specialties have developed good techniques for faculty development. An example is vignettes of resident performance and discussion among faculty about whether the resident is competent. The goal is to develop a shared mental model and try to reduce interrater reliability around each one of the core outcomes.
i. There should be more attention to specific steps that residencies can implementnt to equity in assessment. The Macy conference and the recent NBME conference on this issue need to be referenced. It would be valuable for the faculty development strategy to include this
j. Consider developing a strategy of inclusion of formally Osteopathic residencies. While many of these educators are a part of AFMRD, STFM and other organizations, it is important to be pro-active to reach out.
k. It will be important to have all organizations contribute to the strategy. While STFM has a major role to play, other organizations can play complementary roles. The FMLC meetings are part of that strategy.
l. An important key piece that needs further work is scaling up faculty development – how do we spread? We start with the two big educational meetings (RLS, STFM) with support from smaller leadership groups - the ADFM and the AFP. STFM can do an updated certificate but how do we spread it out.

   Pathology, Pediatrics and Surgery have done a lot of work in both spreading among groups of Program Directors and developing techniques of faculty development in CBME. The combined message we've recommended is a key strategy, but the specialty needs to identify a spread strategy. Can the Assessment Task force (or others) develop and propose this?

We recommend that FMLC review and give input on the current version of the national faculty development strategy.

6. <u>Handheld Digital Apps</u> – There is **strong** consensus that Family Medicine needs handheld apps that will make it easy to give feedback to residents—and vice versa. Furthermore, the consensus of our group was that it was important to integrate

such technology into New Innovations and Med Ed Hub – our programs are already using those and the burden of multiple data entry is something to avoid.

We recommend that the specialty now focus on key design features: what should the app capture? Core outcomes? 2, 3, or 5 levels? Bidirectional? What analytics? This merits discussion at FMLC. SIMPL has some very desirable features: how important are they, and can SIMPL be integrated into the learning management systems. A related issue is the strategy for building analytics into the app—what and how. Importantly, for example, Pediatrics is building analytics that address health equity.

A related issue is how to get the right tools into New Innovations and Med Ed Hub. Dr. Holmboe has indicated that the ACGME will support adviocacy if asked. The specialty will need to develop a strategy for this. ***We propose that this also be discussed at FMLC.***

7. The STFM Assessment Committee has drafted a mapping of milestones to core outcomes. This is a very important contribution. To that end, the committee gave initial peer review feedback to the STFM assessment group working on this:
    i. It will be important to have a preface, explaining the purpose of the document and how it should be used. A key element is underscoring the need to track both ACGME core competencies (which extend thinking beyond patient care and knowledge) and to assess the endpoints (core outcomes). Our specialty will need to do both.
    ii. It is important to underscore that the expectation for graduation for each of the ACGME Core competencies is "proficiency" --level 4. This needs to be both stated explicitly and built into the mapping.
    iii. The mapping should link the ACGME competencies to the outcomes. Separate mapping can link the milestones to the outcomes, and the outcomes to the program requirements (a draft of the latter was done by Colleen Cagno and the RC and may be helpful to include)
    iv. It may be helpful to look at models of these kinds of mapping from other specialties. We have asked Eric Holmboe for examples and will pass along.

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