MEMORANDUM

TO: Family Medicine Department Chairs

FROM: Warren Newton, MD, MPH
President/CEO ABFM

RE: An Update on ABFM Activities

DATE: February 11, 2024

I look forward to "coming home" to the ADFM next week. On Wednesday, I will be meeting with the LEADS fellows and the ADFM Board of Directors, and on Saturday I will be conducting a breakfast discussion to get input on the 2025 core outcomes and presenting the 2023 ABFM data review. And, of course, I will be meeting with many of you informally.

What follows is an update since the last ADFM annual meeting, organized into three parts: an update related to the topics I hope to talk with the ADFM Board/present at the meeting, then other recent ABFM news most relevant to Departments,, then other ABFM news. I am also attaching three key articles published by ABFM in the last 8 months which are most relevant to our work together. I hope that providing this context will be useful for you. As usual, please feel free to give me feedback or ask any questions while we are together!

Research Capacity Building

Thank you to ADFM for your leadership with NAPCRG in developing a specialty wide strategy for research capacity building. You have made great progress!

ABFM is committed to advancing research in Family Medicine. Much of this is through direct involvement in research by Drs. Bazemore, Phillips and Peterson and their colleagues on the ecology of family physicans and their practices, Measures that Matter and targeted research focusing on adjustment of reimbursement for social risk and improvement of the effectiveness of EHRs. In addition, ABFM and its foundation have made deep commitments to development of the specialty's research capacity. *JABFM* represents a key outlet for faculty research on clinical care, and we support *Annals of Family Medicine* along with the other family medicine organizations. Finally, over the last 20 years, we have gradually built out our data resources, starting with the demographic data all Diplomates fill out with recertification, then the graduate survey 3 years out and recently the ITE survey of residents this fall. The PRIME registry is the largest registry in primary care—national in scope, with a tilt towards rural and underserved populations. All of these have been used to develop collaborative research with the CDC, ONC, CMMS and a developing distributed network work of

researchers and institutions. We believe that a major facilitator of impactful research are robust data systems, and we are committed to continued development of data systems and to making them available to Family Medicine scholars.

We are also committed to help develop researchers in the specialty. 12-18 scholars/year from medical school, residency and fellows work with us in Lexington or Washington, in addition to senior fellows and a full time fellow at George Washington. For established family medicine scholars, we have expanded the National Academies/Puffer to 2 fellows per year. In the last two years, ABFM has also launched a major new initiative to train Family Medicine researchers in AI/ML techniques, supported a GGP track devoted to AI research and funded STFM to develop a curriculum in AI/ML. Finally, this year, the Foundation supported the development of a new editorial fellowship at JABFM; in addition to participation of ongoing editorial work, fellows will have the opportunity to do research at Lexington and participate in one cycle of the ABFM national journal club. We are hopeful that these fellows will add to the research capacity of the specialty. Please contact Marjorie Bowman or Dean Seehuesen if you have an interest faculty.

We look forward to learning ADFM's priorities for building research strategy. Departments play a critical role—nurturing curiosity in medical students, giving residents core skills in evidence and QI, and, in many settings hiring reserachers. I am eager to hear your priorities. A related question has come up with the sudden closure of the *Journal of Family Practice*: should the specialty try to resurrect that journal or a similar one.

Residency Redesign

As the result of a specialty wide campaign, the ACGME changed the requirement for residency faculty teaching time in June, effective July 2024, reverting to the 2019 standard. The 2019 cut in faculty time had devastating impact on family medicine residencies; now the challenge is to "win the peace"—use the time effectively. Please see the attached editorial; I welcome your thoughts.

The source of support for residency redesign has shifted to the academic organizations. The STFM CBME Task Force has played a critical role:

- Sponsoring monthly webinars for the next 10 months (Webinar Series)
- Publishing Principles for CBME Implementation (out soon)
- Setting up a Website: https://stfm.org/cbmetoolkit
- Developing a list of available assessment
- leading effort to get a mobile app integrated in New Innovations and Med Ed Hub.

Both STFM/AFMRD have also committed to having their conferences have a major focus on CBME for 3 years: this is a critical part of our learning community.

The ABFM Foundation, with Jay Fetter on point, has focused on supporting the specialty to support residency redesign. Over the last year, the Foundation has led the following initiative t:

> *Developing Human Capital:* The "Train the Trainers" ACGME courses, have trained >80 family physicians who have had deep training in competency-based medical education. Our

hope is that they will support both their own residencies and participate in learning networks. T

- The RFP for *planning residency learning networks* has been completed; 36 residencies have been funded. What is striking is that many in our community don't really understand what can be learned from other residencies. The RFPs for s*eed funding for learning networks* and *evaluation of residency learning networks* are out. Contact Jay Fetter at jfetter@theabfm.org if interested.
- *SOAR (theFMRD/ABFM collaborative*)will have another pre-conference at the spring meeting of program directors. The last one attracted a hundred residencies. The overall focus is on learning from the graduate survey results. Other goals of SOAR are development of a *GME Hub* website and a*n annual fellowship for residency directors i*nterested in research related to residency policy.
- For *AIRE*, after a year working on infrastructure, the focus is now recruitment. 9 residencies have been approved.. Last summer we had the first AIRE collaborative meeting , and we are now kicking off a formal recruitment campaign, with a targe of 45 in the next year. .

Eric Holmboe has resigned from the ACGME to become President of Inthealth formerly the ECFMG. Eric has been a major supporter of CBME at the ACGME and a wonderful colleague for the ABFM. The ACGME has committed to continuing the transition to CBME.

I look forward to hearing Departments' ideas about supporting residency redesign and driving innovation. Your discussion of changing faculty roles at last year's meeting was critical to the specialty.

Competency Based Board Eligibility

Starting in June 2024, ABFM will begin instituting competency based board eligibility. Our rationale and schedule is laid out in the article accompanying this update. As you know, Program directors now must attest that a resident has completed residency and is ready for autonomous practice. In June, we will extend this process so that program directors will need to attest to competence in five areas. The implementation will be phased in over three years.

We are currently considering recommendations for establishing competency in the core outcomes scheduled for attestation in 2025. These are:

- Practice as personal physicians, to include care of women, the elderly, and patients at the *e*nd of life, *with excellent rate of continuity and appropriate referrals.*
- Provide care for low-risk patients who are pregnant, to include *management of early pregnancy*, *medical problems during pregnancy*, *prenatal care, postpartum care* and *breastfeeding*, with or without competence in labor and delivery.
- Diagnose and manage of common *mental health problems* in people of all ages.
- Perform the *procedures* most frequently needed by patients in continuity and hospital practices.
- Model *lifelong learning* and engage in self-reflection.

On Saturday morning, I'll conduct a focus group on how best to assess these competencies. Wisdom welcome! We are also getting input from STFM, AFMRD, and others.

What assessments are currently being used in Family Medicine residencies? Over the summer, we did an almost complete census of FP residencies; the summary article is attached to this update. The important lesson is that family medicine residencies are **already** doing the assessments needed for the future: we just need to learn from each other!

ABFM 2023 Data Review

ABFM has committed to annul reporting to the specialty of trends we seeing in the specialty, based on our data systems. In the last year, we have reported to the AAFP Commissions on Education and Continuing Professional Development, the Family Medicine Review Committee, the STFM Board of Directors, the Scott and White meeting and the Residency Program Solutions.

On Saturday morning, we will present what we've learned about assessments in residency, trends in burnout prevalence among residents, early graduates and all Diplomates and hours worked and pay. These topics were chosen by the leadership of ADFM and the conference. We also have other data available for presentation if departments are interested: AAMC data on preparedness for residency, trends in intraining examinations, the new intraining exam survey, trends in scope of practice of recent graduates and Diplomates, trends in behavioral health, POCUS use and other procedure.

Other ABFM News Most Relevant to ABFM

1. ***Nominations for ABFM and the National Academy Fellows:*** ABFM seeks nominations for its Board of Directors by mid-March. Please contact Amanda Weidner or me for more information. Later in the spring, we will seek nominations for the Puffer fellowships at the National Academies. These are 2 year part time fellowships for accomplished junior researchers. They are a major career development opportunity for your faculty; they are very competitive.

2. ***Professionalism*** As ABFM develops its 2025-29 strategic plan, an important consideration is what our professionalism agenda should be. We welcome the perspective of ADFM and chairs. In recent years, ABFM has revised its professionalism policy to provide more flexibility for specific cases and addressed mis-information and sexual boundary violations. Now we are beginning an important discussion on guidelines for the supervision of advanced practice practitioners (APPs). We are also joining a national collaborative on professionalism across 10 specialties which considers professionalism a competency and hopes to develop optional assessments of professionalism for Diplomates. What do you think are the most pressing issues in professionalism that our specialty and profession face? What are priorities for departments??

3. ***Opportunities and Threats of AI/ML*** Exploring the opportunities and mitigating the risks of AI/ML has been a significant focus of ABFM over the last year. Most importantly, we have successfully installed a safe space for AI/ML experimental work within the Microsoft Azure cloud. We are using this for a variety of applications. Most prominent have been the use of Microsoft Copilot to assist with code writing, the evolution of customer relations solutions, and the augmentation of item classification.

   I want to highlight a newABFM offering in Performance Improvement-the use of AI to improve care and decrease burden for physicians and their staff. In early October, we received

our first PI request using AI to manage physicians' inboxes. ABFM staff were able to turn this around quickly so that it is now listed as a formal option, with over 100 PI projects approved in the first several months. We believe that AI can help reduce burden, through managing inboxes, prior authorization and documentation. We want to promote and spread best practices.

4. The ***ABFM Health Systems Learning Collaborative*** "*Making Primary Care Primary for Population Health*" (or *MP3)* kicked off in Dallas in the fall. With 11 participating health systems representing 7000 family physicians/12,000 clinicians, the collaborative chose as its first year's focus the review of comparative data on panel size, continuity, and access; a separate survey will address the organization of primary care within these large systems. We hoping to recruit for a second cycle later this spring. Please let me know if you are interested in participating.

5. The **Health Administration, Leadership and Management (HALM) subspecialty** is being launched in the near future. This will be administered by the American Board of Emergency Medicine; ABFM is a co-sponsor. ABFM's goal is to support family physicians in major health systems leadership roles. We are now engaged in writing the initial examination and announcements will be coming soon. I would welcome your support in spreading the word to those who may be interested. Let me know if you have any questions.

Other ABMS News

1. After the fall examinations, the ***total number of Diplomates as of December 31, 2023 was 105,016*****,** an increase of 2,881 since January 1, 2023. Of initial certifiers, 4,357 or 29% were DOs; the proportion of DOs among initial certifiers has increased from 22% just 5-years ago in 2018 to 29% in 2023; this will rise. An important question is whether the percentage of older Diplomates recertifying has increased in recent years. I am hopeful that FMCLA will help older physicians continue certification longer; economic conditions are also very important.

2. ***FMCLA*:** Currently about 34,000 of Diplomates been now been exposed to FMCLA; those that have love it. Diffusion of innovation theory suggests that around 40% participation is the "early majority" tipping point. Of note, the final four-year FMCLA passing rate is approximately 92.7%, which is comparable to the initial 2019 cohort and to the one-day exam.

   More broadly, the Continuous Knowledge Self-Assessment (CKSA) seems to have plateaued, with approximately 34,000 Diplomates doing it every quarter. The National Journal Club has grown rapidly, with a significant increase in the number of residents using the service.

3. ***New Blueprint implementation***: The new blueprint continues its long march to implementation. This fall has seen the implementation of a new "item bank" software, and we are now developing the score report. The new blueprint is grounded in a large survey of what all family physicians do, and features a component of the risk of harm as well as priorities of health and health care. Later this spring, we will reconvene the Blue-Ribbon panel nominated individuals for as well as a residency director focus group to give feedback on the score reports as well as provide input on a communication plan for the new blueprint. We believe that most Diplomates will not see a dramatic

impact of the new blueprint on their experience of taking examinations, but we hope the new blueprint will allow us to better target education. .

4. ***Health equity***: We continue to work towards health equity along a variety of different lines. Performance Improvement and Knowledge Self-Assessment work continues, as does research and policy related to disparities. These are mentioned in the Health Equity report we sent to all Diplomates in the fall. We continue Differential Item Functioning testing of our examination questions and will be adding rurality and first generation in college to the analysis this year. Interestingly, this fall we received many more negative comments about asking about race and ethnicity during the certification exam registration process than ever before. We've been collecting this information for years, so "why now" is an important question. We believe that there are likely multiple causes. First, the placement of the request in the portfolio was different, and we added additional options for race and ethnicity, both of these factors perhaps called more attention to the question. We also think there is increasing outspokenness to what we call racialization of discourse. The latter was evident in the comments, many of which were sarcastic and angry. We intervened in a number of ways, including pre-filling information, adding a "prefer not to respond" option in the question about race and amending the rationale given for collecting the data. We are clear that the purpose of collecting the information is to assure fairness of the exam (through differential item functioning analysis), promoting diversity of item writers and to track the ecology of the specialty/advocate for policy change. The comments quieted down substantially after those changes, and we believe that there will not be a substantial loss of data. Routine collection of this data is a bedrock of our certification data enterprise.

5. ***Sports Medicine***: After approximately six months of deliberation, the Sports Medicine Blueprint Committee has delivered a draft of the Sports Medicine Content Outline, which has now been sent out to the co-sponsoring boards and the American Medical Society for Sports Medicine (AMSSM) for input. The next step will be a practice analysis, which will take place over the next six to eight months. As we did with the Family Medicine blueprint, we will ground the new examination in a survey of what sports medicine physicians are doing across the country.

6. ***International Family Medicine*:** Dr. Lauren Hughes and I attended the WONCA World Council in Sydney in Australia in October. I had a site visit and presentations at the Royal Australian College of General Practice (RACGP) and attended the Australian College of Rural and Remote Physicians meeting. Coming out of the meeting has been an effort to develop a robust WONCA North American region: we plan a meeting this fall. More to follow!

   Importantly, Australian general practice has split into two separate movements over the last generation---the Royal College and the Australian College of Rural and Remote Medicine (ACRRM); to American eyes, the split is of great concern and understanding what happened was an important rationale for travelling to the end of the earth(Tasmania!). Each of them has an advocacy arm, splitting the voice nationally, and both run training systems. The flavor of the ACRRM meeting was not dissimilar to meetings of the Alaska AFP—with the concerns of frontier family physicians that their needs are not being heard by the rest of family medicine. The strategic question is how to avoid a similar split in the US.