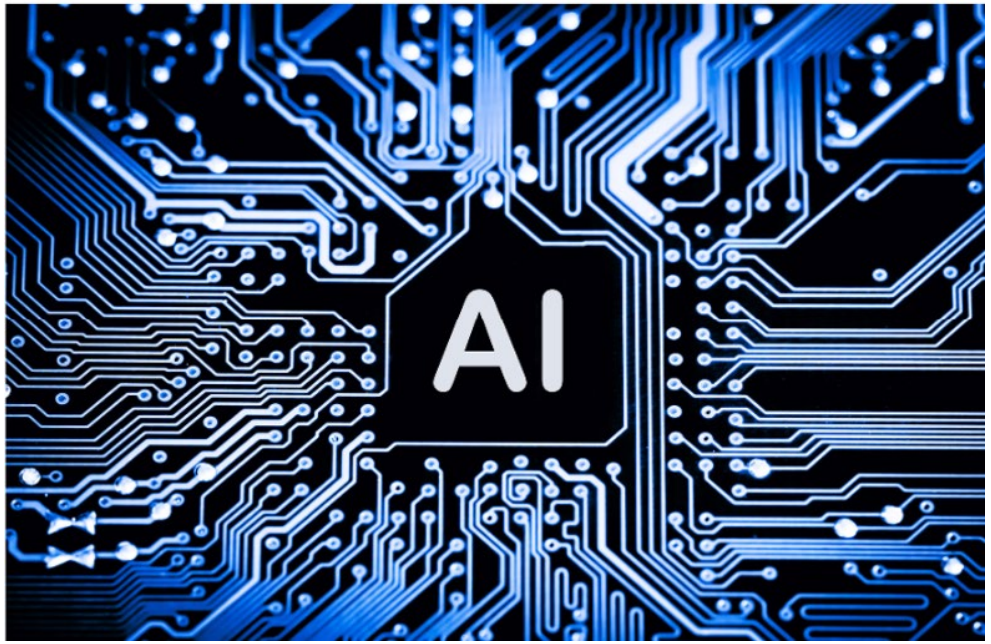
The Future of Residency Training=the Future of Family Medicine

Warren P. Newton, MD, MPH
President & CEO, ABFM
RMTC
April 11, 2024

Thank You!

The Implications of AI



- What health systems are focusing on: inbox, prior authorizations, documentation…
- ABFM opportunities and threats; new PI focus
- But…hallucinations and Google Gemini/Adobe…

The Future of ERAS…

APGO

INSPIRE • INSTRUCT • DEVELOP

ABOUT APGO ▾ FACULTY DEVELOPMENT ▾ RESOURCES MEETINGS ▾ GRANTS & AWARDS RRR GRANT ▾

New Residency Application Platform for Obstetrics and Gynecology

The American College of Obstetricians and Gynecologists (ACOG) is pleased to announce a specialty-wide initiative to design and implement an obstetrics and gynecology residency application starting in the 2024-25 residency application cycle. This new specialty-specific process for residency application, review, and selection will be used across all obstetrics and gynecology residency programs and applicants in lieu of the Electronic Residency Application Service (ERAS).

Emerging from efforts catalyzed by grant-funded work with the AMA Reimagining Residency grant program "The Right Resident, Right Program, Ready Day One", this initiative led by ACOG, CREOG and coordinated with the Association of Professors of Gynecology and Obstetrics (APGO) will improve the ability of obstetrics and gynecology residency programs to evaluate candidates holistically and better ensure that our obstetrics and gynecology trainees are able to meet the needs of the communities for whom we provide care.

The new application will be user friendly and efficient, less expensive for applicants, and will directly decrease the burdens faced by program directors, program managers, and applicants alike. It will incorporate the entirety of interview season functions, from application submission, review, interview offers and interviews, to rank list submission. ACOG's partner in this effort, Liaison International, has more than 25 years of experience developing and supporting such application services in over 31,000 programs, including 31 health professions.

ACOG, CREOG, and APGO are making a coordinated effort and look forward to incorporating feedback from program directors, program managers, and applicants as they move forward with the building, testing, and implementation of this application. More information will follow in the coming months.

- ACOG, Plastic Surgery so far
- Neurology, Anesthesiology and others in the wings
- Major income stream for AAMC (>$119M/year)
- Students applying to FP averaged 40.5 applications (down 1.8) this year
- ERAS evolving…

The Fracture of Internal Medicine?

- Proposal for new American Board of Cardiovascular Medicine to ABMS
- Hard to do, and slow
- Oncology, Gastroenterology and others watching: parallelling surgery in 60s-70s?
- Residency training will change…
- Implications for FM?

Access/Workforce hot issue in states…

Tennessee Law HB1312

BILL SUMMARY

Present law provides that a person desiring to practice medicine or surgery in Tennessee must submit an application in writing to the board of medical examiners or via an online application, which must include the following if the applicant is an international medical school graduate:

(1) A certificate from a medical school whose curriculum is judged to be acceptable by the board;

(2) A copy of a permanent Educational Commission for Foreign medical Graduates (ECFMG) certificate;

(3) A nonrefundable application fee as set by the board and by an examination fee;

(4) Sufficient evidence of good moral character;

(5) Evidence of being a citizen of the United States or Canada, or legally entitled to live or work in the United States; and

(6) Evidence of satisfactory completion of a three-year post-graduate training program approved by the American Medical Association or its extant accreditation program for medical education, or its successor. Such a person may apply to the board for licensure or testing in accordance with the present law within 12 months of completion of the post-graduate training program if satisfactory performance in such program is demonstrated to the satisfaction of the board.

This bill adds that, if an applicant is a licensed physician outside the United States or Canada who has completed a residency program or otherwise practiced as a medical professional performing the duties of a physician for at least three of the last five years outside of the United States, then the application must include the following:

(1) A certificate from a medical school whose curriculum is judged to be acceptable by the board;

(2) A nonrefundable application fee as set by the board and by an examination fee;

(3) Sufficient evidence of good standing with the medical licensing or regulatory institution of the applicant's licensing country;

(4) Sufficient evidence of either the completion of a residency or substantially similar post-graduate medical training or practice as a medical professional performing the duties of a physician for at least five years;

(5) Sufficient evidence of good moral character;

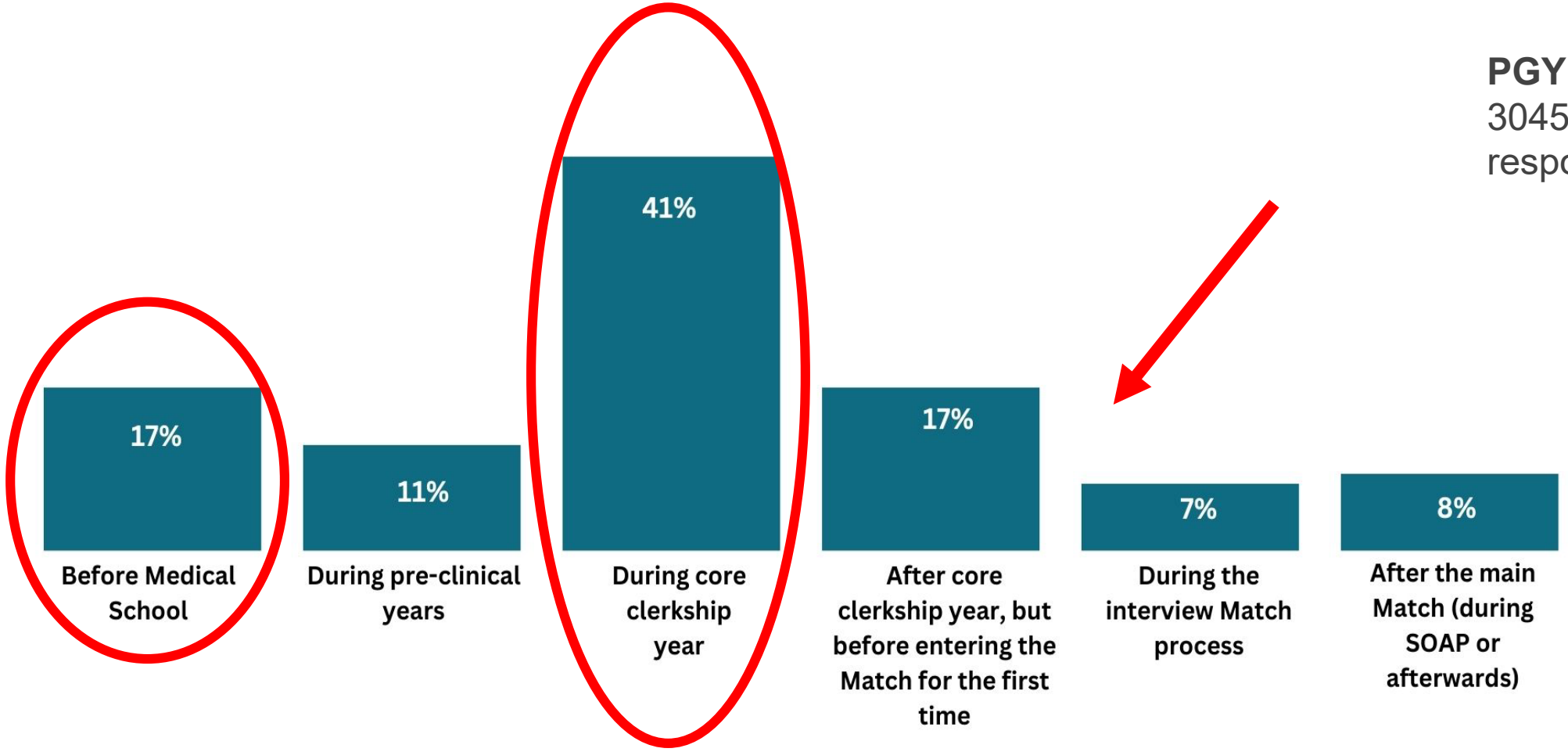
(6) Evidence of being a citizen of the United States or Canada, or legally entitled to live or work in the United States;

(7) Evidence of basic fluency in the English language; and

(8) Sufficient evidence that the applicant is an international medical graduate and has an offer for employment as a physician at a healthcare provider that operates in Tennessee and has a residency program accredited by the Accreditation Council for Graduate Medical Education in place.

National Resident Survey: When Did You Choose Family Medicine?

PGY 1
3045=65%
response rate



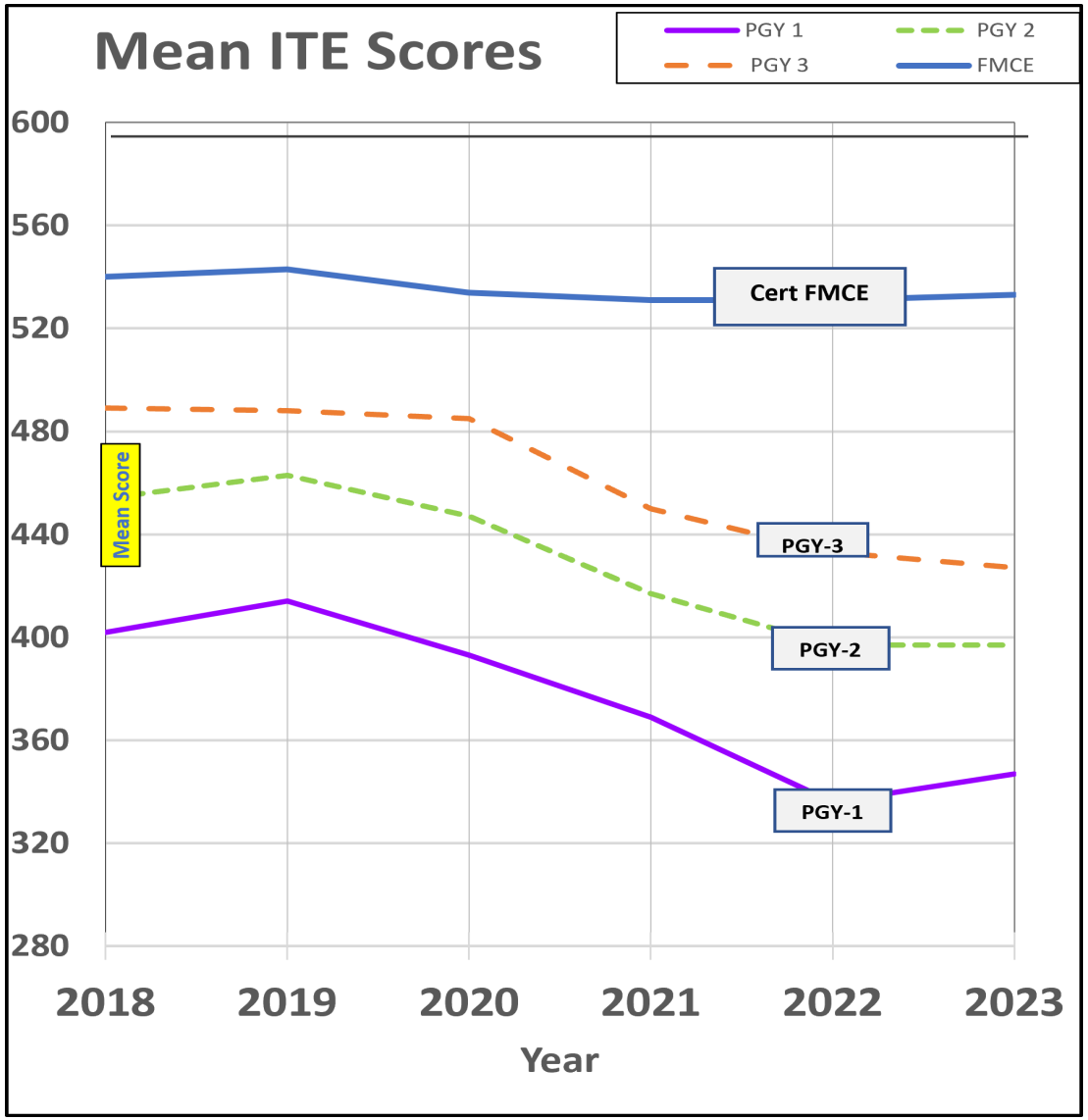
RTT%	17	5	38	15	14	11

Other Learnings from the National Resident Survey

- 53% of interns had in-person interview; >20% said it made a difference, and >60% had some in person contact (RTT: 64% had an inperson interview)
- In 2023, 16.1% of current interns applied for 1.2% slots that were in 4 year residencies
- 5% in couple match

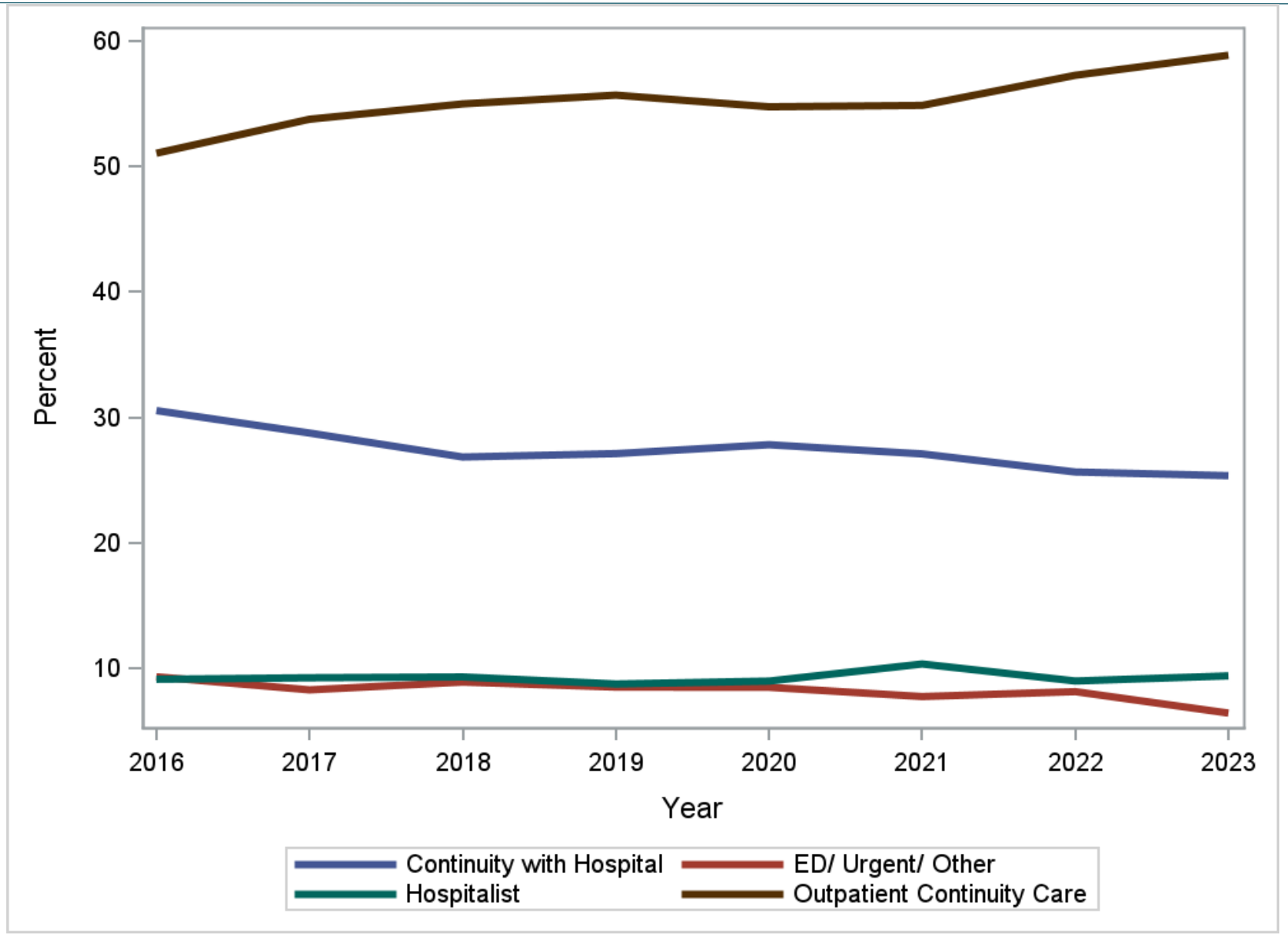
Help us to frame questions and increase response rates! (wnewton@theabfm.org)

Family Medicine Intraining Exam Trends--2018-2023

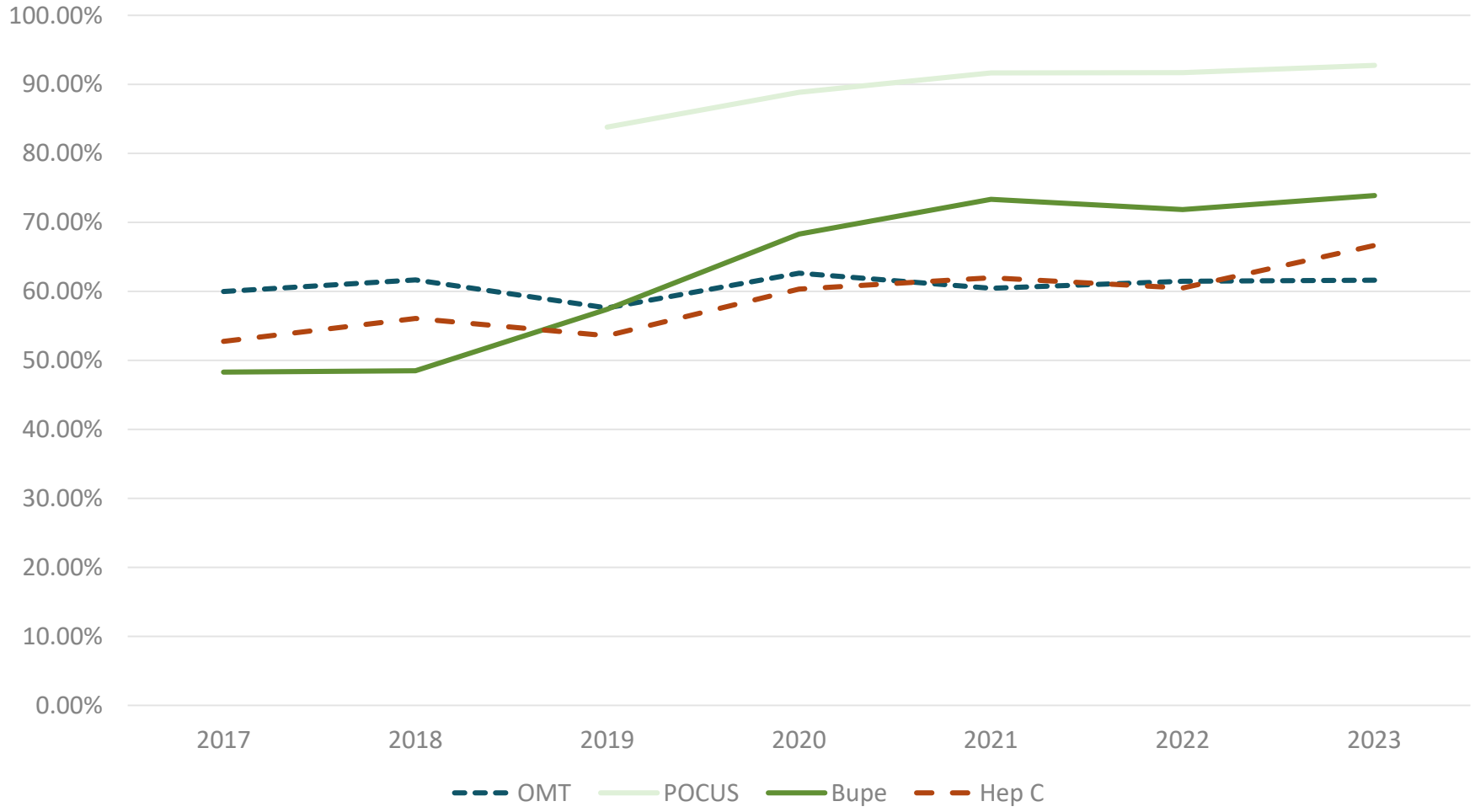


- 52% residencies improved (vs 17% last year)
- Free fall of ITE has stopped, no change in certification scores but third years still 1.25 years behind
- Best strategies: Programs directors signal importance, include prep in didactics, set resident accountability

A Non-Trend: Clinical Scope 3 years out



Residency Programs With Any Residents Intending to Provide Procedures by Year



Changes in Burnout Over Time

Burnout by Survey and Year			
Year	Initial Certification Cohort	National Graduate Survey	Continuing Certification Cohort
2019	37%	44%	37%
2020	36%	40%	41%
2021	37%	43%	35%
2022	43%	45%	44%
2023	43%	43%	43%

Questions, Comments?

Residency Redesign and Competency Based Board Eligibility

The End of the Flexnerian Revolution

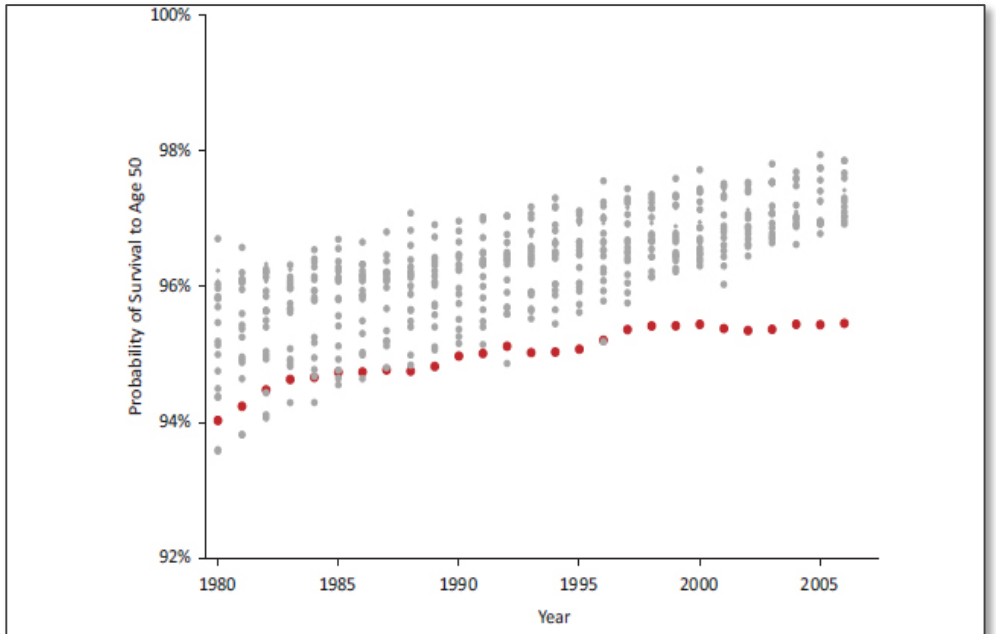


FIGURE 1-8 Probability of survival to age 50 for females in 21 high-income countries, 1980-2006.
NOTES: Red circles show the probability a newborn female in the United States will live to age 50. Grey circles show the probability of survival to age 50 in Australia, Austria, Belgium, Canada, Denmark, Finland, France, Iceland, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, the United Kingdom, and West Germany.

Clinical Review & Education

JAMA | Special Communication

Life Expectancy and Mortality Rates in the United States, 1959-2017

Steven H. Woolf, MD, MPH; Heidi Schoomaker, MAEd

IMPORTANCE US life expectancy has not kept pace with that of other wealthy countries and is now decreasing.

OBJECTIVE To examine vital statistics and review the history of changes in US life expectancy and increasing mortality rates, and to identify potential contributing factors, drawing insights from current literature and an analysis of state-level trends.

EVIDENCE Life expectancy data for 1959-2016 and cause-specific mortality rates for 1999-2017 were obtained from the US Mortality Database and CDC WONDER, respectively. The analysis focused on midlife deaths (ages 25-64 years), stratified by sex, race/ethnicity, socioeconomic status, and geography (including the 50 states). Published research from January 1990 through August 2019 that examined relevant mortality trends and potential contributory factors was examined.

FINDINGS Between 1959 and 2016, US life expectancy increased from 69.9 years to 78.9 years but declined for 3 consecutive years after 2014. The recent decrease in US life expectancy culminated a period of increasing cause-specific mortality among adults aged 25 to 64 years that began in the 1990s, ultimately producing an increase in all-cause mortality that began in 2010. During 2010-2017, midlife all-cause mortality rates increased from 328.5 deaths/100 000 to 348.2 deaths/100 000. By 2014, midlife mortality was increasing across all racial groups, caused by drug overdoses, alcohol abuse, suicides, and a diverse list of organ system diseases. The largest relative increases in midlife mortality rates occurred in New England (New Hampshire, 23.3%; Maine, 20.7%; Vermont, 19.9%) and the Ohio Valley (West Virginia, 23.0%; Ohio, 21.6%; Indiana, 14.8%; Kentucky, 14.7%). The increase in midlife mortality during 2010-2017 was associated with an estimated 33 307 excess US deaths, 32.8% of which occurred in 4 Ohio Valley states.

CONCLUSIONS AND RELEVANCE US life expectancy increased for most of the past 60 years, but the rate of increase slowed over time and life expectancy decreased after 2014. A major contributor has been an increase in mortality from specific causes (eg, drug overdoses, suicides, organ system diseases) among young and middle-aged adults of all racial groups, with an onset as early as the 1990s and with the largest relative increases occurring in the Ohio Valley and New England. The implications for public health and the economy are substantial, making it vital to understand the underlying causes.

Editorial page 1963
Supplemental content
CME Quiz at jamanetwork.com/learning

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Corresponding Author: Steven H. Woolf, MD, MPH, Center on Society and Health, Department of Family Medicine and Population Health, Virginia Commonwealth University School of Medicine, 830 E Main St, Ste 6035, Richmond, VA 23298-0212 (steven.woolf@vcuhealth.org).

JAMA. 2019;322(20):1996-2016. doi:10.1001/jama.2019.16932

Life expectancy at birth, a common measure of a population's health,[1] has decreased in the United States for 3 consecutive years.[2] This has attracted recent public attention,[3] but the core problem is not new—it has been building since the 1980s.[4,5] Although life expectancy in developed countries has increased for much of the past century, US life expectancy began to lose pace with other countries in the 1980s[6,7] and, by 1998, had declined to a level below the average life expectancy among Organisation for Economic Cooperation and Development countries.[8] While life expectancy in these countries has continued to increase,[9,10] US life expectancy stopped increasing in 2010 and has been decreasing since 2014.[2,3] Despite excessive spending on health care, vastly exceeding that of other countries,[11,12] the United States has a long-standing health disadvantage relative to other high-income countries that extends beyond life expectancy to include higher rates of disease and cause-specific mortality rates.[4,7,10,13]

This Special Communication has 2 aims: to examine vital statistics and review the history of changes in US life expectancy and increasing mortality rates; and to identify potential contributing factors, drawing insights from current literature and from a new analysis of state-level trends.

Methods

Data Analysis

Measures

This report examines longitudinal trends in life expectancy at birth and mortality rates (deaths per 100 000) in the US population,

1996 JAMA November 26, 2019 Volume 322, Number 20 jama.com

Family Medicine Residency Redesign – Key Elements

- The Practice is the Curriculum
- Community Engagement to address disparities and social determinants of health
- Residency Learning Networks
- Flexibility for residencies and residents
- Competency-Based Medical Education
- Faculty Time for Education

Faculty Educational Time: Winning the Peace

October 11, 2022

Claudia J. Wyatt-Johnson, MA
Chair, Board of Directors
Accreditation Council for Graduate Medical Education
401 N. Michigan Avenue, Suite 2000
Chicago, IL 60611

Thomas J. Nasca, MD, MACP
President and Chief Executive Officer
Accreditation Council for Graduate Medical Education
401 N. Michigan Avenue, Suite 2000
Chicago, IL 60611

Dear Ms. Wyatt-Johnson, Dr. Nasca and the ACGME Board of Directors:

We write on behalf of the specialty of family medicine to request reconsideration of the decision of the Committee on Requirements (COR) and the ACGME Board of Directors to reject the Family Medicine Review Committee's request for a variance regarding support for dedicated educational time for residency faculty.

As you know, there has been great engagement of the family medicine community in re-envisioning family medicine residency education. Despite the pandemic, over 3,500 people participated in surveys, focus groups were conducted by all of the national organizations of family medicine, a national summit was held, and 36 peer-reviewed articles were published over two years. This was all in addition to and coordinated with the ACGME scenario planning process of November 2020. We believe that the proposed major revision published by the ACGME Family Medicine Review Committee in December 2021, and improved by extensive comments from the community, captured the broad innovations the specialty wanted to better meet the needs of the country. These include:

- Transition to competency based medical education and assessment (CBME)
- Emphasis on reforming residency practice
- Community engagement to address disparities and social determinants of health
- Development of residency learning networks
- A partial return of the faculty time dedicated to residency education taken away by the ACGME in June of 2019.

We believe that the proposed changes were the most significant and important ones since the founding of our specialty in 1969, and that they are necessary to position family physicians to meet the crisis of American health care evident in our declining life expectancy, disparities in health outcomes, out of control cost, and burnout among physicians and their clinical teams.

The leadership of the national family medicine organizations (the American Academy of Family Physicians, the American Board of Family Medicine, the American College of Osteopathic Family Physicians, the Association of Departments of Family Medicine, the Association of Family Medicine Residency Directors, the Society of Teachers of Family Medicine and the North American Primary Care Research Group) met in Boston on August 20 to review what has happened. We are very disappointed in the process of review at the COR level. We expect peer review by the COR to be both constructive and critical. Each of the major changes proposed, however, has been eliminated or greatly attenuated. Thus, we have two requests.

First, we formally ask that the ACGME Board of Directors reconsider the request for additional time dedicated to residency education. This is essential to create an effective program learning environment and is aligned with the ACGME's longstanding commitment to excellence in education, along with its mission to improve the health of the public through graduate medical education. Additional residency faculty educational time is necessary because of the changes proposed by the Review Committee. In particular, the transition to CBME requires significant faculty time and development, as recently

underscored by many specialties at the ABMS/ACGME summit on CBME on August 11-12. Our request was grounded in the ACGME's own data over 10 years describing family medicine faculty time dedicated to residency education, supported by the recommendations of a national expert panel, and by published evidence of the devastating impact of the ACGME decision of June 2019 which cut dedicated time for education for family medicine residency faculty by two thirds. Importantly, the requested changes represent only a partial return to the situation before June 2019. We have published in the peer reviewed literature both the survey of program directors conducted by the Association of Family Medicine Residency Directors describing the impact of the 2019 cuts and the case for dedicated educational time. These papers are attached.

Second, we request transparency about the role, structure and function of the COR. Basic information about the COR role and membership is not available on the ACGME website. It appears to outside observers that the COR peer reviewers have been allowed to thwart the will of the specialty. Yet their expertise in primary care residency education and their rationale for rejecting the strategy of the specialty remain unknown.

We understand from Dr. Nasca that there is not a formal appeal process within the ACGME structure. Therefore, we are appealing for reconsideration directly to the Board of Directors as the responsible governing body of the ACGME. We believe the specialty of family medicine should have a major voice in the future of residency education in family medicine. We would welcome the opportunity to discuss the options we see with representatives of the ACGME Board.

We feel compelled to add a broader concern, illustrated by the COR decision, that the overall ACGME accreditation process is not working specifically for family medicine or for primary care overall. As recommended by the recent National Academies report on Implementing High Quality Primary Care, reinvestment in primary care is critical for the health of the country, and a key part is re-envisioning primary care residency training. One size does not fit all. We believe that family medicine has done its part to develop an ambitious plan for transformation of residency education in family medicine—and now all of the family medicine organizations have plans underway to support the major changes in residency education. We ask that the ACGME to do its part.

We look forward to your response.

Sincerely yours,

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
President, Academy of Family Physicians

Kim Stutzman, MD, FAAFP
President, Association of Family Medicine Residency Directors

Lauren Hughes, MD, MPH, MSc, MHCDS, FAAFP
Board Chair, American Board of Family Medicine

Linda Myerholtz, PhD
President, Society of Teachers of Family Medicine

Bruce Williams, DO, FACOFP
President, American College of Osteopathic Family Physicians

Diane Harper, MD, MPH, MS
President, North American Primary Care Research Group

John Franko, MD
President, Association of Departments of Family Medicine

WN:cs

- Back to 2019 rules
- Now: **use it**!
- Key issues: core faculty, defining work week and year, and what time is necessary
- Perfect is the enemy of the good

Competency Based Board Eligibility: ABFM Strategy for Implementation

- In June, we will ask program directors to attest that each resident has completed residency **and** that they are competent in the five specific outcomes required for 2024. This are necessary for ABFM Board Eligibility.
- CCCs need to be involved!
- Build over 3 years; by 2027, PDs will attest to competence in all core outcomes.

Competency Based Board Eligibility Requirements for 2024

- Practice as *personal physicians*, providing first contact, comprehensive and continuity care, to include excellent doctor-patient relationships, excellent preventive care , care of chronic disease and effective practice management.
- Diagnose and manage acute illness and injury for people of all ages in the emergency room or *hospital.*
- Provide comprehensive care of children, including *diagnosis and management of the acutely ill child* and routine preventive care.
- Develop *effective communication and constructive relationships* with patients, clinical teams, and consultants
- Model *Professionalism* and be trustworthy for patients, peers, and communities.

How to make decisions of competency?

- Similar to what is done now: judgement of PD and CCC
- Gold standard: would you be comfortable with this resident taking care of a member of your family?

What will it look like in June?

American Board of Family Medicine

Organization Name Here

jphysician | ACGMEID: 1234567890

Logout

Resident Training Management System

Resident | Reports | Program Information | In-Training Exam | ABFM Certification Examination | Graduate Survey | Policies/Resources | Program Administration

RTM > Main Menu > Certification > Residency Completion Verification

Residency Program Organization Name Here — All Programs

Residency Program Completion Verification

The ABFM requires that Program Directors and their Clinical Competency Committee verify that residents have satisfactorily completed the ACGME requirements for 36 months of family medicine residency training and are ready for autonomous practice. Verification may be submitted as early as 15 days prior to the resident's "Training Completion Date" or any time after by checking the box for each resident for each of the five (5) CBME columns. Any resident who is not expected to complete training by the training completion date listed should be left unchecked and an explanation from the Program Director should be entered in the "Reason for NOT Verifying" box. Verifications should be submitted promptly to ensure that residents who took the examination will meet the requirements for certification.

ABFM ID	Last Name	First Name	Date of Birth	Training Year	Training Completion Date	Communication and Relationships[1]	Excellence as Personal Physician[2]	Manage Acute Illness[3]	Care of Children[4]	Professionalism[5]	Reason for NOT Verifying Limited to 7,000 characters
999901	Wayne	Bruce	MM/DD/YYYY	PGY-3	MM/DD/YYYY	☐	☐	☐	☐	☐	
999902	Kent	Clark	MM/DD/YYYY	PGY-3	MM/DD/YYYY	☐	☐	☐	☐	☐	
999903	Grayson	Richard	MM/DD/YYYY	PGY-3	MM/DD/YYYY	☐	☐	☐	☐	☐	
999904	Prince	Diana	MM/DD/YYYY	PGY-3	MM/DD/YYYY	☐	☐	☐	☐	☐	
999905	Romanof	Natasha	MM/DD/YYYY	PGY-3	MM/DD/YYYY	☐	☐	☐	☐	☐	
999906	Lance	Dinah	MM/DD/YYYY	PGY-3	MM/DD/YYYY	☐	☐	☐	☐	☐	
999907	Queen	Oliver	MM/DD/YYYY	PGY-3	MM/DD/YYYY	☐	☐	☐	☐	☐	
999908	Allen	Barry	MM/DD/YYYY	PGY-3	MM/DD/YYYY	☐	☐	☐	☐	☐	
999909	Bertinelli	Helena	MM/DD/YYYY	PGY-3	MM/DD/YYYY	☐	☐	☐	☐	☐	
999910	Jordan	Hal	MM/DD/YYYY	PGY-3	MM/DD/YYYY	☐	☐	☐	☐	☐	

[1] Develop effective communication and constructive relationships with patients, clinical items, and consultants

[2] Practice as personal physicians, providing first contact, comprehensive and continuity care, to include excellent doctor-patient relationships, excellent care of chronic disease, routine preventive care and effective practice management

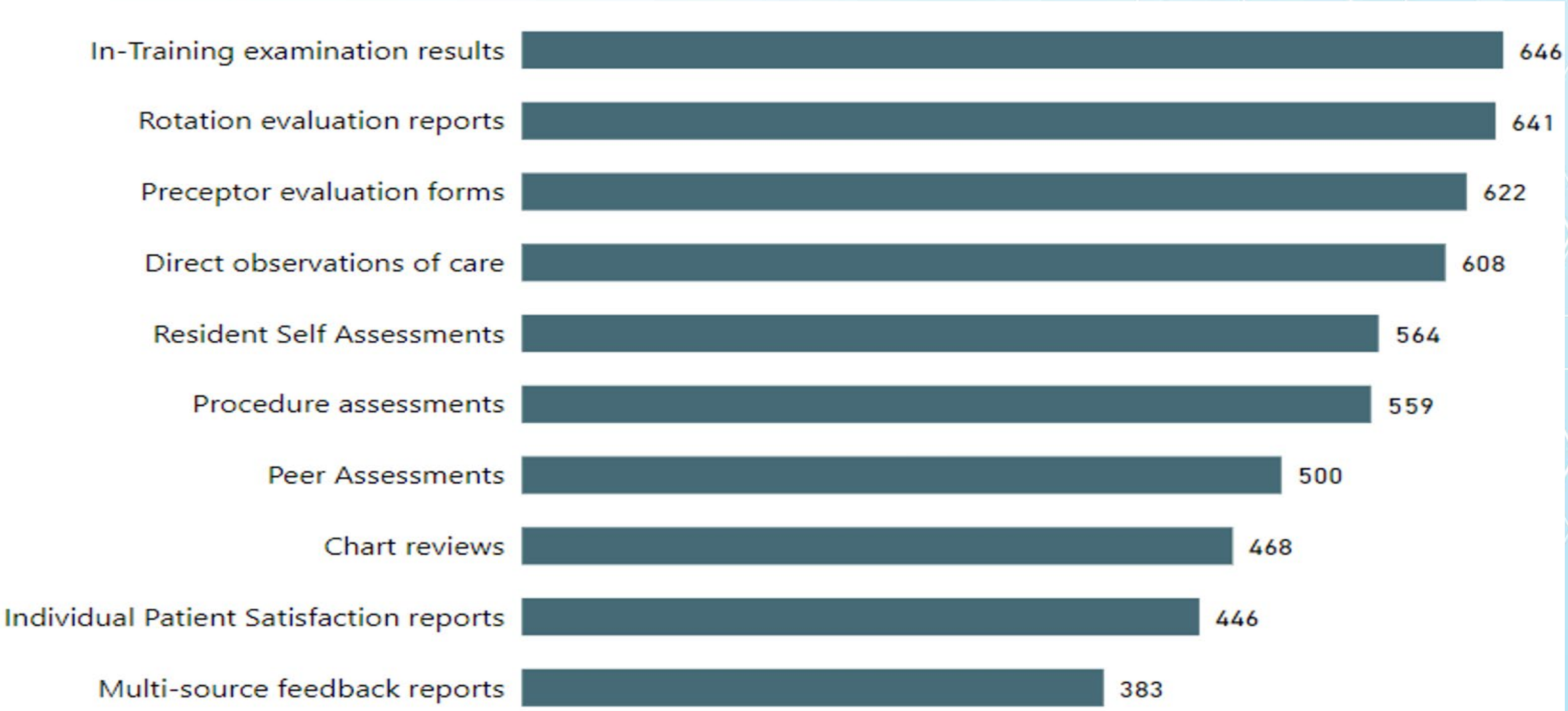
Why is competency important?

- What do patients and employers say?
- Duration and counts not sufficient…
- *Confidence* is also critical

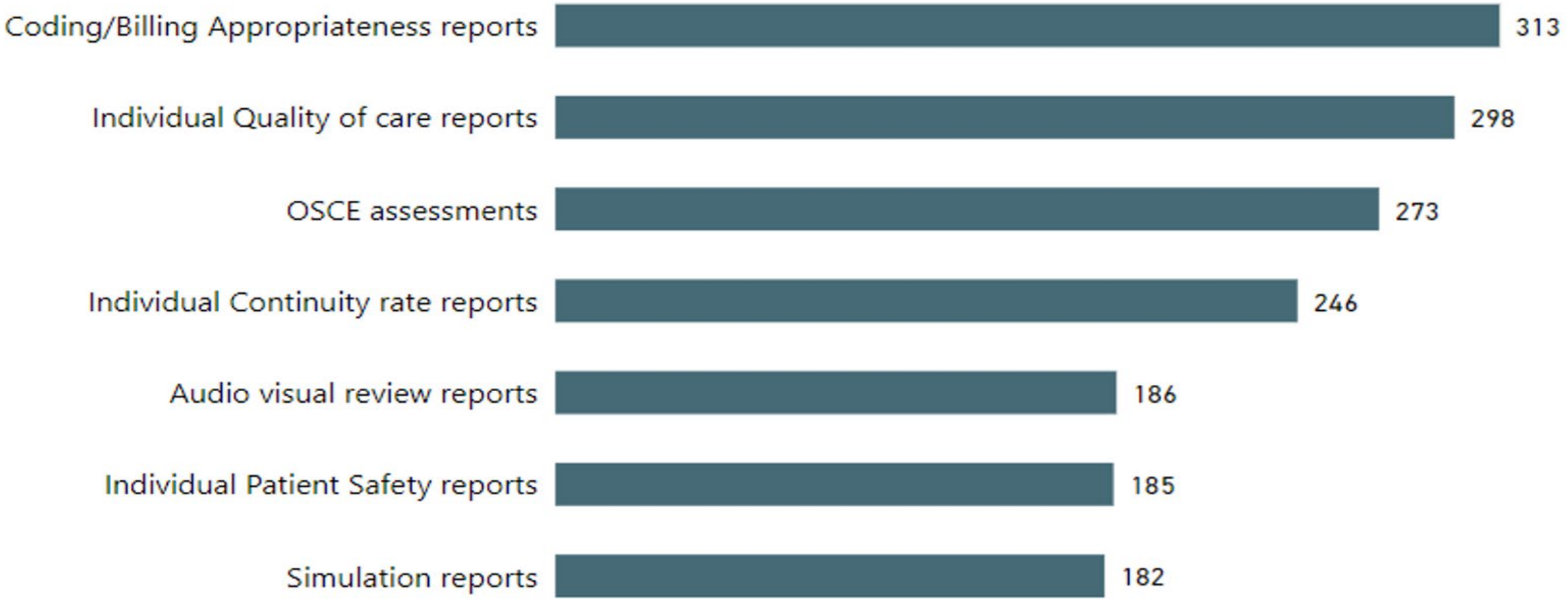
What happens if a resident is *not* competent in a specific outcome at end of year 3?

- Similar to now: a rare event
- Prevention is key: Set *expectations of core outcomes from the beginning*, use an *assessment system* to identify gaps, use *individual learning plans* and *electives* to address gaps proactively
- CCC work must include reviewing number and sampling of assessments, suggest additions
- In some cases, residents will need additional time…

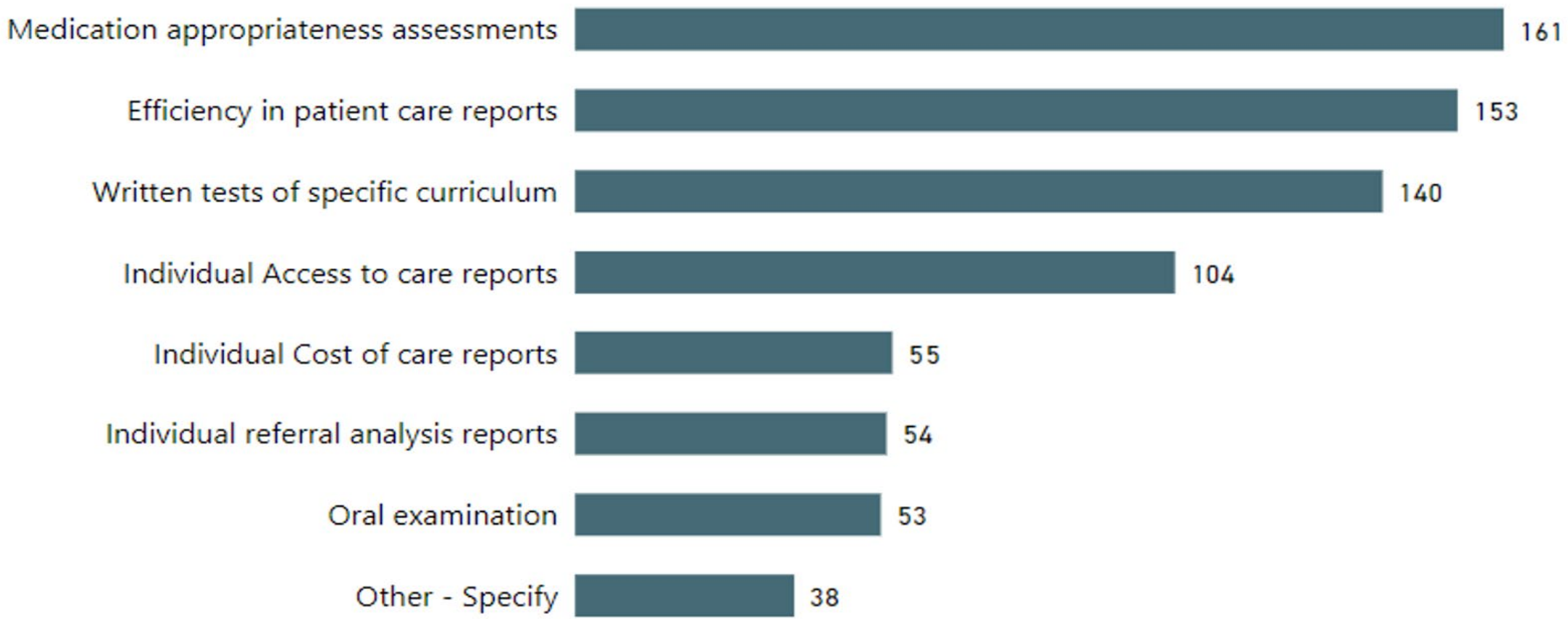
What assessments are residencies using? Attestation Survey: >50% residencies use (Total=655 Residencies)



What assessments are residencies using?
Attestation Survey: 25-50% residencies…
(Total = 655 residencies)



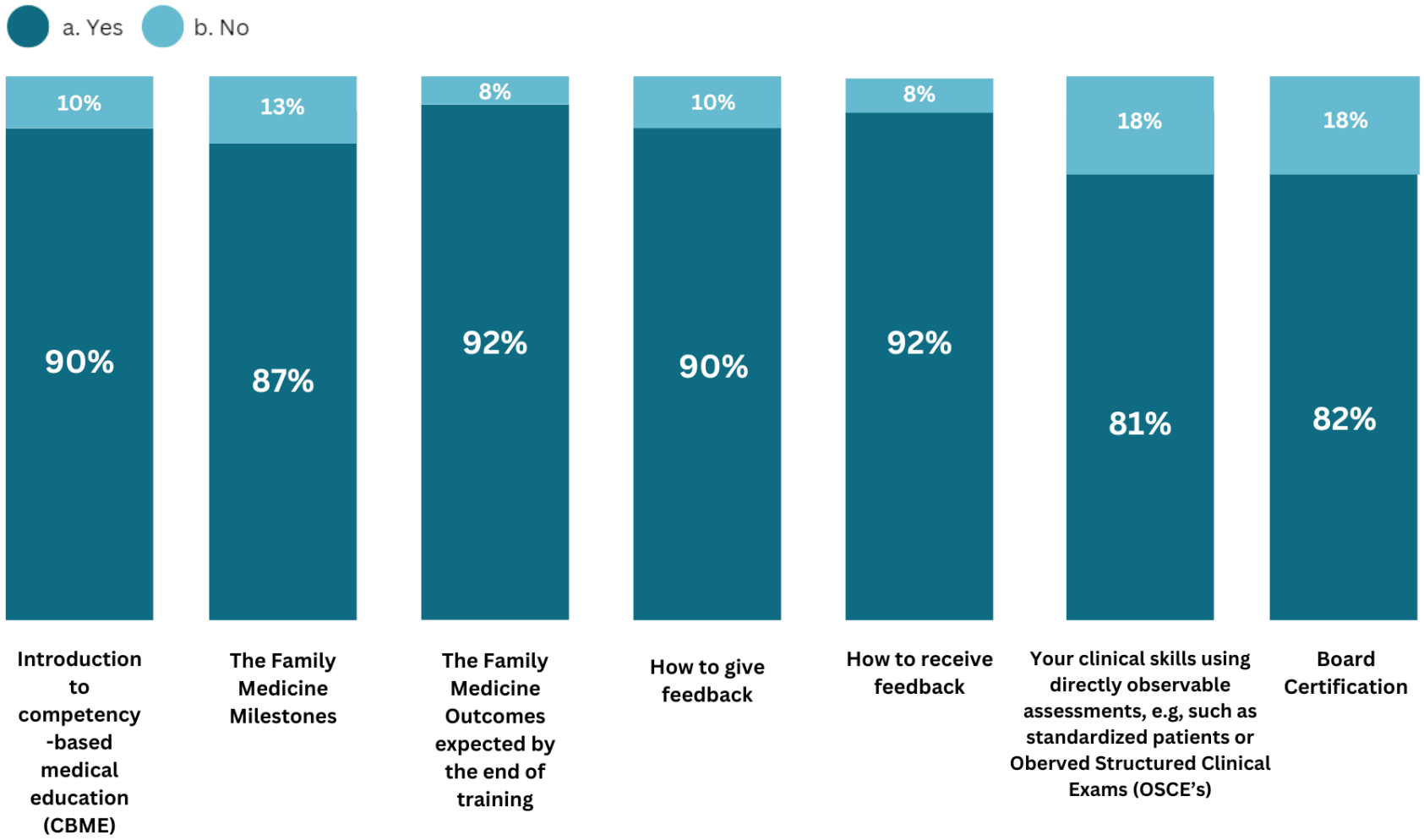
What assessments are residencies using?
Attestation Survey: <25%
(Total=655 residencies)



National Resident Survey 2023: Resident Experience of CBME Orientation

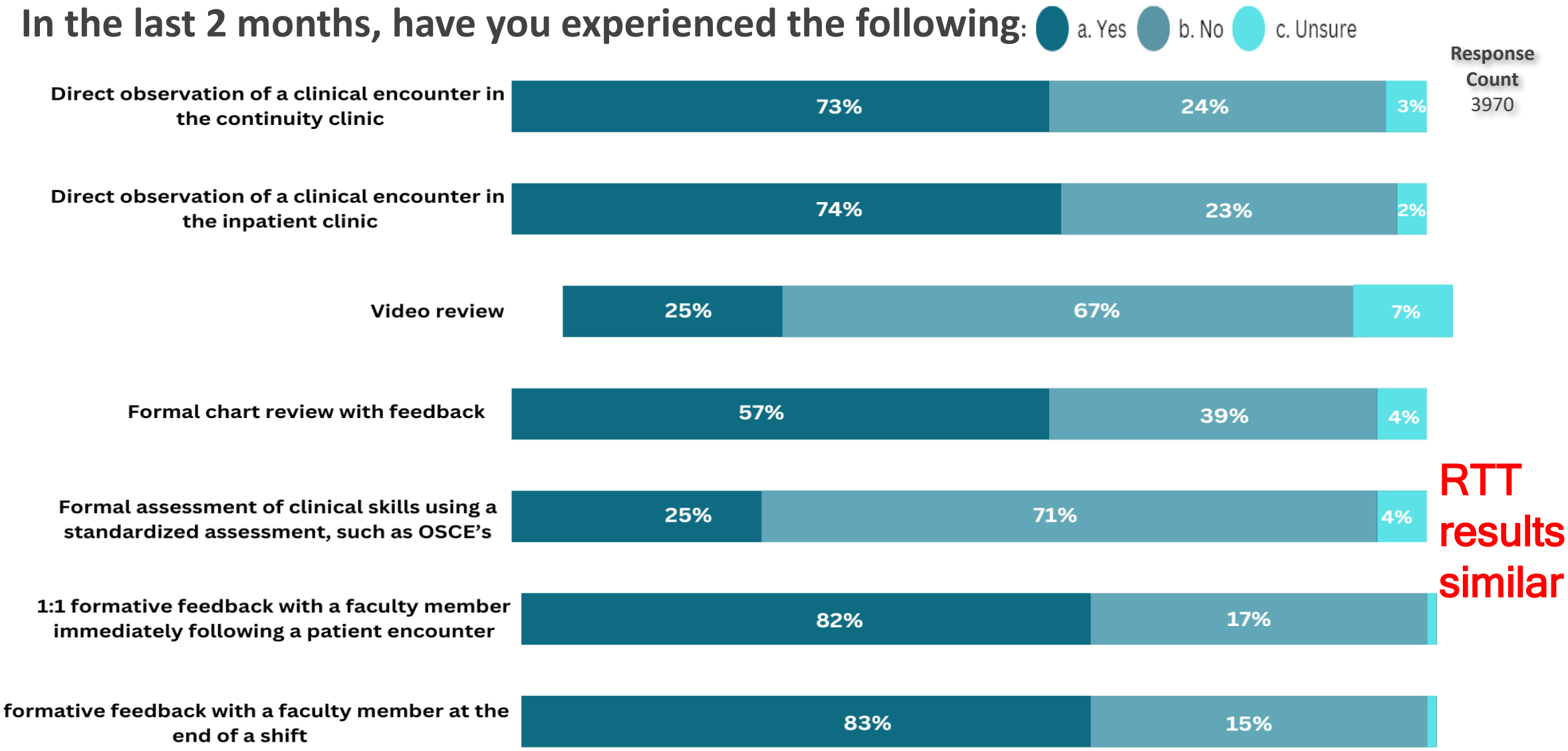
During your first 3 months of residency, did you receive instruction or assessment in (yes/no to each)

Response Count 2114



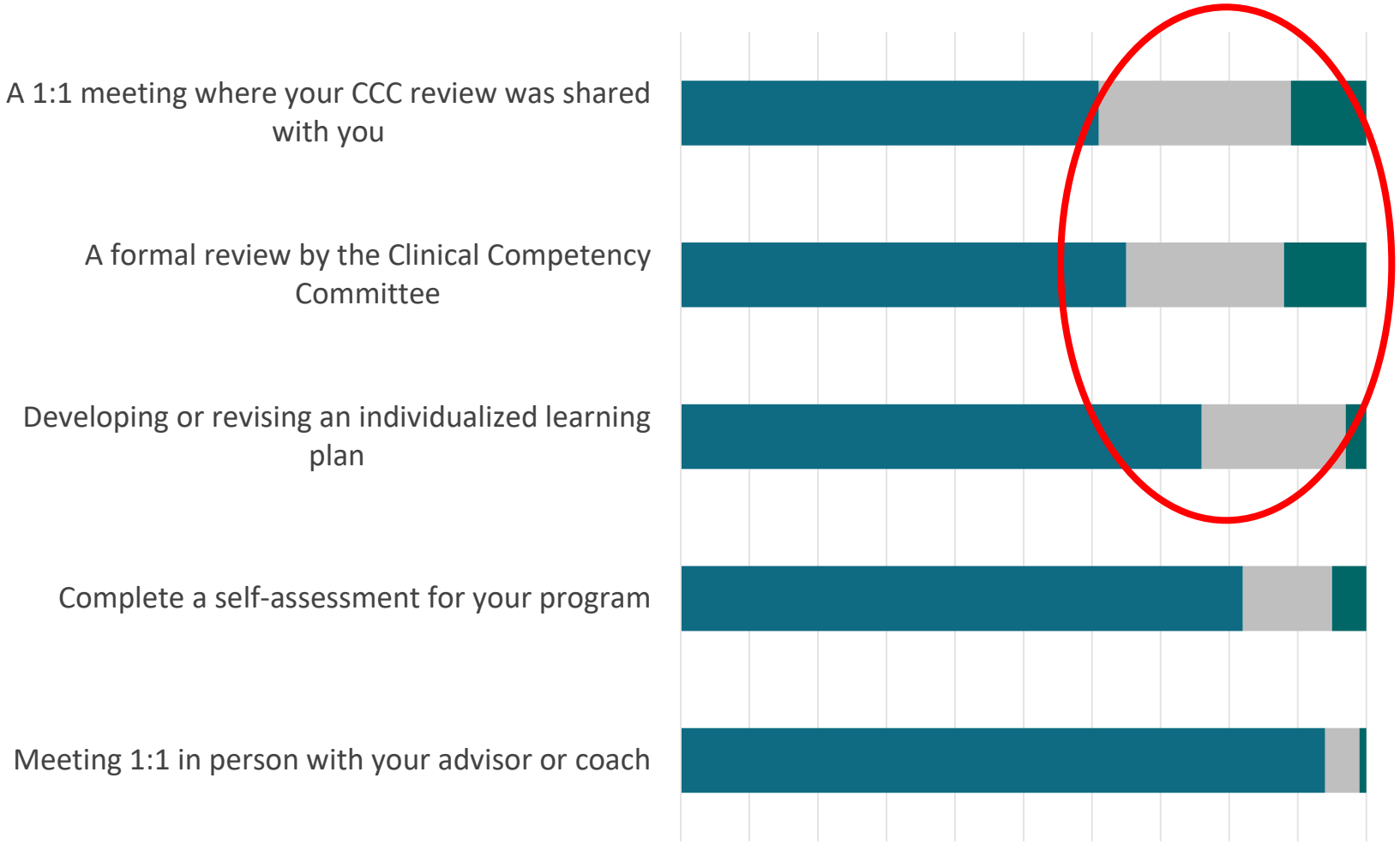
RTT results similar

National Resident Survey: Experience of Assessments



RTT results similar

National Resident Survey
In the last 6 months, have you experienced :



- 60-65% of PGY2-3 report CCC reviews in last 6 months
- 76% of PGY2-3 report having ILP
- RTT results similar

Good News: Faculty Development

- STFM—CBME Task Force
  - Webinars every month x 10 (Webinar Series)
  - Principles for Implementation submitted for publication
  - Website: https://stfm.org/cbmetoolkit
  - List of assessments coming, leading effort to get app integrated in New Innovation and Med Ed Hub
- Both STFM/AFMRD have committed to having their annual meetings have major focus on CBME for 3 years
- More to follow!

Engaging Residents

How do we engage residents in their own education?

Individual Learning Plans from day 1

How to support a "growth" mindset

Focus on Core Outcomes from day 1, at transition of years and every CCC

Requirements for 2025

- Practice as personal physicians, to include care of women, the elderly, and patients at the *end 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.

How should these core outcomes be assessed?

ABFM does not mandate specific assessments, but we will publish initial recommendations in June.

Increasing the focus on "the clinic is the curriculum"

- Our expectation is that residencies should thrive as *practices*, supporting *readiness for practice* and *imprinting* important behaviors
- 1000 hours continuity=scheduled time, in person or video, **not** routine charting; 40 weeks of continuity/year
- 2024 standards started where we are—quality doctor patient relationships, quality of care, practice management/efficiency
- 2025: Empanelment, Continuity, Referral Appropriateness

Empanelment: why and what?

Allows measurement of continuity, access, and effectiveness

Portal to teaching population health and role of teams

For practicing physicians, self reported panel size has dropped from 2386 to 1786 over last decade. (ABFM data)

MP3: 1600-1800/FTE across 10 large health systems

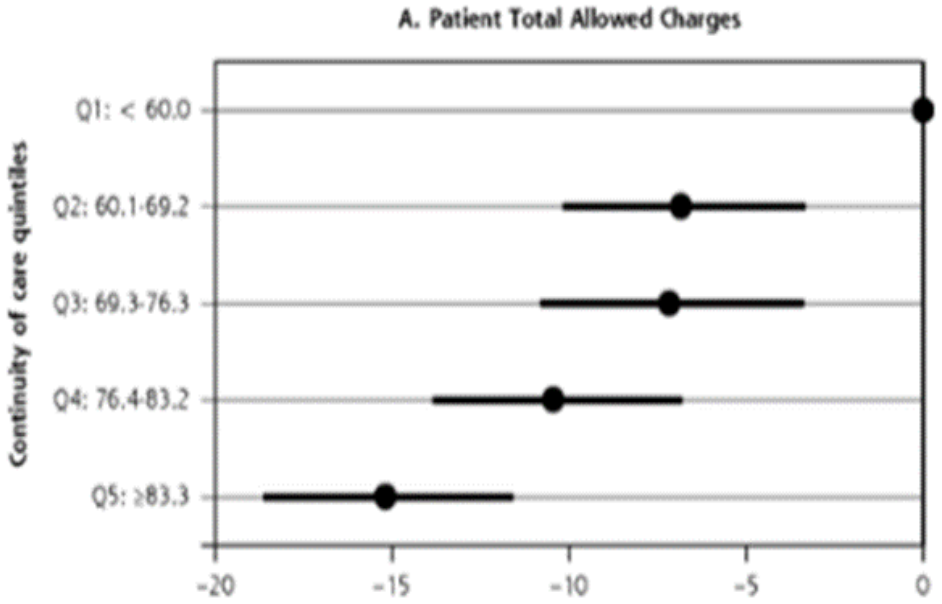
Requires active patients (e.g. 2 visits in 18 months) and recalculation regularly

What is right panel size for each year? Depends on patients and half days, but perhaps:

- PGY 1=200
- PGY 2=400
- PGY 3=800

Continuity of Care

- Emphasize patient centered approach, but physician centered also valuable
- Measure both physician and team continuity
- Flavors:
  - ACGME measure (Both patient and resident centered)
  - Usual provider continuity (UPC)
  - Bice Boxerman (uses CPT codes)

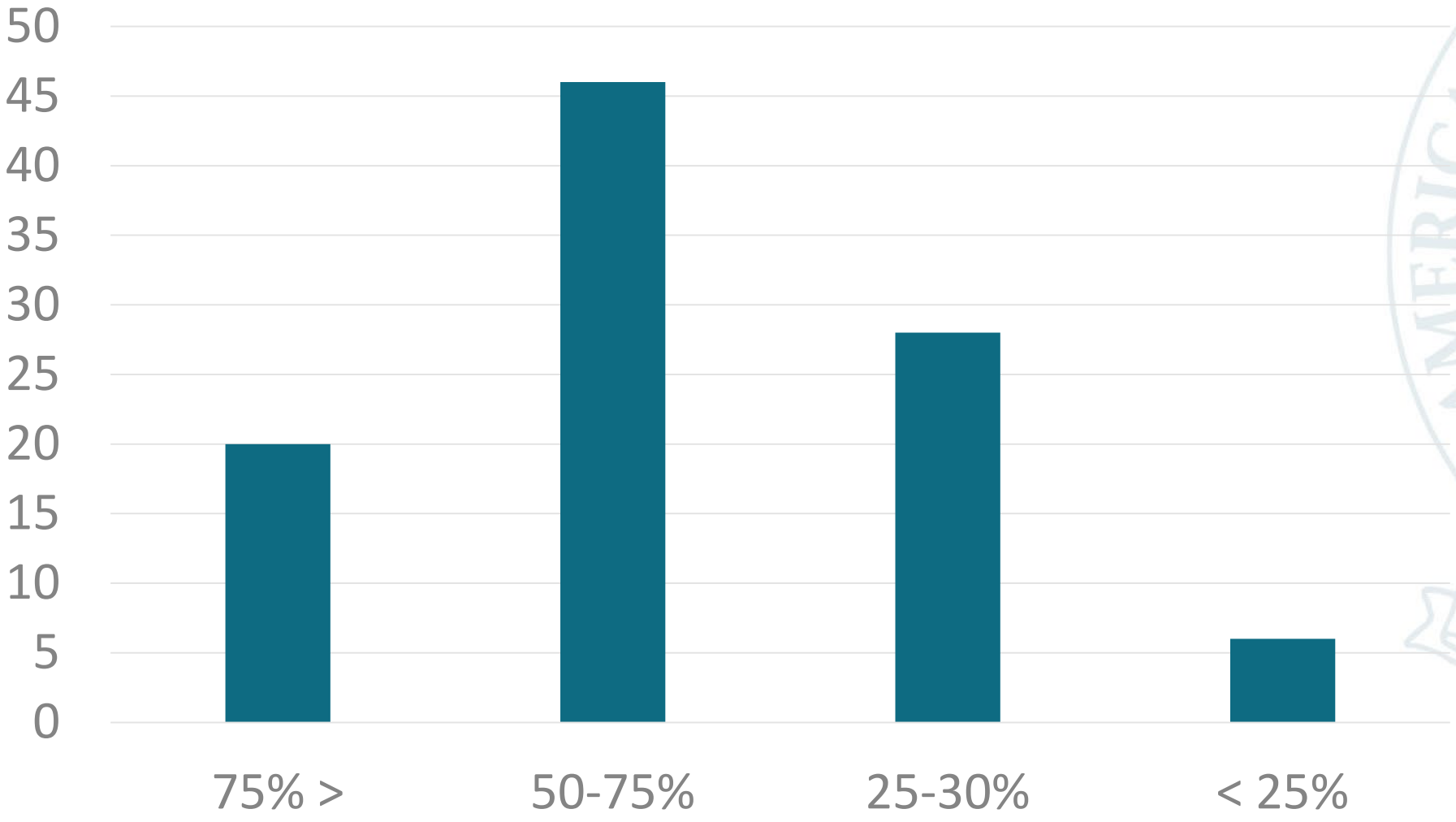


Every .1 increase in continuity decreases costs of care and hospitalizations, with both personal physician and team effects.

(Zhou Y et al. Health Serv Res. 2022;57:914–929.)

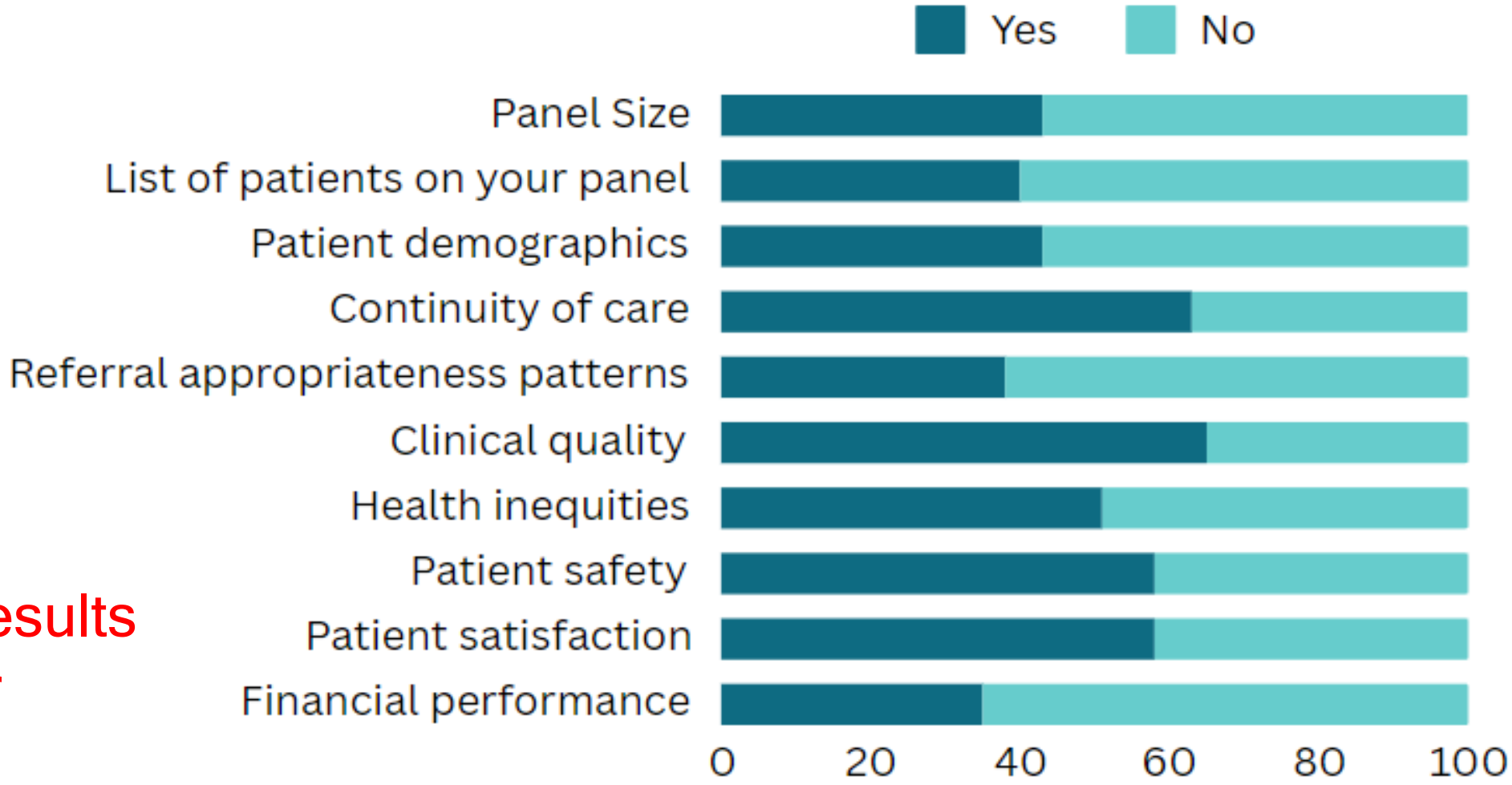
National Resident Survey:

In typical half day of clinic, what percentage of patients you see are assigned to your patient panel?



RTT Results Similar

National Resident Survey:
In the last 6 months, have you received either written or oral feedback or reporting on the following:



RTT results similar

Rates of Appropriate Referral

From Starfield Summit Surveys (2020):

Residents: N=597: referrals to physicians almost never (45%), occasionally (15)% vs usually (16)% reviewed with preceptor; Faculty: N=834: 70% say residents do not get feedback on rate or appropriateness of referral

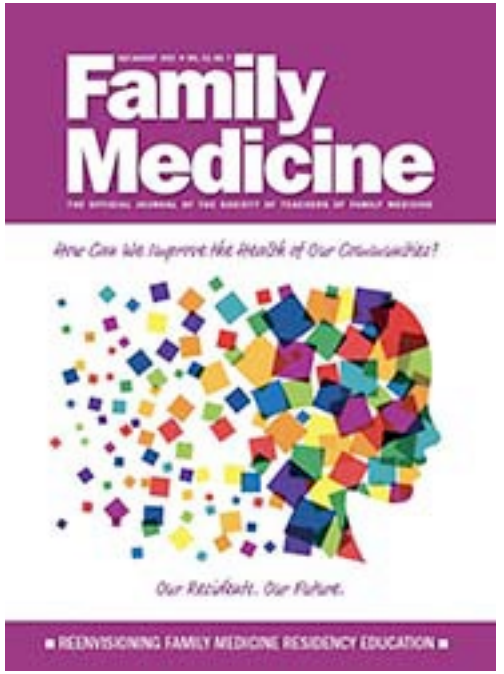
Community Dialogue — RE-ENVISIONING FAMILY MEDICINE RESIDENCY EDUCATION (starfieldsummit.com)

4 fold variation of referral rate across Family Medicine residencies controlling for age, race and payors

Gwynne M, Page C, Reid A, Donahue K, Newton W. What's the Right Referral Rate? Specialty Referral Patterns and Curricula Across I3 Collaborative Primary Care Residencies. Fam Med. 2017 Feb;49(2):91-96. PMID: 28218933.

Your special role…

- You lead at critical time in our specialty and in our country's health care system
- What you do will determine the long-term future of the specialty—and health care
- ABFM promises to journal with you
- We trust you—and we are grateful!



Questions, Comments?

Whither Rural Residency Education?

? What volumes, what procedures?

? Block or longitudinal curricula?

? What assessments?

? What community experiences? How address disparities?

? How to use flexibility--for residencies, for residents?

Consider using ABFM activities as educational tools

- KSA's addressing disease or scope of practice
- National Journal Club—100 articles per year, curated, no limit
- Continuous Knowledge Self Assessment
- Performance Improvement
- All free…

Residency Learning Networks: Start where you are…

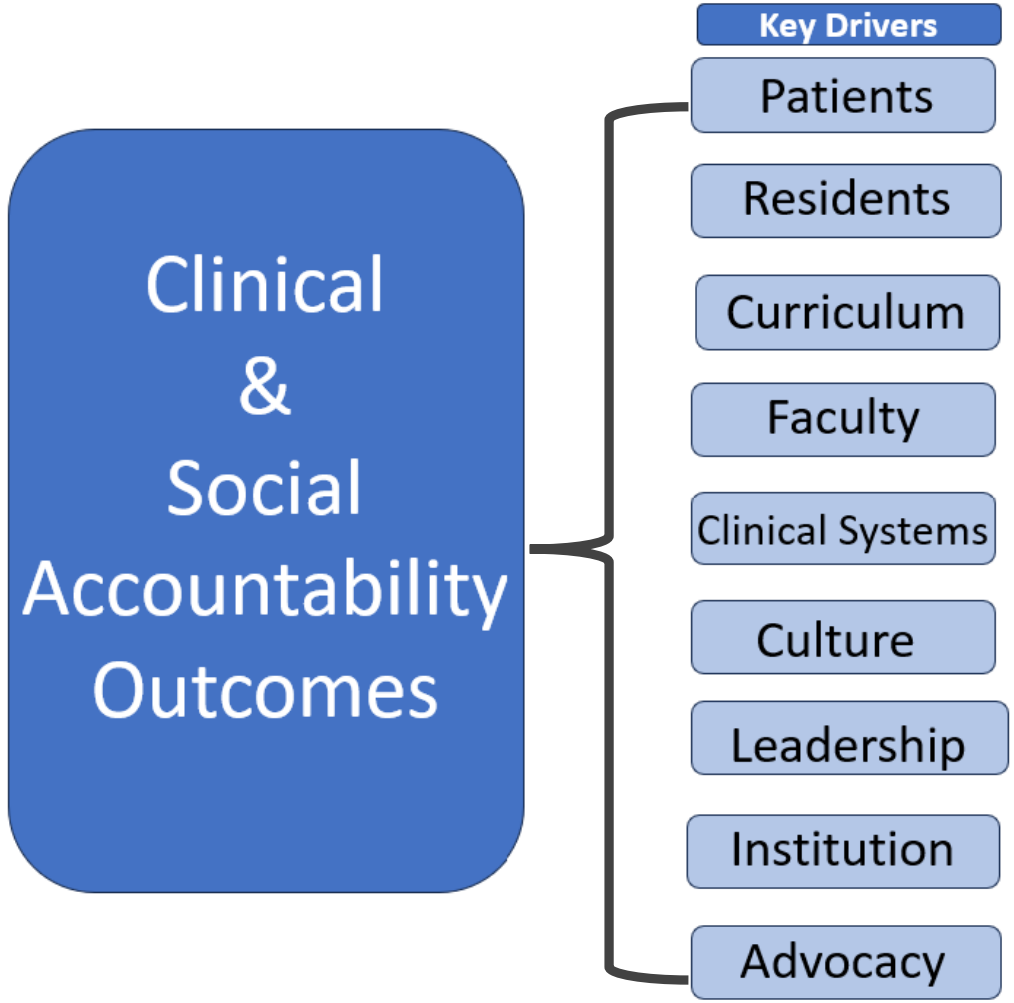
- Evidence Based (I^3, P4, Length of Training)
- Contributor to *innovation* and *wellbeing*
- No single recipe: *both* practice transformation and CBME
- Variety of sponsors—state chapters, large departments, other organizations…
- Learning how to learn from each other

- Goal: all 770+ residencies in *some type* of network
- ABFM Foundation: 43 planning grants have been given out; RFPs for $75K seed funding; 21 under review

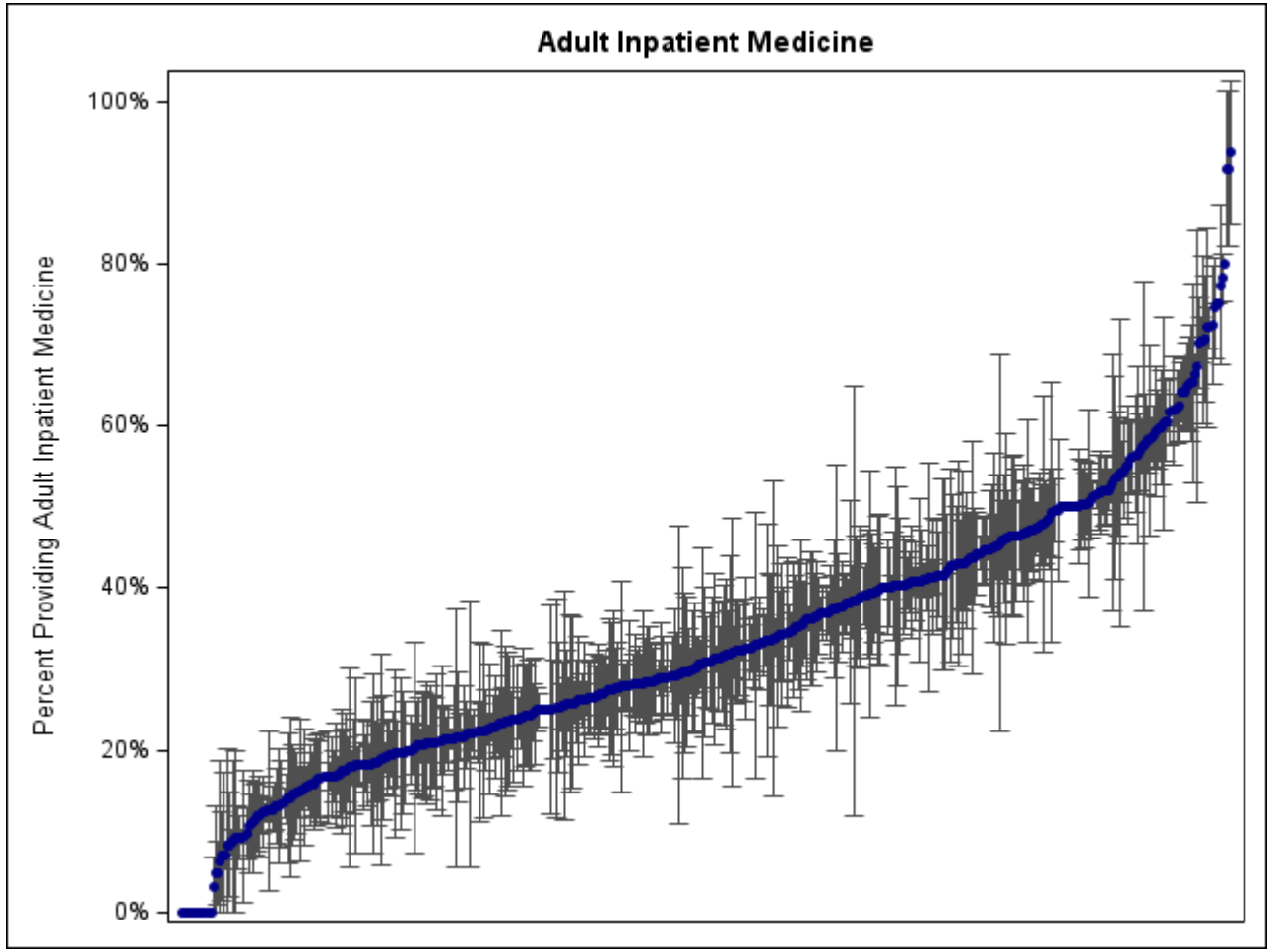
Email jfetter@theabfm.org if interested

Strengthening Outcomes and Assessment (SOAR) Using Outcomes to Learn From Each Other

- Using Graduate Survey (>2500 residents) to identify exemplars
- 2023 Examples:
  - Care of Children
  - Behavioral Health
  - Inpatient Care
  - POCUS
- Contact Jay Fetter at jfetter@theabfm.org if you want to join this community of practice.



Distribution of GME Outcomes by Residency



FM-AIRE

FAMILY MEDICINE - ADVANCING INNOVATION IN RESIDENCY EDUCATION

To prepare the best possible personal physicians for service to patients and communities… over their lifetime, wherever they go

FM-AIRE
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Current Status

- AIRE quid pro quo: freedom from ACGME rules in return for additional competencies, data submission, participation in annual collaborative meeting
- Infrastructure in place—smoother application process, ACGME RC/ABFM committees, annual meeting launched.
- 8 approved (+6 in 12 months), about 150 residencies have contacted us, focus next 12-18 months is recruitment
- 16.1% of current interns applied for four year residencies (1.2% of slots)

Questions, Comments?