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TO: ADFM Board of Directors
ADFM Members

FROM: Warren P. Newton, MD, MPH
President and CEO
American Board of Family Medicine

RE: An Update from ABFM

DATE: February 9, 2025

Colleagues, I look forward to seeing you in Nashville. Times are tumultuous and troubling and, for me, connection will bring support and direction.

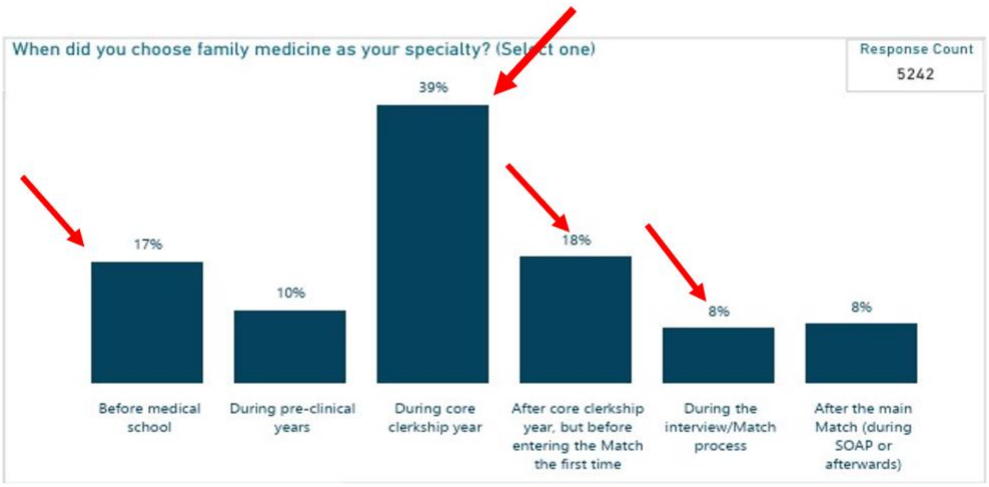
I will be meeting with the LEADS fellows and the ADFM Board on Tuesday and presenting some of the ADFM data on Thursday to the wider group: I will also be in task force meetings and the halls…

With respect to my formal meeting with the ADFM BOD, I have had a chance to communicate with Amanda and Jehni about an agends:-- the pathway to family medicine residency, the status of residency redesign and an update on our learning health system collaborative. What follows sets up these issues as well as my data presentation to the larger group, then provides updates of particular interest to ADFM and then more general information about ABFM doings. This is a once a year update, so I've gone into more detail than usual—forgive the length! As always, please feel free to ask me any questions on anything in this written report at any time during the meeting.

Agenda for ABFM/ADFM BOD discussion

1. **The Pathway to Family Medicine**--The initial results of the National Resident Survey are in. We have not completed analysis yet—just received the data 2 weeks ago—but response rate is 94% (!) For this topic, of particular interest, is the following data from over 5200 current family medicine interns, which I look forward to talking with you about. The question is: what are the best interventions currently from your departments, at which level of learners, to attract people into family medicine?

The Pathway to Family Medicine



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2. **The Status of Residency Redesign.** I will present some more detailed data on what the experience has been Thursday AM, but on Tuesday I'd like to focus on the core outcomes scheduled for 2025. See the following slide for context, and the attached advanced copy of the recommended procedures for ABFM Board Eligibility. As you appreciate, there has been great passion about what are the required procedures should be—but these are only modestly changed since our discussions last spring.

ABFM Competency Based Board Eligibility Requirements for June 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 soon.

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3. **The MP3 Collaborative**—approximately 18 months, the ABFM launched the Making Care Primary for Population Health (MP3) learning systems collaborative. The first 3 meeting cycle has included 10 health systems with 7000 FPs/12000 primary care clinicians and primary care service lines led by FPs. They chose to focus on access measures and benchmarks, team structure and panel size and continuity. As a separate issue, they've looked at how primary care is organized in their systems. With the Board, I'll briefly summarize the methodology and some of the initial results and will be glad to discuss with any of you. I look forward to your reactions and input on the question of growth of MP3? . How do we spread FM leadership of health systems.

4. **ABFM data review**—I haven't finalized my slides yet before sending this, but I'll include the ITE results, data on CBME and Competency Based Board Eligibility outcomes in 2024 and what to expect in 2025—and perhaps one or two others. I'll build in time for discussion.

Issues of Possible Interest to ADFM

1. ADFM and NAPCRG are co-leaders of the **specialty wide plan to build research capacity**. This is scheduled to be a major component of the Family Medicine Leadership Council the week before we meet. Of course, there is huge tumult now with the new administration, and it will be a while before the dust settles, but I would encourage to keep our eyes on the long term issues: The future of our specialty over the long term depends on the right kind of research, and our ability to lead that research. The plan calls for more than advocacy—for work in pathways and mentorship. There is much to do and the Departments are uniquely placed to make a difference. How can we promote a culture of curiosity that attracts those students interested in research with humans (!) into family medicine. And: how can we develop a pipeline of mentorship for residents and faculty interested in research. Likely this will be across departments or regional consortions. Ideas welcome.

2. The ABFM Foundation will be announcing a **modest RFP for research on POCUS patient outcomes in continuity care settings.** This comes out of the FMLCs discussion of developing a more organized approach to the implementation of POCUS in teaching and practice in our specialty. The Foundation has also funded STFM to lead a formal consensus development process across the specialty about education and practice organization for POCUS. What is striking for ABFM is that, despite huge enthusiasm for POCUS in residencies and departments, virtually all of the research on POCUS in patient care has been done in EDs and hospitals—and by Emergency Physicians and Internists.—and virtually none on the patient outcomes in the continuity setting. I welcome discussion and input during the meeting.

3. **Health Administration Leadership and Management (HALM)**—The initial exams have been completed—and were hard, with only 75% passing. Family Physicians were among the most common applicants. I appreciate the ADFM study group—and look forward to feedback about the test. Now the administrative Board (EM) moves on to develop the continuing certification process. David Price is the ABFM lead in developing the portfolio. Please give me your ideas about what the continuing certification process should include!

4. **Professionalism**—ABFM has doubled down on professionalism in its new strategic plan, with research on the right language (concerned that some residents and younger Diplomates believe the term has been weaponized), support of professionalism as a competency (with optional modules), a possible specialty wide "code of conduct" or compact and continued work in measures that matter and payment adjustment for social risk to support family physicians being professional. Led by Joe Gravel, STFM is developing a focus on professionalism as a part of its new strategic plan, and the AAFP is considering developing future components of their educational plan. We look forward to a dialogue with ADFM members about next steps in the development of a specialty wide strategy in this area.

5. **Has Family Medicine residency growth been too rapid?** Approximately 2 months ago, the AAFP leadership contacted me with a concern about the number of residencies closing. I've followed up with the RC leadership and with Karen Mitchell. Of course, the concern is not just numbers but quality and faculty development. After reviewing the data/data sources, we do not believe that the rate of closure is greater than usual. I have also observed the RC's rigor in reviewing (and rejecting) if necessary) possible new residencies. The reality is that the growth of residencies is extraordinarily rapid—similar to the 1970s! (a slide I will show you if possible). The data from residents and from the RC suggests that we are making good progress with many aspects of redesign, and the work in CBME and faculty development by the STFM, AFMRD and the AAFP is impressive. So: I'd love your perspective and we'll need to keep vigilant.

6. **Alternative Pathways to Medical Licensure.** The Commission on Alternative Pathways to Licensure, led by FSMB, Inthealth (formerly ECFMG) and the ACGME, will finalize its recommendations to state medical boards soon. I do not believe that it will be that much different from the draft recommendations published in the early fall after the public comment period. In the meantime, two additional states (Massachusetts and Maine) have passed similar laws. Importantly, this is a **purple issue** politically**.**

   The ABFM believes that this movement represents a major strategic risk for family medicine and primary care. Of course, IMGs—almost all of whom have done residency training in the US—are a critical part of the overall physician and the Family Medicine workforce. Practically, however, the horse is out of the barn, and the question is what we should do now. Our stance has been to emphasize comparable training, assessment beyond passing an exam, rigorous observation over time—along with evaluation of whether communities of need are actually being served. ABFM will be very cautious about an alternative type of Board Certification: we are very concerned about creating a "separate but equal" class of family physicians—as well as the potential exploitation of this new class of doctors.

   I believe that the critical driver of this movement is access, which is the worst it has been in my lifetime—and that the legislatures are responding with blunt policy. Before we are too judgemental, however, remember that it was the legislatures—not our profession—that first identified and began to respond to the opioid epidemic in the late 2000's.

   I encourage department chairs to engage in this issue in their hospitals and health system.

7. **ACGME leadership change—**the transition of Tom Nasca to Deb Weinstein at the leadership of the ACGME represents a major change in the medical ecosystem. It is my job to be worried, but I am concerned that we will need to protect the faculty teaching time issue—we are an outlier among specialties, a nailhead to be hammered. Also on the horizon are a major revision of the "Common Program Requirements", a reorganization of institutional review and the CLR review processes and…a possible return of duty hours, hastened by unionization. Hawks are recommending 48 hours, but the discussion is still mostly behind closed doors (!). I have met Dr. Weinstein once so far; she has been at MGH for most of her career and has been a national champion of both CBME and family leave. More to follow!

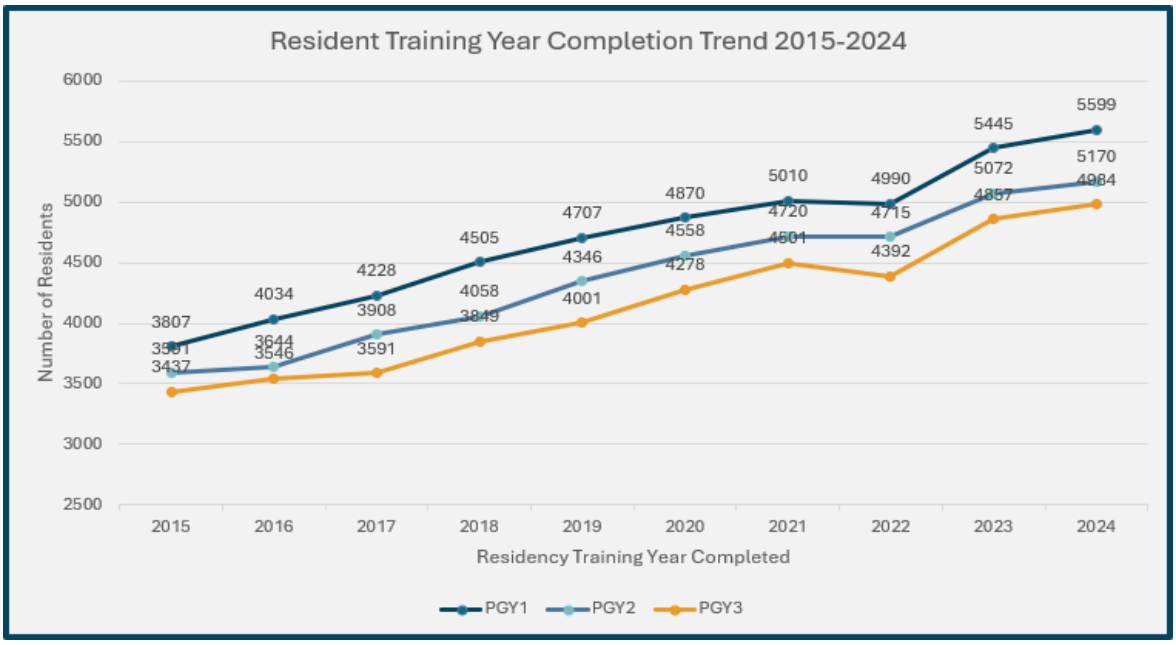
8. After a long deliberation, the ABMS will make a decision about the possible new **American Board of Cardiovascular Medicine in mid-February.** This is a fateful decision for all of medicine. The vote will be close; if turned down, they would have two years to revise. If they move forward, expect oncology and gastroenterology to move forward quickly, with rapid changes in residency requirements in internal medicine. Academic medical centers will change significantly.

9. Towards **a new model of family medicine**: Last summer, the FMLC expanded its summer retreat to begin to address a new model for family medicine—altogether, there were about 40 more people that usual; the program included a description of the changes of scope of practice, the key drivers of these changes and then a series of "bright spots". These are now pulled together in an evergreen website, kept by STFM:. Family Medicine Leadership Consortium You can see the topics and almost all the ppts. We are now working to develop the 2025 summer retreat. The focus will be the promises we will make to the American People—and then we will hope address the clinical/organizational controversies—what we will offer, when we will see people and where we will see them.

Other News from ABFM

1. The **ABFM 2025-29 Strategic Plan** has been approved and we will be communicating it our. Much of the work of the plan is carryover from the last plan, such as the new 5 year cycle, the new blueprint and a variety of research initiatives, but there are also major new initiatives in assessment of communication, performance improvement and professionalism. I believe that there are rich opportunities for collaboration between ABFM and ADFM. More to follow!

2. **Numerology**: As of 12/31/24, we had 107,625 Diplomates, a growth of 2.7% over last year at this time. What the numbers demonstrate is that the market continues to value ABFM Board certification. An important potential long term strength is the growth of residencies and residents. See below for graphic.



3. **<u>The new ABFM blueprint</u>** was implemented in the fall with the Intraining Examination. We believe that examinees will see no difference in the exam—there were essentially no comments—and we hope that the new blueprint with its additional focus on new domains (Emergent/Urgent Care, Acute Care, Chronic Disease, Prevention, and Foundations of Care) will provide additional opportunities to assess gaps and give feedback. The new test includes a component of risk of harm, with increased weighting for clinical problems with high risk of harm if there are errors in diagnosis or treatment. The basic publications describing the derivation of the new blueprint are in the publication process.

4. **<u>Performance Improvement</u>**: ABFM continues its support of Diplomates doing performance improvement. As of this writing, analyses of 2024 are pending but Diplomates completed over 35K projects, with an increasing number of "self guided projects"—eg "get credit for what you are already doing." The aggregate impact—for example, the number of patients for whom disparities have been reduced—is impressive. Going forward, we envision broadening the scope of the PI opportunities we offer to include educational and executive interventions, with all following the measure, intervene, measure strategy.

5. The **<u>Health Equity Report to Diplomates</u>** went out to all Diplomates on December 12th, highlighting various aspects and interviews. Over 70,000 people clicked on the opening letter within 24 hours. Going forward, we plan to report on our work in health equity report to the ABFM Board of Directors annually in August, and report results to Diplomates throughout the year in the Phoenix and other portals. I would welcome your feedback.

6. **<u>The Future of CME</u>**-- On December 5th, I was invited to give a brief talk on the future of CME and its alignment with the ABFM certification portfolio to the ACCME Board, along with other Boards. The CME industry has bounced back well from COVID—in terms of volume—but the majority of CME remains "butts in your seats"—passive. From ABFM's point of view,

we hope for evolution of pedagogy (of which there has been some movement) but more focus on communications, broadening performance improvement to include broader dimensions of work, the core outcomes of family medicine and components of professionalism such as teamwork and shared decision making. Of course, Family Medicine provides only a small part of the CME market (about 5%), but what do we want and where do we want to go? Continuing professional development will key to our future. I look forward to discussion with you about this. Not urgent but important. In a time of flux, change is possible.

Look forward to the chance to visit!

Warren