American Board *of* Family Medicine

How are we doing?

Implementing Core Outcomes and ABFM Competency Based Board Eligibility

Warren P. Newton, MD, MPH
President & CEO
American Board of Family Medicine

January 8, 2025

Objectives

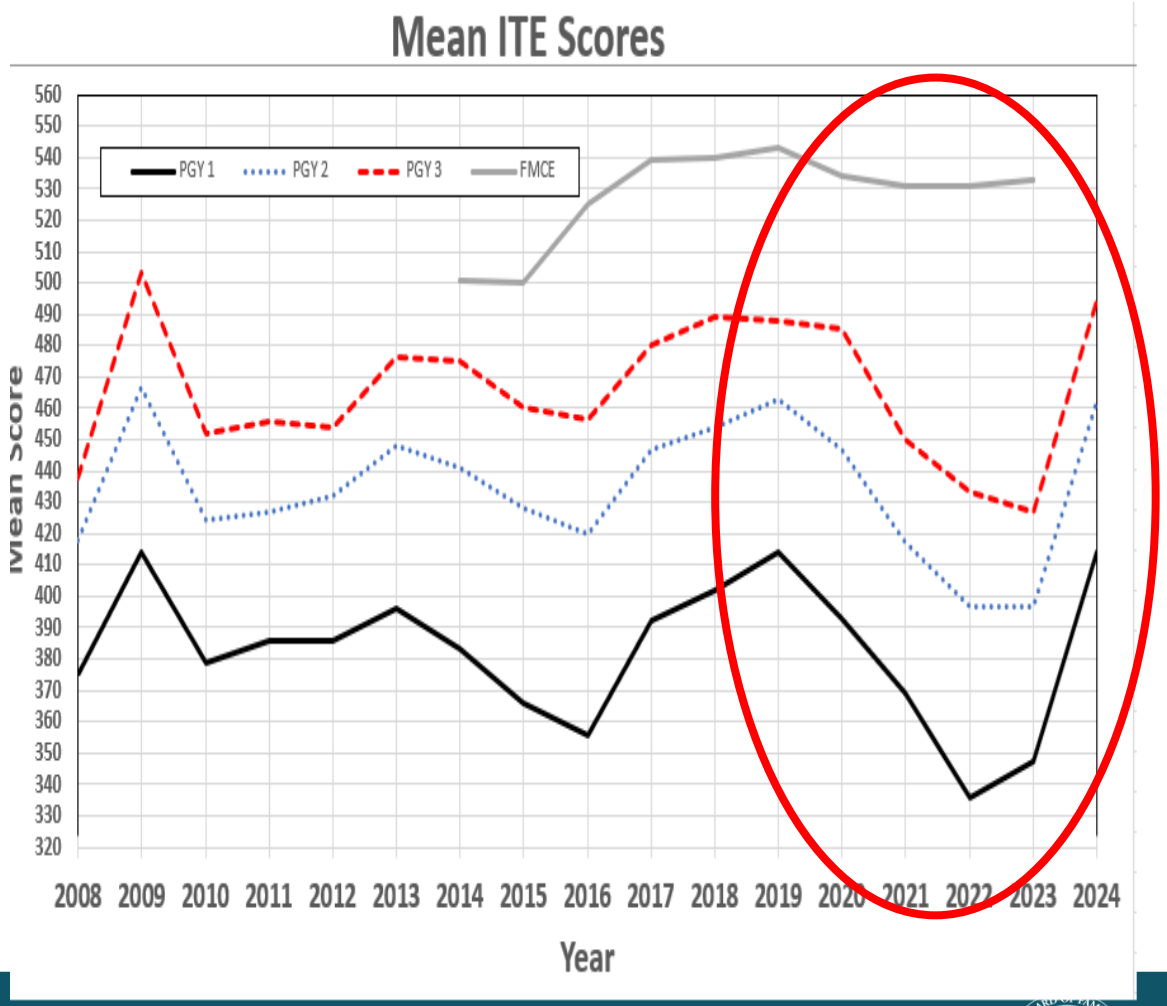
- Distinguish the different roles of the ACGME Family Medicine Review Committee and the ABFM
- Describe development of the Core Outcomes and ABFM Competency Based Board Eligibility
- Provide an update on residency redesign and 2024 core outcomes results
- Describe what to expect in the next six months and resources
- Answer questions, hear your thoughts!

Major Messages

- The ACGME Review Committee and the ABFM are different organizations with different goals. Residencies need to follow the ACGME rules for accreditation, residents need to follow the ABFM rules for certification.
- Family Medicine residency redesign is substantial, will take 5-7 years…and is making excellent progress.
- ABFM Competency Based Board Eligibility is going well, thanks to you. It will roll out over three years, and we are learning important lessons as a community…

Thank you!

Let us celebrate!



Represents >**15,000** residents taking ABFM Intraining examination

A lot of hard work by the entire community:

- Return to in person patients and feedback
- Setting expectations
- Renewing didactics
- Personal accountability
- Reading

Thank you!

Why Residency Redesign?

Clinical Review & Education

JAMA | Special Communication

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

Steven H. Woolf, MD, MPH; Heidi Schoomaker, MA(Ed)

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.

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

Editorial page 1963

Supplemental content

CME Quiz at jamanetwork.com/learning

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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.[1,2] Despite excessive spending on health care, vastly exceeding that of other countries,[11] 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.[4,12,13]

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,

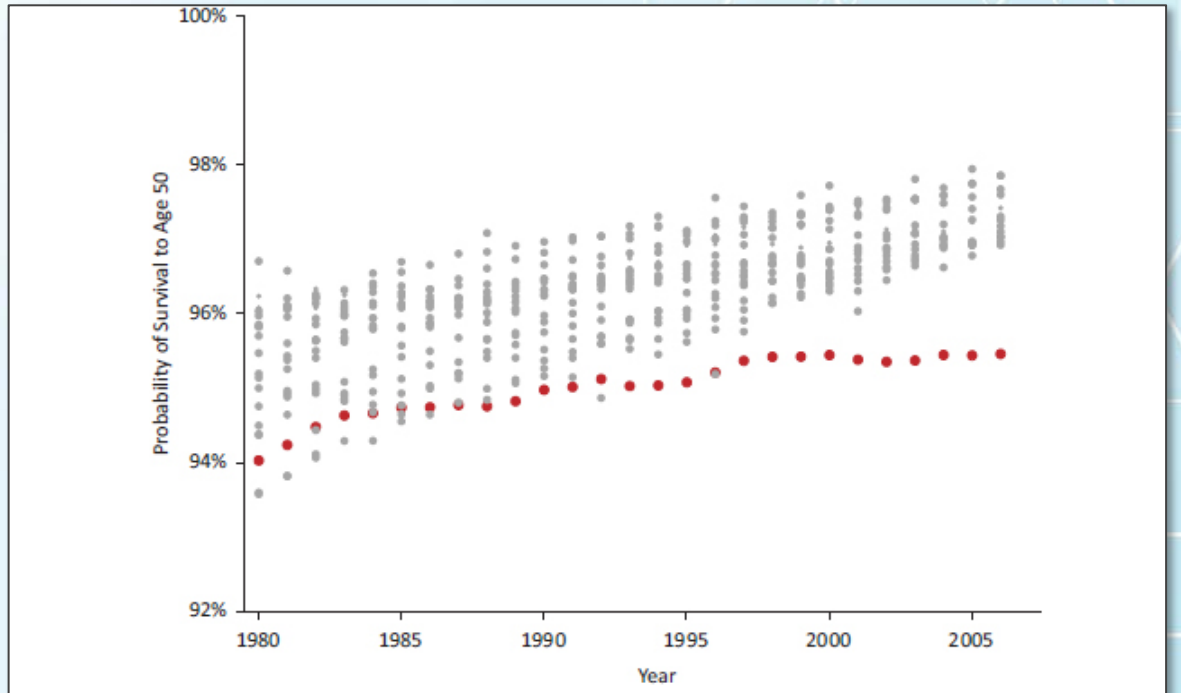
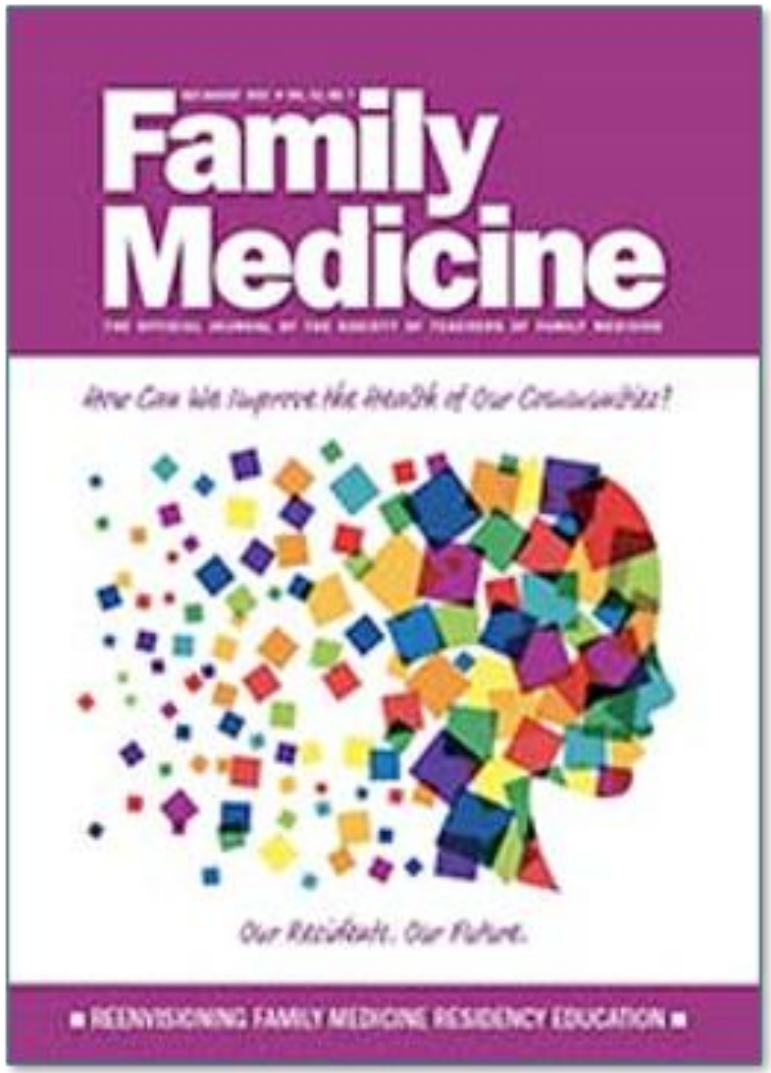


FIGURE 1-8 Probability of survival to age 50 for females in 21 high-income countries, 1980-2006.
NOTES: Red circles show the probability a newborn female in the United States will live to age 50. Grey circles show the probability of survival to age 50 in Australia, Austria, Belgium, Canada, Denmark,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

Family Medicine Residency Redesign



Key changes/innovations:

- Practice is the Curriculum
- Address Community Disparities
- Individual learning plans; flexibility for residents and residencies
- Competency Based Assessment
- Residency Learning Networks
- Dedicated educational time

Why is competence important?

- What do patients and employers want?
- Number of months/hours or counts visits (eg 1650) not sufficient…
- Consider this standard: would you want this resident taking care of a family member?

ACGME Family Medicine Review Committee and ABFM are different organizations with different roles

- **The Review Committee accredits residencies, ABFM certifies individuals.** They are Independent organizations that are interconnected
- Individuals cannot get ABFM certification without graduating from an ACGME accredited residency; hospitals can not receive Medicare funding without ACGME accreditation.
- Dr. Lou Edje is chair of RC and will speak for the RC; I will speak for ABFM. Both of us will be at the Residency Leadership Summit.

ACGME Major Revision of Residency Standards

As of 7/1/23…

Replacing duration with competence assessment for many areas

Practice is the curriculum: Standards for empanelment, continuity, referrals

Community outreach to address disparities

Flexibility for residencies; 6 months of electives for residents

Two tracks for obstetrics

….and many others!

All residencies, MDs **and** DOs

You submit administrative data to ACGME; milestones, resident and faculty surveys are part of this data and are required…

The ACGME Family Medicine Review committee uses data for accreditation decisions about your residencies

Residency Faculty Educational Time (7/1/24)

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

- Impact of 2019 ACGME changes
- Now back to 2019 rules with more core faculty
- PD/APD time allocations non-clinical
- **Core Faculty .6 FTE/4 residents** (6 if <12 residents)
- **Use it!**

Starting With End in Mind: the Core Outcomes

1. Develop effective communication and constructive relationships with patients, clinical teams, and consultants
2. Practice as personal physicians, providing first-contact access, comprehensive, and continuity medical care for people of all ages in multiple settings and coordinate care by helping patients navigate a complex health care system
3. Provide preventive care that improves wellness, modifies risk factors for illness and injury, and detects illness in early, treatable stages for people of all ages while supporting patients' values and preferences
4. Evaluate, diagnose, and manage patients with undifferentiated symptoms, chronic medical conditions, and multiple comorbidities
5. Diagnose and manage common mental health conditions in people of all ages
6. Diagnose and manage acute illness and injury for people of all ages in the emergency room or hospital
7. Perform the procedures most frequently needed by patients in continuity and hospital practices
8. Care for low-risk patients in prenatal care, labor and delivery, and post-partum settings
9. Effectively lead, manage, and participate in teams that provide care and improve outcomes for the diverse populations and communities they serve
10. Model lifelong learning and engage in self-reflection
11. Assess priorities of care for individual patients across the continuum of care—in-office visits, emergency, hospital, and other settings, balancing the preferences of patients, medical priorities, and the setting of care
12. Model professionalism and be trustworthy for patients, peers, and communities.

- Collaboration of ABFM and RC, with input from all FM organizations, published March 2023.
- Started with Family Medicine Entrustable Professional Activities (EPAs) developed as part of *Family Medicine for America's Health.*
- The goal of training is independent **(=autonomous)** practice capable of **broad scope of care**.
- We named "core outcomes" because of confusion about what EPAs were. **Core outcomes replace EPAs.**

Core Outcomes are the foundation of ABFM Competency Based Board Eligibility

Announced in spring 2023

All residents must achieve competency in <u>all</u> core outcomes to be eligible for ABFM board certification.

Program directors, backed by CCCs, attest to completion of residency, readiness for autonomous practice and competence in the core outcomes--**<u>in addition</u>** to passing examination and fulfilling professionalism guidelines

As result of your feedback, implementing over three years--2024, 2025, and 2026

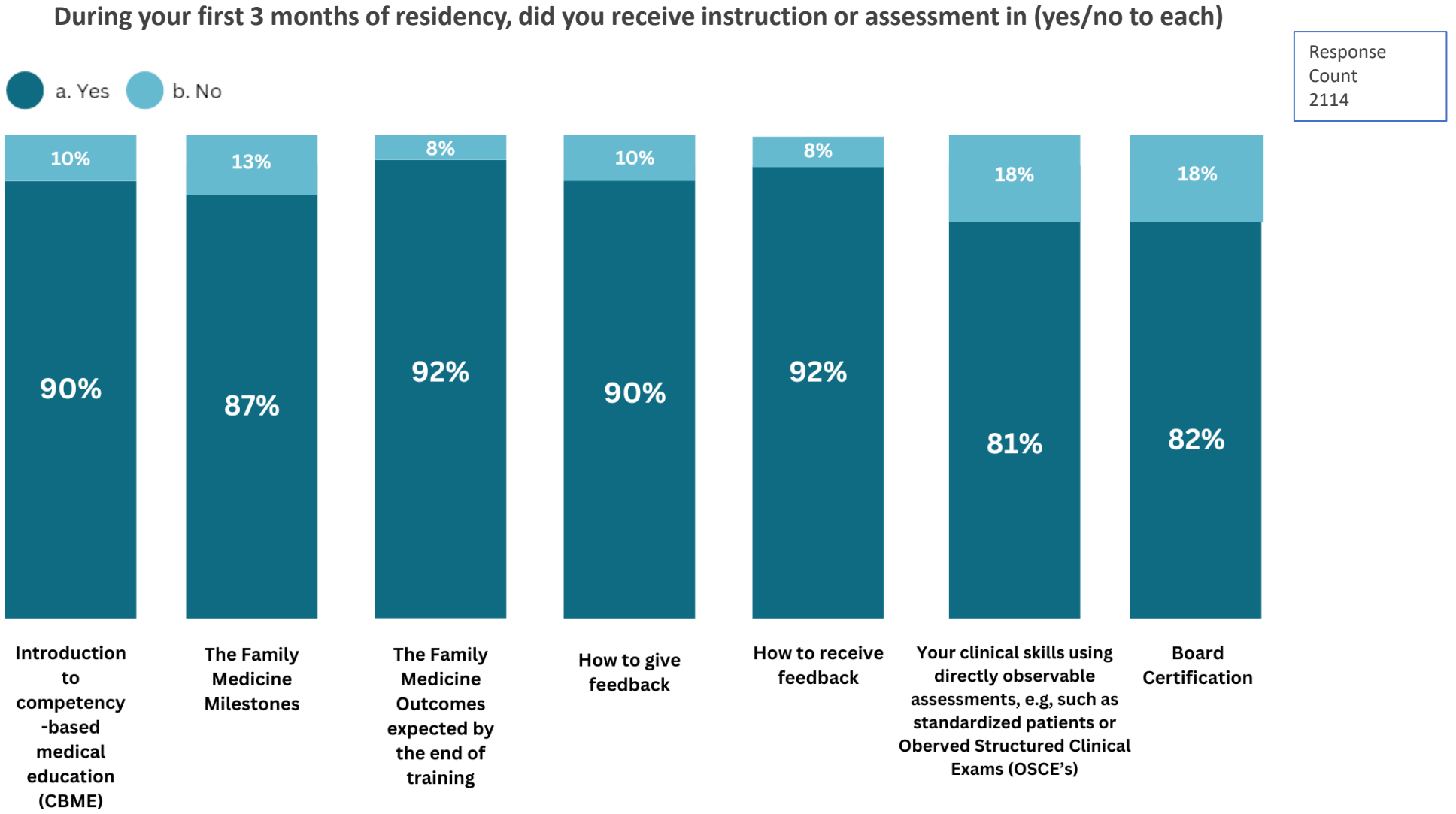
2024 prioritized outcomes easier to assess and emphasizing broader scope of care.

Note 15 core outcomes—split out components of practice as personal physicians to ease implementation

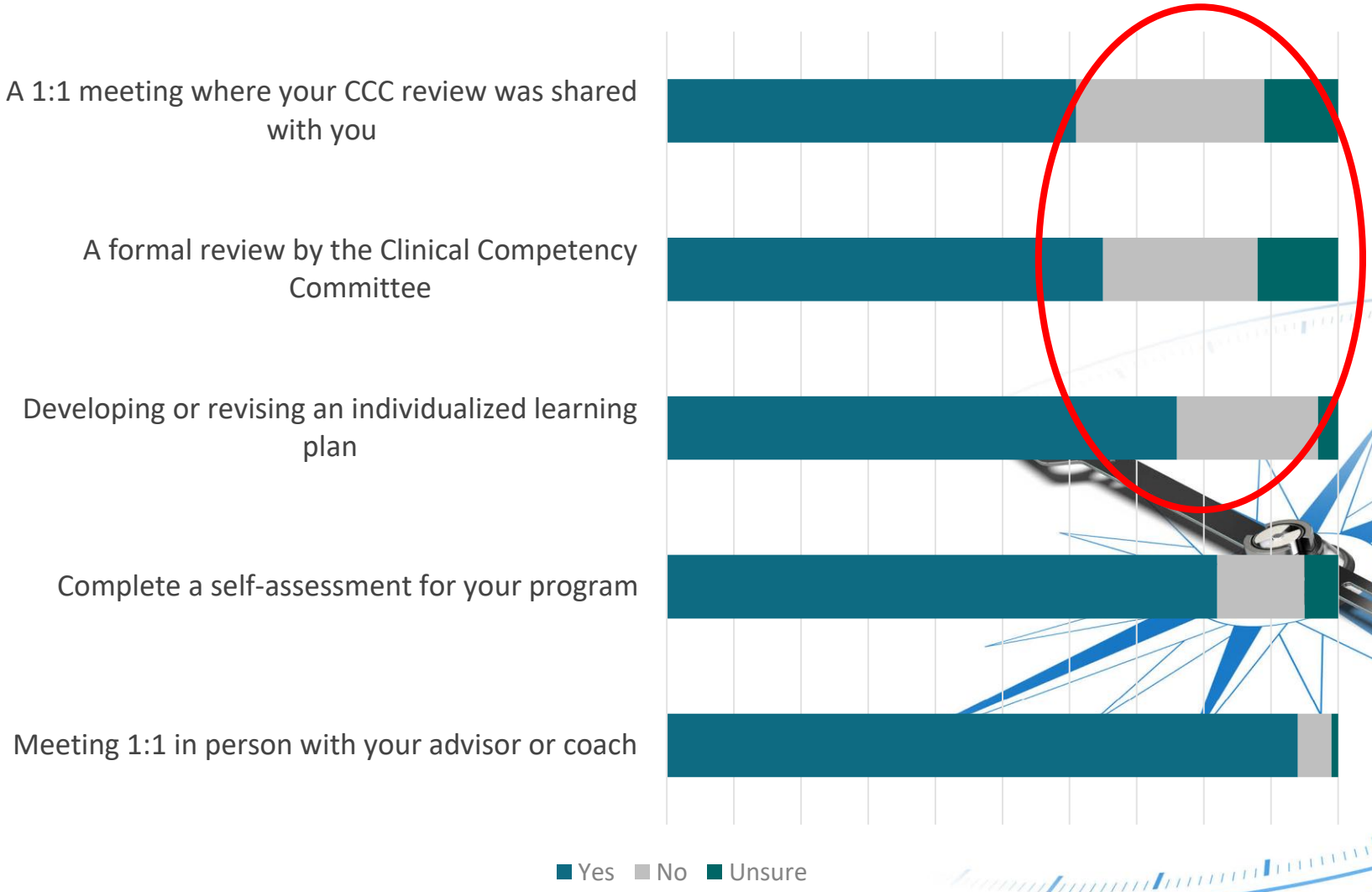
We rely on PDs/CCC because you see residents in many contexts, reviewed all evaluations, discussed in CCC.

How are we doing with residency redesign and competency based board eligibility?

National Resident Survey 2023: Resident Experience of CBME Orientation



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

ABFM Core Outcomes in 2024: What happened?

- 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.

- End of residency attestation by PDs: completion, ready for autonomous practice and competent in 5 outcomes
- Judgement of PD and CCC
- Focus, number and sampling of assessments become critical

ABFM Core Outcomes for 2024: What happened?

Mechanics worked well…

4/4867 not attested to…

Discussed each case with residency leadership:

- All had professionalism concerns, some had other concerns also
- Each case is unique, with different follow up depending on what the resident needed
- Program Directors/ Residencies did well!

What Assessments Should We Use?

- ABFM does **not** require specific assessments!
- Use your best judgement as educators and learn from others. And…
- The perfect is the enemy of the good!

Recommendations:

- Use rotation evaluations; link to key clinical behaviors.
- Increase volume of direct observations
- Summarization/analytics critical
- CCC balance of rigor and efficiency critical

How should faculty and residencies develop?

- STFM CBME task force: https://www.stfm.org/facultydevelopment/otherfacultytraining/facultydevelopmentdelivered/overview/
- Thanks to AFMRD, AAFP and STFM for focus in conferences: bring your experience to others!
- SOAR—RLS preconference—learning from exemplars from national graduate survey for specific outcomes
- Residency Learning Networks ABFM foundation support (jfetter@theabfm.org)

Growing infrastructure for faculty development:

- Regular schedule for faculty development
- Shared mental model of assessments and development
- Use apps in New Innovation and MedHub to increase numbers direct observation
- Nurturing a growth mindset among residents
- Improving CCC and PEC Function

What to expect in the next several months?

- ❑ Results from the 2024 National Resident Survey (presented at RLS and other meetings)
- ❑ Participate in our learning community: dialogue and debate at SOAR, RLS, STFM meetings, residency learning networks and other settings
- ❑ ABFM2025 Core Outcomes required for June 2025
  - Process will be similar, but with 10 core outcomes
  - Includes continuity and appropriateness of referrals, mental health, care of pregnant patients, lifelong learning, procedures
  - Suggestions on assessments will be published soon

More questions from you:

Do we still need to do milestones?	Yes, these are an ACGME requirement. Milestones allow you to review resident trajectories and the RC to evaluate residencies
Does ABFM competency-based board eligibility apply to both MDs and DOs?	ABFM has over 17,000 DO Diplomates! The standard for board certification is the same for all; ABFM rules apply to both MD/DOs

More questions

How do we manage residents who are not yet competent in the core outcomes?

Prevention is key –

- Set core outcome expectations on orientation and in ILPs
- Engage residents in their own education—the "growth" mindsets
- Target selectives and electives to remediate and build competency

What happens if the resident is not competent in a specific competency at the end of residency?

Graduates are ABFM board eligible for 7 years

Remedies individualized, but might include additional rotations, referral to PHP, feedback from employers

We are developing systems to support this process; we will work with you.

Comments/Questions?