Family Medicine Updates

From the American Board of Family Medicine

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HOW THE ABFM WILL ADDRESS HEALTH EQUITY

America is transfixed by 2 epidemics. First, the COVID pandemic, with over 155,000 deaths in the United States and new outbreaks here and across the world, is crippling the financial engines of our economy and stoking conflict among groups. Second is the more silent epidemic of pervasive health disparities, demonstrated yet again by the pandemic. In the United States, and indeed the world, the murder of George Floyd, historical acknowledgement of the pervasive legacy of racial injustice, and its recognition as a cause of disparate rates of infection and death among minorities during the pandemic has created a period of intense focus and conflict. In 2003, the Institute of Medicine's *Unequal Treatment* report found evidence that these disparities were not just the result of social policy, but also of intrinsic bias in the health system and among physicians.[1] Mindful of the many people and organizations who will contribute to the solutions, the question for ABFM is: what is the role of a certifying board in addressing health disparities and their underlying causes?

A starting point is our mission and vision: ABFM's vision statement includes a goal of *"Optimal health and health care for* all *people and communities that family physicians serve."* Our 2019 strategic plan[2] commits us to *"Include health into its program of lifelong learning and quality improvement. We will support organizations and people developing innovative curricula in professionalism, the social contract, advocacy, health equity, and social drivers of health at all levels of education."* ABFM is committed to finding and implementing changes in its certification program which may help eliminate health disparities. This may include current tools, like performance improvement, self-assessment, and reflection and formative feedback from our examination, but we also remain open to new mechanisms that serve our Diplomates and the public.

A first step is to support family physicians making improvements in their practices. We have heard from some Diplomates who are already moving to action (see ABFM social media posts with hashtag #positiveprofessionalism), but many others are searching for ways to change their practices to improve equity. Based on our recent success in a self-directed COVID performance improvement (PI) activity, we have extended that option to Diplomates wishing to improve health equity. Deployed on June 29, 2020, this activity provides a variety of options for Diplomates—from reviewing differences in clinical quality among groups who historically have experienced disparities, to assessing previously unrecognized barriers to equal access in their own practices and staff, to community-level assessments and interventions addressing social determinants of health. Responding to Diplomates who indicated that they want to do something but don't know where to start, we have included more resources to help physicians make these positive health equity changes. Beyond the PI activity, another available tool is ABFM's Population Health Assessment Engine (PHATE), which allows users to map their practices and patients to known social determinants of health.[3] Having access to this data helps in numerous ways. For example, one practice used PHATE to find that despite serving a very affluent area, their patients from more deprived neighborhoods had lower scores on quality metrics.[4] Another practice used PHATE to identify the neighborhoods where their patients consistently had food insecurity, allowing them to develop and support appropriate community interventions.[5]

A second step is to provide an opportunity for physicians to assess their own knowledge of health disparities and their underlying causes. We are fortunate to be able to utilize educational materials developed by family physicians as part of the Family Medicine for America's Health (FMAHealth) Initiative, which had a major focus on addressing health disparities. The American Academy of Family Physicians (AAFP) assumed leadership for this initiative after the completion of FMAHealth and these materials are now housed within their Center for Health Equity.[6] ABFM has initiated efforts to partner with the AAFP so Diplomates can utilize these materials, in a self-directed manner, to gain both knowledge self-assessment credit and CME credit. The material will be available for all Diplomates. Knowledge is power, and can heal individuals, groups, and communities.

We are also committed to learning if there are any disparities among different groups of family physicians in their results on ABFM certification examinations. For the past 7 years, and alone among the ABMS Boards, ABFM has collected data on Diplomate race and ethnicity in order to assess whether any bias exists in our

examination questions. Formally termed Differential Item Functioning (DIF),[7-9] this process compares, on an item-by-item basis, whether examination questions perform differently among physicians from different self-designated racial and ethnic groups, as compared to examinees of similar ability. Any questions which appear to perform differently (using a 2 standard deviation plus clinical significance threshold) are reviewed further by a diverse panel of family physicians. Over the years, we have identified a number of questions which may be biased against one race or ethnic group and have removed them from our item bank. Going forward, we will extend our DIF process to the questions in the new Family Medicine Certification Longitudinal Assessment (FMCLA) and ultimately to the Sports Medicine examination, which we administer. Of course, we will encourage the sponsors of our other Certificates of Added Qualifications to apply this technique to their examinations.

Table 1. Race and Ethnicity of 2019 ABFM Exam Candidates

	Initial Certification No. (%)	Continuing Certification No. (%)	Total No. (%)
Total	3,668 (100.0)	9,184 (100.0)	12,852 (100.0)
Race			
White	2,261 (61.6)	6,394 (69.6)	8,655 (67.3)
Asian	805 (21.9)	1,484 (16.2)	2,289 (17.8)
Black or African American	262 (7.1)	624 (6.8)	886 6.9)
American Indian or Alaska Native	25 (0.7)	78 (0.8)	103 (0.8)
Native Hawaiian or Other Pacific Islander	12 (0.3)	51 (0.6)	63 (0.5
Other	303 (8.3)	553 (6.0)	856 (6.7)
Ethnicity			
Non-Hispanic	3,321 (90.5)	8,522 (92.8)	11,843 (92.1)
Hispanic or Latino	347 (9.5)	662 (7.2)	1,009 (7.9)

Table 2. Gender Breakdown of Family Medicine Residents and ABFM Diplomates

	Resident No. (%)	Diplomate No. (%)	Total No. (%)
Total	13,455 (100.0)	93,455 (100.0)	106,910 (100.0)
Male	6,210 (46.2)	50,504 (54.0)	56,714 (53.0)
Female	7,245 (53.8)	42,951 (46.0)	50,196 (47.0)

We will also look for disparities in examination outcomes across race, ethnicity, and other groups of family physicians. Approximately a decade ago, we observed a substantial difference in examination performance among international medical graduates (IMGs). Working closely with the Family Medicine Review Committee of the Accreditation Council of Graduate Medical Education (ACGME), ABFM intervened in multiple ways to try to improve the performance of IMGs. The Family Medicine RC, recognizing the Board Examination as the best single measure of the cognitive expertise of family physicians, increased the residency standard to 90% passing, and added a requirement that residents take a Board exam. The ABFM moved its exam to April, giving more control to the Program Directors, and created a Bayesian score predictor that allows conversion of in-training examination scores to a probability of passing the Family Medicine Certification examination. Family Medicine Residency Directors responded brilliantly, and the differences between IMGs and American graduates have narrowed dramatically in recent years.[10] We will now turn this lens on the educational environment to explore disparities in examination outcomes across other groups.

What will we do if we do find significant disparities? In addition to looking for bias in the specific questions which make up our examination, as described above, we will include this issue as we consider the major revision of the ACGME residency requirements[11] and the corresponding Board Eligibility requirements. More broadly, we also recognize that board certification is at the end of the educational pipeline, and that we will need to work upstream with those who work with learners at earlier stages. ABFM has an important role convening all those interested in working on this problem.

We are also committed to having the ABFM Board and volunteers reflect the diversity of our Diplomates, and to having our Lexington staff reflect the diversity of our community. Table 1 gives the race and ethnicity of our Diplomates as estimated by our 2019 certification/recertification data, and Table 2 gives the gender distribution of Family Medicine residents and Diplomates. Family Medicine is becoming more diverse and more female. We will initially focus on not only gender and minorities under represented in medicine but also geography and kind of employment. Over the longer term, we will consider other populations with health disparities that are more difficult to track such as those who have come from poverty and LGBTQ+. In Board Certification, as in clinical practice, diversity of perspective is critical if we are to achieve our vision of optimal health and health care for all patients and communities that family physicians serve.

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From the Society of Teachers of Family Medicine

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STFM LAUNCHES INITIATIVE TO POSITION ACADEMIC FAMILY MEDICINE IN HEALTH SYSTEMS

Family physicians have been at the center of the response to COVID-19,[1-2] and the pandemic has underscored what was already an urgent need for more family physicians. The Association of American Medical Colleges estimates a primary care physician shortage of up to 55,200 by 2033.[3]

Over the past few decades, most family physicians have transitioned from private practice to employed practices.[4] Throughout this transition—for a number of reasons—there has been a general reduction in scope of practice, in spite of evidence that primary care is "associated with better health outcomes, lower costs, and greater health equity."[5]

To address the changing employment landscape for academic family physicians, faculty, and learners, the Society of Teachers of Family Medicine has launched a new initiative to:

- preserve comprehensive practice for family physicians and family medicine faculty who wish to practice broad scope
- ensure that family medicine faculty—including community preceptors in non-academic settings—have sufficient time and institutional resources to teach and meet academic and accreditation requirements
- improve faculty and learner well-being
- transform family medicine training sites into clinical and teaching models of excellence

The initiative will be chaired by Christine Arenson, MD. "This is a critical time for family medicine," said Dr Arenson. "We have the evidence we need that team-based family medicine, with physicians operating with a broad scope of practice, is critical to improve health and health equity while reducing the total cost of health care for our nation. And yet we also know that traditionally structured health care systems are not designed or prepared to meet this mission."

As the chair of the initiative, Dr Arenson will work with STFM staff to convene workgroups to develop and deliver training, build connections with health systems leaders, and advocate for family medicine.

Specifically, the initiative will:

Train Family Medicine Educators and Learners on the Business of Medicine

Because most family physicians are employed by health care systems, it is important that physician training leads to an understanding of the business of medicine and how system leaders make decisions. This knowledge is fundamental to business-based solutions that incorporate the needs of medical education, family medicine, and health systems.

Make the Business Case for Investment in Primary Care/Family Medicine

There aren't enough family physicians to meet the nation's health care needs,[3] and there is a shortage of family medicine faculty.[6] Faculty are struggling with workload/administrative burden/competing priorities.[7] Communications to health care system leaders will advocate for equitable resource allocation and