members were tasked with helping to help recruit individuals by reaching out to colleagues and inviting them to apply for positions regardless of previous service. Through intentional efforts, we hope to develop an ongoing pipeline of prospective leaders.
b) Build on existing efforts where available: The Board acknowledged the work of other family medicine organizations as resources for education and training.

STFM

One of STFM's core values is diversity and being intentional about diversity in the broadest sense is woven into the fabric of STFM in the following ways.
• The voices present and missing from leadership roles are prioritized and considered first when selecting the board, committees, and task force members.
• Conference planning committees are intentional about ensuring diversity is represented as plenary speakers and on the main stage. Numerous conference sessions cover content focused on diverse populations.
• The STFM URM Initiative is a 3-year effort to develop more URM learners and family medicine faculty. Areas of focus include leadership, scholarship mentorship, and faculty pipeline. The STFM Foundation raises funds for these efforts and recently received grant support from the ABFM Foundation.
• STFM board has updated its strategic plan to include antiracism with new objectives and tactics. A new Antiracism Task Force has been created to implement a number of strategies approved in the plan.
• To increase racial/ethnic diversity in STFM staffing, the CEO and legal staff reviewed and updated its staff policy manual and hiring policies, increased its position announcements to colleges and places where diverse applicants might see job postings, began training staff to screen applicants in more inclusive ways, and increased its network of Black and Brown colleagues to help identify candidates for open staff roles.

More information about the leadership opportunities available across the "family" of family medicine can be found on the STFM website, here: https://stfm.org/facultydevelopment/leadership.

We recognize this is just the beginning of the work we must do to change the leadership landscape in family medicine and look forward to reporting on the progress we have collectively made in this space in the future.

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Amanda Weidner, MPH and
Deborah S. Clements, MD, FAAFP

From the American Board of Family Medicine

THE FUTURE OF FAMILY MEDICINE RESIDENCY EDUCATION: THE SPECIALTY HAS SPOKEN

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We are now at the end of the beginning of re-envisioning the future of residency education in Family Medicine. On December 6-7, 2020, after almost a year of preparation, representatives of the specialty came together at the fourth Starfield Summit to review the past and present, and to envision the future of Family Medicine residencies. Our goal was to provide input from the discipline to the development of the next version of ACGME Program Requirements for Graduate Medical Education in Family Medicine, expected to be implemented in 2022. We write to summarize the results of this process to date and describe next steps.

We thank the specialty and the participants for their extraordinary effort and creative ideas. All of the clinical and academic organizations in Family Medicine—in alphabetical order, the American Academy of Family Physicians, the American Board of Family Medicine, the American College of Osteopathic Medicine, the Association of Departments of Family Medicine, the Association of Family Medicine Residency Directors, the North American Primary Care Research Group and the Society of Teachers of Family Medicine—have been involved in significant ways. Each organization nominated a person to plan the process. The planning group implemented a nomination process for participants in the Summit and finalized a set of core questions[1] (Table 1) to frame input from focus groups, surveys, papers, and the meeting.

NAPCRG designated the conference as a Starfield Summit, underscoring the connection to the evidence that underpins what we do. AAFP, ACOFP, ADFM,

AFMRD, and STFM led focus groups addressing various aspects. AFMRD conducted a survey of curricular elements (303 respondents), and ABFM surveyed over 3,000 residents and Diplomates. Researchers from ABFM, the AAFP's Robert Graham Center, and the ACGME wrote 15 background papers, and invited authors wrote 31 papers on key issues, with initial drafts sent to all. Fifty-two invitees participated in the highly interactive virtual conference, with the ACGME Standards Writing Group and an ABFM Residency Task Force as observers. The papers are now under peer review for publication in a dedicated issue of *Family Medicine*. We believe that this extraordinary effort reflects the passion of the specialty for residency education—and the awareness that we are in a special time in history.

The conference was organized around the core questions: each segment included background papers, short presentations, with the majority of time spent in discussion. Many different approaches were used to engage participants, including Zoom polls, different types of small groups, and point/counterpoint sessions. Discussion groups were also organized around career stage and region of the country. Each segment included a summary of the sense of the group, typically a poll.

Table 2 summarizes the interim conclusions. These have been reviewed by the summit planning group and all participants; each has been approved by large majorities of the participants. Figure 1 summarizes the vote on which clinical and health care problems all family medicine residents should be trained to address. Going forward, the website https://residency.starfieldsummit.com/ documents all of this work, from background papers and key literature to focus group and survey findings to the final conference agenda, summary of the themes, votes, conference chat, and eventually the papers and commentaries as they are accepted for publication in *Family Medicine*.

We emphasize 5 points in the conclusions so far:

1. New voices were heard! The national nomination process yielded over 170 candidates: the 52 final participants were selected with planned diversity of underrepresented minority, gender, career stage, osteopathy, other professions, residents, and students. There were 5 patient/public representatives and 2 representatives from Canada.
2. The participants were engaged. All participated in a gated social media community before the conference, beginning the discussions, and all reported reading all or almost all of the articles in advance. That preparation showed in the discussion, which was respectful, crisp, and insightful. When you consider the final votes, keep in mind that the voters were broadly representative of the specialty, had done virtually all of the reading, heard presentations, and participated in the discussions. They were an informed electorate.
3. The group affirmed our commitment to help meet society's needs—now and over the next generation. This commitment was striking for observers outside of Family Medicine. This means addressing not only burning clinical problems, such as behavioral health, multimorbidity, and opiates, but also social and health care problems that are so urgent such as disparities, rural obstetrical deserts, and the cost of care. This seems appropriate for Family Medicine, the largest and most widely distributed tribe of personal physicians: if physicians are to tackle the wicked problems we face, family physicians must do it.
4. There was a lot of discussion about what and how to teach, which will be best described in the peer-reviewed papers. After preparation and discussion, the summit affirmed:

- The centrality of the core functions of primary care—first contact care, comprehensiveness, continuity and coordination, while underscoring the need for updating how we measure them and including a fifth C—community as a core element
- Training to full scope in residency
- Embracing the residency practice as the curriculum
- Implementation of competency-based education as fast as practical

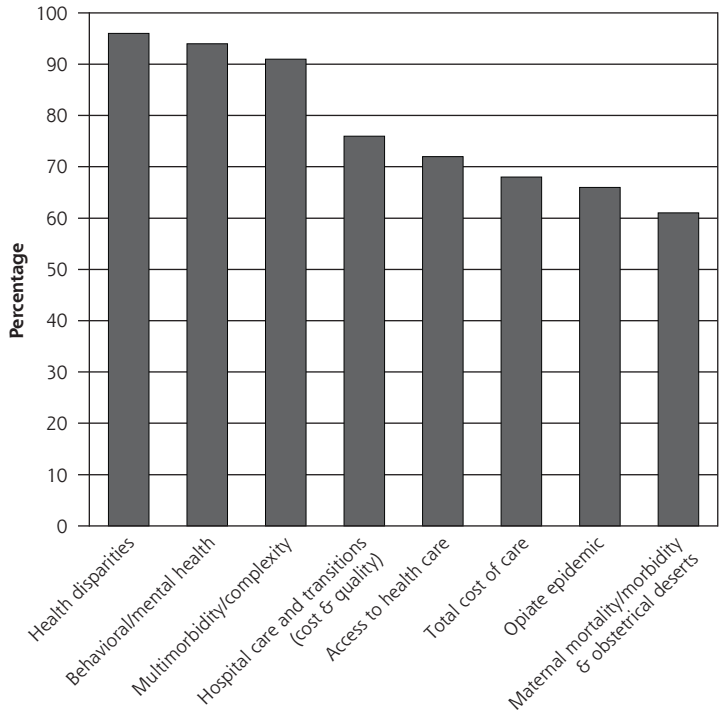
Table 1. Fundamental Questions for Major Revision of Family Medicine Residency Guidelines[1]

1. What does society need from the personal physicians of the future?
2. What should we teach?
3. How should we teach?
4. How will we prepare graduates for practice over their lifetimes?
5. What is the right balance between innovation and regulation?
6. How can we improve the social accountability of residency education?

Table 2. Key Interim Conclusions

1. First Contact, Comprehensiveness, Continuity, Coordination with the addition of Community should be central to Family Medicine education.
2. The residency practice is the curriculum.
3. Competency-based assessment needs to be implemented as soon as is practical.
4. A major goal of Family Medicine residency education is to produce master adaptive learners.
5. Society needs both more innovation and better standardization in residencies.
6. Residencies must become more socially accountable through continuous quality improvement of the residency education and clinical practice.
7. We must invest in the future of the specialty by increasing diversity, recruiting future teachers and researchers, providing adequate faculty time and support, and preparing family physicians for leadership in health systems.

Figure 1. What clinical and health care problems should all family medicine residents of the future be trained to address?



(Percentage participants including as priority, N = 54).

editorial, they are beginning to integrate the results of the summit process and a parallel scenario planning process. They plan to post draft principles for the new residency standards soon.

We are now at the "end of the beginning." We anticipate at least a 15-month process to develop the new Program Requirements. We invite you to read, comment, and get involved, not just now but as the standards are drafted and as they go through the ACGME review process. Residencies are the future of the specialty.

Warren P. Newton, MD, MPH (WNewton@theabfm.org), American Board of Family Medicine and Department of Family Medicine, University of North Carolina; Karen B. Mitchell, MD, American Academy of Family Physicians; Michael K. Magill, MD, American Board of Family Medicine and Family and Preventive Medicine, University of Utah.

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• Training residents to be master adaptive learners

5. We must also improve our national system of residency education:

• Core faculty must have dedicated time for education

• We must build in both substantial innovation and better standardization

• The processes by which individual residencies continuously improve their education, clinical care, and response to community needs must be more robust

• The overall GME system must become more accountable to the needs of society

The summit closed with a consideration of how much change in Family Medicine residency was necessary. After reading all the papers and deliberating for 2 days, 94% believed that change was necessary. When asked how much, on a scale of 1 = none, 5 = moderate change in target areas, and 10 = aggressive change across many areas, the average rate was 6.5. The specialty wants substantial change quickly.

The specialty has spoken. Now the ball is in the court of the ACGME Standards Task Force and the ABFM. The Writing Group, most of whom are former or current Residency Directors and members of the Review Committee for Family Medicine, reviewed the papers and observed the summit. As we write this

AAFP From the American Academy of Family Physicians

AAFP TO DEVELOP VALUE-BASED PAYMENT MODEL FOR PRIMARY CARE

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In many ways, family medicine has been ahead of the value-based care (VBC) delivery curve for years. In a policy statement on value-based payment developed more than a decade ago, the AAFP recognized the urgent need to "improve both efficiency and effectiveness in the delivery of medical care, in which 'efficiency' is understood to mean 'doing the thing right' and 'effectiveness' means 'doing the right thing.'"

For their part, family physicians are hard-wired to deliver high-value, evidence-based care, which they do in 90% of counties across the United States. Although FPs make up only 15% of all US outpatient physicians, they provide nearly one-quarter of all outpatient visits and are more equitably distributed than any other physician specialists.