

cians play in improving care and outcomes helps all students to see family physicians as foundational to well-functioning health care systems and patient-centered medical homes. DFMs must ensure that medical schools provide an environment of professionalism that discourages the toxic and untoward effects of 'professional badmouthing' and the 'hidden curriculum' on student interest in family medicine and primary care.

### Practice

The practice pillar encompasses the dynamic interplay of the learners' experience of clinical care. DFMs need to position themselves as leaders in the rapidly changing clinical environment to ensure students participate in interprofessional teams and robust medical homes. Support for community faculty, who often provide the window through which students view what they consider the 'real world' of family medicine, improves the likelihood that students will view a possible future practice that improves care and outcomes of care.

### Payment

Payment, over which DFMs and medical schools have the least direct control, is the last pillar. It is also the most important in influencing specialty choice. The gap between primary care and specialty care salaries must be narrowed. When relative reimbursement is normalized, graduating medical students select careers in primary care at rates adequate to the needs of the population.<sup>4</sup> The factors associated with reimbursement (prestige, lifestyle, ease of loan repayment, status of medical school departments) have a potent influence on specialty choice. The rising cost of medical education discourages students from lower socioeconomic status from choosing family medicine.<sup>5</sup> Students from wealthier families (particularly with physician parents) are less likely to choose family medicine for reasons associated with perceived prestige of various medical disciplines.

Specific ways that DFMs can influence the payment pillar demand our best attention. Developing scholarships and loan repayment programs for students, especially those from underrepresented minority groups is a priority. DFMs should assume roles of leadership in value-based payment mechanisms within respective practices, and advocate for reimbursement that values effectively improving the health of individuals and communities over quantity of services provided. Without meaningful payment reform, current fiscal realities dictate that the interest in primary care and family medicine will continue to lag, and population health gains that would be made with a more robust primary care foundation will remain elusive, at both human and economic cost. Ensuring a pipeline and investing in the educational process are necessary but not sufficient to

create a more robust primary care workforce: payment reform that rewards family medicine based on the evidence for the contributions of our practice is essential for fixing a broken system. Working together with other partners committed to positive change, academic departments of family medicine can create meaningful change that will influence medical education and health care delivery for generations to come.

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*\* The opinions herein are those of the author. They do not represent official opinion of The Uniformed Services University, The Dept of the Navy or The Dept of Defense.*

*This commentary is endorsed by the ADFM Board of Directors.*

### References

1. Hepworth J, Davis A, Harris A, et al; and CAFM Four Pillars Taskforce. The four pillars for primary care physician workforce reform: a blueprint for future activity. *Ann Fam Med*. 2014;12(1):83-87.
2. Smedley BD, Stith Butler A, Bristow LR, eds. *In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce*. Institute of Medicine (US) Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Healthcare Workforce; Washington, DC: National Academies Press; 2004.
3. Grumbach K, Odom K, Moreno G, Chen E, Vercammen-Grandjean C, Mertz E. Physician Diversity in California: New Findings From the California Medical Board Survey. San Francisco, CA: University of California, San Francisco, Center for California Health Workforce Studies; March 2008.
4. Kruse J. Income ratio and medical student specialty choice: the primary importance of the ratio of mean primary care physician income to mean consulting specialist income. *Fam Med*. 2013;45(4):281-283.
5. Asch DA, Nicholson S, Vujicic M. Are we in a medical education bubble market? *N Engl J Med*. 2013;369(21):1973-1975



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## THE RESIDENCY PERFORMANCE INDEX (RPI): AN AFMRD TOOL FOR FAMILY MEDICINE RESIDENCY PROGRAM ASSESSMENT

The Residency Performance Index (RPI) was developed by the Association of Family Medicine Programs (AFMRD) in 2012 to spur residency program quality improvement, using program metrics and benchmark criteria specific to family medicine training.

RPI provides a “dashboard” for program directors, using criteria believed to be critical to program quality and yet measurable and/or published. Using concepts borrowed from AAFP Residency Program Solutions' *Criteria for Excellence* and TransforMED MHIQ, the dashboard uses the convention of red, yellow, and green to indicate achievement of targets representing the floor, status quo, and excellence. Like the dashboard of your car, the intent of the RPI is to monitor the important functions of the program and alert the driver (program director/program evaluation committee) if maintenance is required.

The development of RPI was well timed, considering the ACGME's emphasis on conducting meaningful quality self-assessment and improvement. The RPI can summarize much of the data used internally by a program's program evaluation committee to conduct its annual program evaluation. Consecutive annual RPI reports tracking progression from deficiency (red) to excellence (green) can be useful trending information for the 10-year self-study process.

RPI is a powerful tool that can easily organize and communicate meaningful data. It can provide faculty and leadership with an at-a-glance view of current status and future needs, and convey the complicated nature of residency training and accreditation. The visual presentation and comparison to aggregate data is appealing to data-minded individuals (DIOs, CMOs, etc) and is consistent with current business practices within and outside health care. Programs could, for example, use “red” items to advocate for corrective resources from their departments and systems, similar to the silver lining of RC citations, but with no accreditation repercussions.

The RPI is available at no cost to AFMRD program directors. Those who use the RPI tool, including AFMRD itself, have a professional obligation to use it for self-improvement purposes only. Publication or comparison of individual RPI data to that of other programs or data sets is strictly prohibited. The tool must never be used as an advertising/promotional tool. It is also *not* an accrediting tool (no accrediting bodies, including the RC-FM have access to the data). In a world obsessed with rankings, it should be noted that RPI does not produce or promote a ranking system of any kind.

The AFMRD owns all RPI data and survey results and uses data only in an anonymous, aggregate form for the purpose of advancing the mission of the AFMRD. Aggregate data can be used as a self-improvement tool for the discipline itself by identifying gaps and potential trends in family medicine training. Once such improvement areas are identified, national organizations such as the AFMRD can:

- Tailor national education offerings to meet identified training and faculty development needs

- Focus advocacy efforts with accrediting bodies, such as the RC-FM and ABFM
- Focus on areas nationally that fall into yellow or red zones of metrics
- Use data to bring context to discussions of training guidelines and best practices

To our knowledge, this is the first US specialty-based comprehensive quality improvement tool for residency programs. The larger GME community has taken notice. The RPI is featured in the December 2014 issue of the *Journal of Graduate Medical Education*.<sup>1</sup> The article outlines the development, implementation, benefits and current challenges of the tool.

The future direction of RPI will address its recognized limitations, which include:

- Single specialty study, which reduces generalizability
- Volunteer participants that introduce the potential for selection bias
- Concerns about data collection, terminology of data, and keeping pace with ACGME
- Redundant data entry and timing of data collection
- Metrics and red/yellow/green levels set by consensus, expert opinion (lack of evidence for metrics)

RPI has been well accepted and shows promise as a self-improvement tool for both individual residency programs as well as the discipline of family medicine itself. It has already been utilized by 122 out of 480 residency programs. In order to realize the full benefits of the tool and rectify its limitations, the family medicine residency training community must embrace the tool and commit to accurate data entry and a higher participation rate.

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## References

1. Hoekzema GS, Maxwell L, Gravel JW Jr, Mills WW, Geiger W. The residency performance index: an effort at residency quality assessment and improvement in family medicine. *J Grad Med Ed*. 2014;6(4):756-759.



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## PBRN CONFERENCE HIGHLIGHTS STAKEHOLDER ENGAGEMENT AND DANGEROUS IDEAS

The 2015 NAPCRG Practice-Based Research Network (PBRN) Conference brought together the energy of