

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*.¹ 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

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North American
PRIMARY CARE
RESEARCH GROUP

**From the North
American Primary Care
Research Group**

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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

232 participants (a new record!) with patients, clinicians, researchers, and PBRN teams networking in Bethesda, Maryland from June 29-30. Conference co-chairs, Rowena Dolor and LJ Fagnan provided the welcome and orientation. Rebecca Roper, Director of the AHRQ PBRN Initiative, described AHRQ's continuing support for the PBRN community—174 PBRNs across 29,455 practices where 153,736 clinicians serve 86 million patients. AHRQ's role in convening the PBRN learning community, creating communication channels, and supporting collaboration is strong.

Three plenary talks provided the framework for 2 days of nonstop engagement—"What is Engagement," "Patient and Clinician Engagement Project (PaCE)," and "A Primer on Engaging Health Systems in Research." The first plenary established the growing evidence and importance for bidirectional engagement of patients, clinicians, and other stakeholders across the continuum of research. Consuelo Wilkins, along with Jaye Bea Smalley and Sarah Daugherty from the Patient-Centered Outcomes Research Institute (PCORI), discussed their rubric guiding patient engagement and the principles of reciprocal relationships, co-learning, partnership, trust, transparency, and honesty. The PaCE project plenary included patients, community members, and clinicians (Maret Felzien, Ned Norman, Rebecca Borchers, Cynthia Wolff, and Jack Westfall) working together in an effort to create relevance and meaning for PBRN research to reach patients and their communities. The third plenary by Jerry Krishnan presented the value opportunities that exist for the PBRN community when the needs and objectives of health systems are intertwined with PBRN research.

The 16-member PBRN Planning Committee reviewed 125 abstracts leading to 60 poster presentations, 12 workshops, and 42 oral presentations. Each submitter was asked to include a statement of why the research is relevant to clinical practice and patients. The 6 oral presentation tracks included stakeholder engagement, clinical topics, electronic medical records, PBRN methods, patient-centered medical home, and quality improvement/practice facilitation. The planning committee allowed for substantial time to accommodate 12 workshops. The workshop topics covered a variety of topics:

- The evolution of practice based research networks into community-based research and multidisciplinary networks
- Boot Camp Translation and Community Engagement Studio to engage communities
- The perspectives of practice facilitators in meeting practices on their terms and effective approaches to dissemination

- Creating the value proposition to engage practices and clinicians in PBRN studies of practice change and improvement
- The utility of qualitative comparative analysis in PBRN research
- Engaging parents in PBRN research by creating a parent research advisory board
- Reducing disparities by collecting sexual orientation and gender demographics in clinical practice
- PBRN best practices regarding stakeholder engagement
- Integrating Maintenance of Certification Part IV requirements in PBRN research

The poster sessions were well attended with ample opportunity for extended conversations and networking. Conference participants voted for the top posters receiving the David Lanier poster awards. There was a tie for third place with "A Novel Method for Achieving Covariate Balance in Cluster Randomized Trials" (Sean O'Leary, Jennifer Pyrzanowski, and Norma Allred) and "Use of the Automated Remote Monitoring System (ARMS) in Los Angeles County: Wrapping Our ARMS Around Chronic Disease and Prevention" (Laura Myerchin Sklaroff, Nina Park, and Sandra Gross-Schulman). In second place was "Vaccine Reminder Messages and Direct-to-Adolescent Messaging: Does Gender Matter?" (James Roberts, Paul Darden, and Erin Hinton). Winning first place was "Identifying Primary Care Measures that Matter" (Rebecca Etz, Marshall Brooks, and Martha Gonzalez).

This year we launched a new format on "daring and dangerous" ideas. We borrowed the concept from our primary care colleagues in the United Kingdom. In a fast paced and interactive session, 5 presenters shared their dangerous PBRN research or clinical care idea that they think needs to be heard in the PBRN community. David Hahn presented, "Guidelines are Dangerous Beasts Requiring Proof of Value Before Being Released." David proposed that all guidelines should be subjected to randomized comparative effectiveness research (CER) in PBRNs prior to being released into the wilds of primary care. Jonathan Tobin, Kevin Fiscella, and Jennifer Carroll dared us to think about a new approach to ethical oversight in quality improvement and quality improvement research. Their idea is to create a new review process to rebalance oversight, appropriate to risk. This approach includes a 2-step review with a much shorter turnaround time. Mark Stephens presented the daring idea that burnout can be identified among physicians by creating masks and describing meaning to the mask. Betsy Escobar's dangerous idea was that we disrupt the current pattern of "permanently hospitalizing" undocumented immigrants and provide a new model of providing social support

and long term care aid, thus saving our health system dollars. Lindsay Kuhn dared us to think about moving beyond the traditional supervising physician-PA relationship to embrace PAs as first-line research colleagues. The audience applause response meter indicated that each of these daring ideas was well received. We all agreed that encouraging out-of-the-box thinking made for a stimulating conference.

The enthusiasm and engagement at the 2015 PBRN Conference was high from start to finish and people are excited about coming back next year. The 2016 PBRN Conference will be July 11-12, 2016 in Bethesda, Maryland with the theme of "Dissemination and Implementation: Ensuring PBRN (and Patient-Centered Outcomes) Research Evidence is Understood and Used." See you next year!

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DIRECT PRIMARY CARE (DPC) SUMMIT DRAWS HUNDREDS OF ENTHUSIASTIC FAMILY PHYSICIANS

The numbers don't lie. The Midwest's first Direct Primary Care (DPC) Summit, held July 10-12, 2015 in Kansas City, Missouri, even surprised event organizers by racking up 317 attendees hailing from 45 states. Organizers knew they'd break even with 200 attendees, but 1 week ahead of the event, registration soared past 300 and suddenly, the 3-day meeting was sold out.

When 10 people showed up to register on site, the AAFP and 2 event partners—the Family Medicine Education Consortium, Inc and the American College of Osteopathic Family Physicians—obliged and squeezed a few more chairs into 3 already packed hotel meeting rooms.

This new practice model—in which physicians charge patients a flat monthly or annual fee in exchange for a wide array of health care services—has piqued the interest of work-weary physicians who like the idea of taking back control of their practices and eliminating insurance hassles.

According to the AAFP's 2014 Practice Profile, 2% of family physicians are already practicing in a DPC setting. Although the survey indicated very few family physicians were transitioning to a DPC setting as of December 2014, 28% of family physicians are aware

of DPC and are exploring the model in more depth before making a decision. Only 21% have explored and decided against the DPC model, and 49% are unaware of DPC.

Engaging the Audience

Attendees at this third national DPC Summit were immersed in learning that came directly from experienced physicians eager to share their knowledge and bring their colleagues on board.

For instance, physicians heard about how to start a new DPC practice or transition an existing one, employ marketing techniques, understand legal issues, recognize financial pitfalls, and navigate a regulatory maze that varies from state to state.

They were even privy to a candid onstage discussion between DPC physician Ryan Neuhofel, MD, of Lawrence, Kansas, and one of his patients, 56-year-old Blaine Milther, who relayed, with humor and honesty, his experiences dealing with a deeply entrenched health care system that left him stranded after a stroke and a diagnosis of type 2 diabetes.

Milther, a self-described small business owner of meager means, said his local safety-net clinic dismissed him as too wealthy and handed him a flyer on his way out. That sheet of paper led him to Neuhofel's practice, NeuCare (<http://neucare.net>).

A year and a half later—after an intensive physician/patient partnership that time-strapped FPs in traditional practices only dream about—Milther is back to full-time work at his heating and cooling company. He's lost 50 pounds and has swapped twice-daily insulin injections for an oral medication.

Milther described Neuhofel as a "breath of fresh air."

Their 1-hour presentation had the audience alternately laughing and applauding. In fact, during the question-and-answer period, a physician approached the microphone and appealed to Milther to meet him later at the Massachusetts House to testify on behalf of the DPC model. "They need to hear from patients like you," said Jeffrey Gold, MD, of Marblehead, Massachusetts.

Getting Down to Basics

Two family physicians, both DPC practice owners, teamed up for a session that addressed how to start a DPC practice.

Kenneth Rictor, MD, owner of Scotland Family Medicine (<http://scotlandfamilymedicine.com>) in Scotland, Pennsylvania, has been in practice since 1988 and transitioned his traditional solo practice to the DPC model in 2014. About 12% of his patients made the change with him, bringing his current patient panel to about 550.