Overall, primary care specialties had a 96.1% fill rate, similar to 2015. The number of positions offered in primary care increased by 42. Primary care positions accounted for 14.5% (4,053 of 27,860) of all positions offered. That figure lags far below recommendations. The Council on Graduate Medical Education, the Association of American Medical Colleges, the Robert Wood Johnson Foundation, the Pew Health Professions Commission, and others have called for at least 40% of US medical graduates to enter generalist careers.

In the American Osteopathic Association Intern/Resident Registration Program, more than one-fourth of the 2,255 matches were in family medicine.

"There is much we can learn from our osteopathic colleagues when it comes to promoting family medicine choice by medical students," Kozakowski said. "We look forward to greater collaboration with them on this vital topic."

The United States invests about $15 billion a year on financing graduate medical education (GME), but AAFP President Wanda Filer, MD, MBA, said taxpayers aren't getting their money's worth. Instead, the country has a fragmented health care system with a heavily specialized workforce.

The AAFP has long called for GME reform. The Academy released a proposal in 2014 with several recommendations, including a call to establish primary care thresholds applicable to all sponsoring institutions and teaching hospitals that receive Medicare and/or Medicaid GME financing.

"One-fourth of all medical students are AAFP members," Filer said. "We're working to close the deal with more of them. We have to do more."

That includes working on payment reform, Filer said. The initial uptick in student interest in family medicine coincided with health care reform policy that introduced new incentives for primary care physicians. Filer said the AAFP now is working to influence the implementation of the Medicare Access and CHIP Reauthorization Act in a way that will be favorable for primary care.

"We expect that in the new system, primary care will be the centerpiece," Filer said. "Primary care physicians will be paid better and paid differently. Students choosing primary care have made wise choices."

Filer said that when she talks to students about family medicine she touts the specialty's ability to provide comprehensive care to everyone, regardless of age or gender. A recent Graham Center study compared the complexity of primary care visits compared to subspecialist visits, and one author said the research points to the need to adjust payment in favor of primary care.

"Family medicine is not a default choice," Filer said. "You're dealing with more than one organ system. We want the best and the brightest, who will be committed to primary care, willing to make a difference in their communities and ready to take a lead role in the new health care system."

David Mitchell
AAFP News Department

From the American Board of Family Medicine

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"THE END OF THE BEGINNING" FOR CLINICAL SIMULATION IN THE ABFM SELF-ASSESSMENT MODULES (SAMS)

"Now this is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning."[1] With these words, Winston Churchill marked the Allied victory of Second El Alamein that represented a major turning point in the struggle against the Axis powers in World War II. ABFM has likewise reached a major turning point in the Maintenance of Certification for Family Physicians (MC-FP) program.

The clinical simulation program began at ABFM in 1992; the ABFM Board intended at the outset to develop the simulation technology as a potential replacement or enhancement for the MC-FP examination. When ABFM embarked on the MC-FP program in 2004, the Board elected to include simulations in the self-assessment process as a means to familiarize Diplomates with the interface and functionality in preparation for simulations' appearance in the part III examination. Since that deployment, ABFM has delivered over 500,000 simulation instances.

Over the past year, ABFM has embarked on several initiatives that have led the Board of Directors to reconsider the role of simulation in MC-FP. The DAIQUERI and TRADEMaRQ registry projects[2] will simplify Diplomates' participation in MC-FP and, potentially, provide performance information that might have previously derived from simulations. Additionally, ABFM has begun development of a continuous knowledge self-assessment (CKSA) process that will involve sending out periodic "mini-quizzes" of 1 or more items (including references and critiques) keyed to the examination content blueprint.[3] This process will provide ongoing prospective feedback for Diplo-

mates and serve as an alternative option for completing MC-FP self-assessment requirements. Given these new options, the ABFM Board of Directors voted at its October, 2015 meeting to de-link the knowledge assessment component of the MC-FP SAMs from the associated clinical simulations. This means that the knowledge assessments and simulations will now serve as independent options for completing the MC-FP self-assessment requirement.

This new role for simulations provides an opportunity to refocus the simulations' operation and functionality to present a much more formative, rather than summative[4], emphasis. Development efforts heretofore have stressed summative scoring models and functionality to support a possible role for simulation in the MC-FP examination. In this summative role, simulation scoring would have necessarily mapped to the existing examination pass-fail threshold, and would not serve easily to motivate and direct higher levels of performance. We can now work to implement formative features such as context sensitive feedback, quick quizzes, short lectures/discussions, and competitive gaming features that represented inappropriate components for a possible high-stakes examination environment. In this new role, scoring can provide feedback on performance, and *can* motivate higher performance levels. The simulator interface can now evolve to include much more guidance (eg, more use of drop-down menus and pop-up balloons) than would have been appropriate in the context of using simulation within the examination.

In addition to this more formative emphasis, ABFM has, along with colleagues from Virginia Commonwealth University, completed recently an extensive review of structured and unstructured SAM feedback from the past 10 years' experience (ABFM internal reports.)[5,6] That review identified a number of Diplomate suggestions for improvements to the simulation interface. During the summer 2015, these suggestions guided multiple interface revisions that ABFM deployed in August. Subsequent feedback indicated favorable response to the revisions (internal report).[7] Work remains, however, on several interface issues, including more responsive natural language processing, easier access to diagnostic studies and therapies, and greater use of media resources. The development team met in Lexington, KY, February 23-24, 2016, to begin work on implementing responses to this feedback and the formative features mentioned earlier. The ABFM has additionally engaged external consultant experts to aid in simulation interface re-design.

The October, 2015 Board action changes the role originally envisioned for the ABFM clinical simulation system. This change, however, clearly represents the "end of the beginning," not the end of clinical simulation in the ABFM MC-FP program.

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SUMMIT WILL ADDRESS THE SHORTAGE OF HIGH-QUALITY FAMILY MEDICINE COMMUNITY PRECEPTORS

Family medicine clerkships are struggling to obtain and retain quality clinical training sites. Contributing factors include time constraints, competition for a limited number of training sites, physicians' concerns about their ability to be effective teachers, physician burnout, and dated practice models that aren't ideal training sites.[1-4]

STFM has agreed to be responsible for Family Medicine for America's Health's Workforce Education and Development Core Team's task of identifying, developing, and disseminating resources for community preceptors.