the Academic Family Medicine Advocacy Committee (AFMAC), and maintain liaisons with external groups

3.5 Determine best utilization of Family Medicine Advocacy Summit Scholarships

4. Communications

Outcome: Pursue communication opportunities and information dissemination through the AFMRD website, discussion forum, and publications

4.1 Identify online special interest community opportunities and initiate a pilot project

4.2 Increase awareness of AFMRD, its programs and board activities through all communications and emerging media opportunities

4.3 Promote membership growth, retention, and value

4.4 Continue to evaluate and improve electronic communications, including the discussion forum, website, development of a Resource Library, social media, etc

5. Infrastructure

Outcome: Provide the governance, staff, and financial support necessary to effectively administer AFMRD

5.1 Develop competency areas for elected positions and utilize them in the selection and/or election process

5.2 Implement changes to the nominating and election procedures

5.3 Implement committee and task force guidelines that include job descriptions and annual charges designed to reflect their role in implementing the strategic plan

5.4 Promote participation in governance by informing members of opportunities for volunteers

5.5 Implement an on-going board self-assessment program to improve efficiency and effectiveness

5.6 Maintain the effective and efficient staff structure through the Management Services Organizational Agreement with AAFP and an annual evaluation of the executive director and administrative services

The AFMRD Board is now in the process of implementing the objectives through identifying specific tasks, assignments and timelines for each objective to reach measurable outcomes. Committed to being responsive to our membership, much of the implementation will be through member task forces. Ultimately, the strategic plan is designed to support program directors to create excellent family medicine education in our changing health care system.

Karen B. Mitchell MD, President-Elect
James Jarvis MD, President
Association of Family Medicine Residency Directors

North American Primary Care Research Group

From the North American Primary Care Research Group

Ann Fam Med 2017;15:184-185. https://doi.org/10.1370/afm.2045.

NAPCRG LAUNCHES TRAINEE ENGAGEMENT PROGRAM

In October 2015, NACPRG passed its first ever Trainee Program committed to providing tailored and personalized experiences specifically for trainees. Composed of 5 major pieces that are designed to give students, residents, and fellows an environment that cultivates their skill sets, the program also provides invaluable mentoring in specified fields.

The first part of this program is a preconference that made its pilot debut at the 2016 NAPCRG Annual Meeting—planned by Victoria Adewale of University of Virginia School of Medicine, and Madison Willenborg of William Jewell College. Two keynote speakers kicked off the preconference with short briefings on important topics to trainee development. Gillian Bartlett, Associate Professor and the Research and Graduate Program Director for the Department of Family Medicine at McGill University, spoke on "Making Meaningful Decisions about Your Future in Healthcare," and Sarah Gebauer, a second year Academic Family Medicine Fellow and an adjunct instructor of Family Medicine at Saint Louis University School of Medicine, spoke on "The Bumpy and Unexpected Road to Primary Care Research."

Next, four round-table discussions took place where trainees had the opportunity to speak with NAPCRG professionals on the topics of finding a mentor, leading a multidisciplinary career, grant writing, and research methodologies. These discussions provided trainees time to cultivate and focus on career development with guidance from professionals in the field. Finally, a "speed-dating" mentoring session was held in which trainees had short, one-on-one discussions with NACPRG members to network and ask questions specific to their field. This time allowed trainees a time to network, to ask questions of professionals, and bring perspective to their professional journeys. Overall, the conference saw great feedback and was warmly welcomed by the NAPCRG community.

A second portion of the Trainee Program is dedicated to promoting trainee attendance at the annual meeting. Ten trainees applied for and were awarded $1,000 training stipends. The stipend program promotes trainee involvement in NAPCRG and also encourages students to attend the Annual Meeting who may not be able to do so on their own.

Another piece of the Trainee Program is a dedication to trainee research. NAPCRG increased trainee research award prizes in order to recognize the immense work that students have tirelessly put into their research. This increase also promotes more trainees to bring their research, and possibly receive help or feedback on certain things they may need help with. Next, a special interest group (SIG) specifically composed of just trainees was created. This SIG will bring ideas to the chairs on the NAPCRG board of directors, provide a more tailored trainee experience at both the Annual Meeting and the preconference, and provide students engagement with their peers from around the world. Lastly, a membership subcommittee was created to provide backing to events and programs designed specifically for trainees. This committee was charged with creating the preconference, creating the stipend application program, and fostering the development of the trainee SIG, all of which will provide feedback and ideas for years to come.

The newly established Trainee Program provides an emphasis on fostering and cultivating trainee careers, because they are the physicians and researchers of tomorrow. NAPCRG holds to empowering and promoting students, residents, and fellows through personalized experiences not found anywhere else.

Madison Willenborg, NAPCRG Intern,
Pre-medicine student, William Jewel College

AAFP From the American Academy of Family Physicians

Ann Fam Med 2017;15:185-186. https://doi.org/10.1370/afm.2046.

TREATMENT OF HYPERTENSION IN ADULTS OVER AGE 60 TO HIGHER VS LOWER TARGETS: A CLINICAL PRACTICE GUIDELINE FROM THE AMERICAN COLLEGE OF PHYSICIANS AND THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

Executive Summary

Hypertension, defined as blood pressure >140/90 mm Hg, is a common chronic disease in the United States. It affects over a quarter of US adults and increases to almost two-thirds of adults aged over 60 years,[1] and represents a substantial burden on health care services and costs in the United States.[2] Appropriate management of hypertension reduces risk of cardiovascular disease, renal disease, cerebrovascular disease, and death.[3-6] There is currently debate, however, on the most appropriate systolic blood pressure target in adults being treated for hypertension, particularly adults aged 60 years and older. The primary purpose of this guideline is to provide clinicians with evidence-based recommendations focused on the benefits and harms of higher (<150 mm Hg) vs lower (<140 mm Hg) systolic blood pressure targets for treatment of hypertension in adults aged 60 years and older.

A joint guideline development panel was convened with representatives from the American College of Physicians (ACP) and the American Academy of Family Physicians (AAFP) to develop recommendations based on a systematic review by the Portland Veteran's Administration Health Care System Evidence-based Synthesis Program[7] sponsored by the Veterans Administration. The guideline was created using the ACP's guideline development process, which is based on the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) approach[8] and is consistent with AAFP's methodology.[9] GRADE is a system where the strength of a recommendation is dependent on both the quality of evidence and the balance of benefits and harms (burden). Strong recommendations for a treatment or test are used when the benefits of treatment clearly outweigh the harms. Weak recommendations are used when there is a close balance of risk and benefit. The ACP and AAFP prioritize patient-oriented outcomes when evaluating the evidence and making recommendations. The outcomes evaluated for this guideline included all-cause mortality, stroke-related morbidity and mortality, cardiovascular events, and harms associated with higher and lower treatment targets.

The evidence report found high quality evidence that treating individuals with hypertension to moderate levels (<150 mm Hg) reduces mortality, stroke, and cardiovascular events. For patients with previous stroke or transient ischemic attack (TIA), moderate quality evidence showed treating to blood pressure targets to <130-140 mm Hg reduced the risk of recurrent stroke, but did not have a statistically significant effect on cardiovascular events or all-cause mortality. Blood pressure targets of less than 140 mm Hg may be a reasonable goal for some patients at high cardiovascular risk. This recommendation is based on low quality evidence showing a small decrease in stroke and cardiac events in patients at high cardiovascular risk who were treated to lower target levels. There were no significant increases in major harms associated with lower treatment targets including end stage renal disease, quality of life, functional status, or falls. There were increased reports of study withdrawals due to adverse events,