ating a collaborative effort around joy in practice for ADFM. Achieving "joy" in what we do to advance care is one facet of being able to sustain our efforts at providing improved health. This effort, ADFM's "Joy in Practice Initiative," has included the creation of a new listserv for individuals in departments who are interested in collaborating and learning more about efforts around the country to support wellness in DFMs. We have also reached out to colleagues in the Society of General Internal Medicine to join our initiative.

The cornerstone of the Initiative is a series of quarterly webinars presented by individuals from the ADFM community and our partners. Each webinar showcases innovative practice features intended to improve system and individual wellness and increase satisfaction with practice. To date, webinar topics have included various methods of team documentation (scribing); an update on the AAMC's Coordinating Optimal Referral Experiences program and the background on the e-consultation strategy; strategies on optimizing team care; using EHR data to quantify "spend" on EHR tasks; and a method for panel size weighting. ADFM has made these webinars available to all who are interested; watch the webinars, join the listserv for conversation and announcements of future webinars, and learn more here: http://www.adfm.org/Members/Webinarsresources.

An additional feature of the Initiative was the intent to highlight efforts underway by individual departments at the 2017 Winter Meeting. This led to a very successful and well-received overall meeting theme of "Joy and Effectiveness in the Work of Family Medicine: Now and in the Future." Sessions focused not only on joy in practice, but on joy in each of the main aspects included in a DFM's mission: research, education, clinical care, and the administrative infrastructure to keep all of these pieces moving. More about the 2017 Winter Meeting can be found in ADFM's commentary in the May/June 2017 issue of the *Annals of Family Medicine*.

ADFM has several DFM Chairs and leaders involved in the Association of Chiefs and Leaders of General Internal Medicine's WELL (Wellness Engaged Longitudinal Leaders) Program and we have been promoting the AMA's STEPS Forward effort as a resource. We look forward to future collaborations around similar efforts and hope that our own efforts can be a resource to the Family of Family Medicine.

All these initiatives can and will help with the problem of physician burnout, and help us get the joy back in doing what we do best, providing the very best in care for our patients, their families, and our communities.

*Amanda Weidner, MPH; Ardis Davis, MSW; Michael Jeremiah, MD; and Alfred Tallia, MD, MPH; on behalf of ADFM's Healthcare Delivery Transformation Committee*

AFMRD Association of Family Medicine Residency Directors

**From the Association of Family Medicine Residency Directors**

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## FIFTY YEARS OF FAMILY MEDICINE

Fifty years ago, a revolution was occurring in American health care. Patients were becoming aware of the implications of the increasing subspecialization of medicine. Leaders were organizing to create the new specialty of family practice to largely replace the general practitioner. Pioneer physicians were leaving their practices, entering the world of academic medicine and beginning to create the very first family practice residency programs. Medical students began seeking a specialty that allowed them to serve their patients in the context of their communities. An awareness of the needs of our nation's underserved was emerging and our youngest physicians began to rise to meet these needs.

Family practice programs sprang up around the country led by those we now recognize as the founders of our discipline: Lynn Carmichael, Roger Lienke, Gene Farley, G. Gayle Stephens, and many others. Finally, in 1968, the "Special Requirements for Residency Training in Family Practice" were approved by the Liaison Committee for specialty Boards, the Advisory Board for Medical Specialties, and the American Medical Association (AMA) Council on Medical Education.

As approved by the House of Delegates of the AMA at its Clinical Convention in December 1968:

> Residencies in family practice should be specifically designed to meet the needs of graduates intending to become family physicians. The family physician is defined as one who: 1) serves as the physicians of first contact with the patient and provides a means of entry into the health care system; 2) evaluates the patient's total health needs, provides personal medical care within one or more fields of medicine, and refers the patient when indicated to appropriate sources of care while preserving the continuity of his care; 3) develops a responsibility for the patient's comprehensive and continuous health care and when needed acts as a coordinator of the patient's health care services; and 4) accepts responsibility for the total health care, including the use of consultants, within the context of his environment, including the community and the family or comparable social unit. In short, family physicians must be prepared to fill a unique and specific functional role in the delivery of modern comprehensive health services.

Using those requirements, 15 family practice programs received provisional approval in 1968. These pioneer programs offered a 3-year curriculum of "essentials" in

family medicine, internal medicine, pediatrics, psychiatry, obstetrics and gynecology, surgery, community medicine, and research. Key to the training was the family medicine practice, offering residents experience with their own patients in an environment similar to their eventual practice. Often, these practices evolved from the program director's own patient panel that they brought to newly developing programs.

Residents treated all ages and sexes of patients across care settings alongside faculty that included physicians, behavioral health providers, nutritionists, social workers, and others. Despite having minimal or no training in either management or educational theory and design, program directors took on the roles of both faculty manager and resident educator.

By May 30, 1969, 20 residency programs were accredited in Family Practice. By 1975, 3,720 family practice residents had joined 250 programs.

It would be more than 10 years before program directors came together to form the Association of Family Practice Residency Directors (AFPRD) in 1990, led Dr Richard L. Layton, MD as the first President.

Why did family practice residency programs become so popular? Perhaps medical students, patients, hospital administrators and communities recognized what Gayle Stephens postulated in *The Intellectual Basis of Family Practice*:

> Family physicians know their patients, know their patients' families, know their practices, and know themselves. Their role in the health care process permits them to know these things in a special way denied to all those who do not fulfill this role. The true foundation of family medicine lies in the formalization and transmission of this knowledge.
>
> What all this means is that the family physician's role has some constants and some variables; there is no homogeneity nor complete interchangeability among all family physicians… medical educators must look carefully at the role requirements for physicians serving the health needs of a particular area, design a program to meet the obvious components of that role, and allow enough flexibility for special circumstances.

We continue to strive as program directors to help our residents learn their patients, patients' families, practices, themselves and the communities that they serve. Our programs owe a debt of gratitude to these early pioneers, many of whom continue to train residents today as one of the more than 500 accredited family medicine residency programs.

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North American Primary Care Research Group

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

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## RELEVANT OUTCOMES FOR PATIENT-CENTERED INTERVENTIONS FOR PERSONS WITH MULTIMORBIDITY: EXPERTS' DISCUSSION

Although patient-centered interventions for persons with multimorbidity are increasingly implemented in primary health care, evidence on effectiveness is still scarce and inconclusive.[1] One potential explanation is the inconsistent use of outcome measures and a lack of a specific multimorbidity-adapted outcome measure.[1,2] Using the 2015 North American Primary Care Research Group (NAPCRG) Annual Meeting, a forum was held with the goal of creating a list of relevant outcomes and to discussing methods of measurement.

### Forum Process

The forum started with presentations on topics related to multimorbidity: concepts, definition, consequences, development of patient-centered outcome, and 2 intervention research examples. Results of a previous short survey on outcome relevance from the International Research Community on Multimorbidity platform were also presented.[3] The online survey included 27 researchers. The main conclusions were that the most relevant outcome type was patient-reported outcome and most relevant domains of outcomes were self-management, quality of life, empowerment, and health behaviors.

Following the presentations, participants were divided into 3 small discussion groups and provided with 3 clinical vignettes (1 for each group) including 3 questions to initiate the discussion: (1) Have you experienced an intervention in multimorbidity and can you share that experience? (2) Which patient-perceived outcomes have the potential to be modified by the intervention? (3) If you had to build a single patient-perceived measure, what would be the outcomes to consider in order to capture the impact of the intervention?

Summaries of discussions were presented during a subsequent plenary session by each group and identified facilitators were invited to analyze the results on the spot to identify the consensual and relevant elements identified by the groups.

From the discussions, a list of relevant outcomes was created, grouped by categories and prioritized by the participants as the most important to consider when designing intervention for people with multimorbidity. Following the forum, the list of outcomes was