the wisdom of those who have moved on from their chair and administrative roles and to support our goal of developing leaders for the future, especially women and those who are underrepresented in medicine. Learn more at http://www.adfm.org/Membership.

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

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MEASURING AND IMPROVING CONTINUITY IN RESIDENCY PRIMARY CARE PRACTICE

Continuity relationships with the patients that we serve are a cornerstone of Family Medicine. Physician-patient continuity has been shown to be valued by patients, decrease overuse of unnecessary tests, decrease overall cost of care, and improve patient outcomes.[1] Frustration with a lack of continuity in residency practice along with poorly performing residency office-based practices can lead family medicine residents to choose practice settings after graduation that do not include continuity primary care. This deprives our health system of desperately needed family physicians.

The Accreditation Council of Graduate Medical Education requirements for family medicine mandate all family medicine residents to care for a panel of continuity patients. Further, The American Academy of Family Physicians Residency Program Solutions (RPS) Criteria for Excellence suggest that achieving benchmarks of continuity is one measure of a high performing residency program.[2]

To improve continuity, a residency program must first be able to measure it. The measurement of continuity can be complex. Metrics can be measured from the patient or the physician perspective and require physician attribution to a panel of patients.[3] Measurement from the patient perspective reports what percentage of visits were to their assigned physician. The metric from the physician perspective measures the percentage of visits made up of patients assigned to the physician panel. One metric used is the Usual Provider Continuity (UPC) which measures the percentage of visits to the assigned clinician.[4] Ideally, residency programs will query reports from their electronic medical record to automate the measurement of continuity. The RPS Criteria for Excellence suggest programs aim for a goal of 70% of routine patient visits with the patient's family physician.[2] A recent review shows mean UPC in residency program clinics of 56% with a range of 43% to 75%.[5]

Once a residency program has a reliable tool for measuring continuity, the program may implement efforts to improve. While improvement is challenging and complex, Gupta and Bodenheimer suggest the following ways to improve continuity: set goals and display results, increase the number of days each clinician is seeing patients in the office, improve same-day or next-day access for all clinicians, and enforce a practice.[3] Policy on continuity and access including training of telephone and front desk personnel. Residency programs across the country have demonstrated that improvement can be made and sustained in a residency practice.[4,6]

The AFMRD, in our mission to inspire and empower family medicine residency program directors to achieve excellence in family medicine residency training, has embarked on a collaborative with the University of California San Francisco Center for Excellence in Primary Care (CEPC). In 2018-2019 we are connecting 18 family medicine residency programs with the CEPC to invigorate the current and future workforce in primary care through the building blocks model for high-performing teaching practices. We hope this collaborative will inspire improvement in these and other residency teaching practices. Our residency practices, our residents, our family medicine workforce, and our patients will benefit greatly from a focus on improving continuity.

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FIRST INTERNATIONAL CONFERENCE ON PRACTICE FACILITATION: A SUCCESS!

Over a decade ago, at the 2007 annual Practice-based Research Network (PBRN) meeting, Melinda M. Davis and Zsolt Nagykaldi first met while participating on a panel on responsibilities and training for practice facilitators (PFs). The profession of practice facilitation has grown substantially since, with support from the Agency for Healthcare Research and Quality (AHRQ), emergence of multiple practice facilitator training programs, and an increasing interest in translating evidence into practice through research and practice improvement initiatives. In recognition of the needs of the emerging professional community of PFs and the opportunity to advance the science and best practices of practice facilitation, members of the Coordinated Coalition of Networks (CoCoNet2), an AHRQ Center for Primary Care Practice-Based Research and Learning, secured grant funding with the support of the North American Primary Care Research Group (NAPCRG) to host the first International Conference on Practice Facilitation (ICPF) on November 29-30, 2017 in Louisville, KY.

ICPF 2017 attracted over 120 attendees, including active PFs, PF managers, and other PF stakeholders. Attendees represented 68 organizations across 37 states and provinces with close to 10% Canadian participants. The ICPF 2017 agenda addressed 4 themes: (1) Building a learning community, (2) Enhancing sustainability and management of practice facilitation programs, (3) Improving training and professional development, and (4) Building the science and best practices. Conference co-chairs Drs Davis and Nagykaldi welcomed participants and led them through plenaries, innovative session formats (eg, speed think-tanks, professional town hall), and networking opportunities intended to foster meaningful interaction and learning.

Day 1 activities focused on building relationships and a shared understanding of practice facilitation. William Hogg, MD delivered the first plenary on "The Past, Present and Future of Practice Facilitation: An International Perspective" describing various models of facilitation in the United States, United Kingdom, Australia, and Canada, evidence on effectiveness, and opportunities for future research. Small group discussions reflected on the plenary and personal experience to build a shared understanding of who PFs are, what they do and where, and how they are supported.

Next, a series of speed think-tanks co-facilitated by PFs and program leads addressed challenging and critical topics that ranged from "The Practice Facilitator's Role with Health Information Technology" to "Practice Recruitment, Engagement, and Retention," and "Moving Beyond the Clinic Walls: The Role of Practice Facilitators in Engaging Stakeholders." Happy hour and dine-around groups closed out the day's activities.

Day 2 began with breakfast roundtables and focused on variation in practice setting and on building a learning community for those engaged in practice facilitation. Three mini-plenaries provided an overview of PF programs in different environments including academic settings, a public health approach for success in payment reform, and health systems and payer-based programs. Key takeaways from small group discussions highlighted expansion of practice facilitation primarily from PBRN settings to programs housed in health systems, payers, and public health programs.

As part of the a' la carte series, national experts gave brief presentations on PF training and courses, successful regional programs, and methods to evaluate effectiveness. The second plenary by Michael Parchman, MD, MPH on "Strategies to Build a Professional Learning Community (PLC) for Practice Facilitation" was followed by a Town Hall hosted by Mindy Stadtlander, which engaged attendees in a lively discussion on building and sustaining a PLC. As one attendee commented, "I came away with a sense of community and felt inspired to try some creative new things." Areas of interest for the PLC included tailoring activities for different target audiences, creating a repository of tools and resources, clarifying skills and competencies, and refining criteria for training programs and skills development.

Six rapid learning workshops provided attendees with tools and resources on topics including program supervision, academic detailing, cognitive task analysis, value-based healthcare, evaluation, and patient/community engagement. The conference concluded with a discussion of key stakeholder groups through the 30-minute "Solution Shop: Do you have Questions? We Will Find Answers!"