ache, as well as common conditions such as hypertension, diabetes, and cardiac disease. In addition, there are categories for types of preventive care and knowledge about pharmacology and disease processes.

We realized that we would need some brief definitions to clarify the difference between such things as urgent and acute, for example. In terms of urgency, acute may mean a problem that requires immediate attention, but in terms of duration it may simply mean a problem that lasts for a limited time. The need for definitions is particularly true for the age category, because the group chose the term *older adult* rather than *geriatric* in order to include problems that become more common starting around age 50, such as arthritis and Parkinson's disease.

The final step in implementing a new blueprint will be to determine percentages for these categories and to gather evidence that these percentages are appropriate for defining the content of the exam. In the past we have looked at data from the National Ambulatory Medical Care Survey (NAMCS) from the National Center for Health Statistics.[3] This provides information about the frequency of ambulatory care visits to family physicians for a large number of problems, and this does help to support the blueprint, but it is also limited by the fact that it does not include nonambulatory settings where family physicians see patients, such as nursing homes, emergency departments, and hospitals.

In addition, it is important to keep in mind that the NAMCS data is strictly a frequency-based guide to the problems that family physicians see in an ambulatory setting. The frequency of particular health problems is not the sole criterion for evaluating the knowledge and skills that family physicians need, however. If that were the case a large number of our questions would be devoted to upper respiratory infections and ear infections. Minor problems such as this are common but they have a lower potential for harm than some less common problems such as meningitis. The ABFM has recently worked on an Index of Harm that can be associated with the NAMCS data. The Index of Harm for the diagnoses listed in NAMCS was assigned by a group of practicing family physicians, and these values were used in studies that evaluated how well the current ABFM blueprint represents both the Index of Harm and frequency, based on the 2012 NAMCS data.[4,5] We expect to use a similar methodology to produce the initial content category weights with the new blueprint.

The design of an examination used to make a decision about whether a physician should be certified should be evidence-informed but not evidence-based. We need to ask about problems that carry a significant potential for harm, we need to place extra emphasis on problems that require training and skill to diagnose and manage, and we need to ask about how to maintain patient health. The blueprint should take all of these factors into account if board certification is to be meaningful to the public.

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STFM 2020-2025 STRATEGIC PLAN OUTLINES FUTURE DIRECTIONS

STFM spent much of 2019 working on the 2020-2025 update to its strategic plan. As part of the strategic plan update process, the Strategic Planning Committee (SPC) assessed the previous goals and strategies and the achievements of the organization in relation to the current plan, and reviewed results of extensive data collected from the STFM member needs survey, interviews with current and past members, a staff survey, and SWOT (strengths, weaknesses, opportunities, and threats) analyses performed by each STFM standing committee.

The mission of the Society of Teachers of Family Medicine is to advance family medicine to improve health through a community of teachers and scholars. STFM relies on its core values of diversity, integrity,

relationships, openness, nurturing, and excellence to achieve this mission.

"I'm really pleased with the work of the Strategic Planning Committee and the STFM Board in laying out the plan for STFM for the next few years. There are some exciting new directions and important challenges for us to tackle."
— STFM President Frederick Chen, MD, MPH, University of Washington

The Strategic Plan is divided into 5 key areas: professional and leadership development, workforce recruitment and retention, scholarship, health equity, and advocacy.

Professional and Leadership Development

GOAL: STFM will be the leader in training, leadership development, and creation of knowledge that improves family medicine education and teaching.

OBJECTIVES

- Provide family medicine faculty with the skills needed to train students, residents, and health care teams to achieve better health, quality care, value, and improved work life of clinicians and staff
- Develop STFM members and their learners into solutions-focused, adaptable leaders within and across our health care systems
- Develop the family medicine education workforce to meet the unique needs of communities, especially in rural settings and in community health centers

Workforce Recruitment and Retention

GOAL: STFM will inspire individuals to become exemplary, fulfilled, and compassionate family medicine teachers.

OBJECTIVES

- Transform family medicine training sites for students and residents into clinical and teaching models of excellence
- Increase the number of family medicine faculty to address the broader goals of the 25x2030 collaborative
- Promote well-being and resilience at the personal and system level

Scholarship

GOAL: STFM will raise the bar on family medicine educational scholarship.

OBJECTIVES

- Promote adoption of best practices of educational scholarship
- Build the educational scholarship capacity within the discipline
- Build the quality improvement capacity within the discipline
- Partner with health care systems to better support medical education scholarship in training program

Health Equity

GOAL: STFM will drive the health equity of communities through medical education.

OBJECTIVES

- Engage in partnerships to contribute to the health equity of communities through medical education
- Increase the skill set of family medicine faculty related to health equity
- Increase the diversity of family medicine faculty and the diversity of learners with an interest in teaching

Advocacy

GOAL: STFM will champion family medicine education, research, and workforce recruitment and retention.

OBJECTIVES

- Develop and communicate the business case for family medicine education, including the financial and patient impact
- Advocate for the teaching and practice of comprehensive family medicine
- Teach advocacy skills to family medicine educators and learners
- Lead and support the Academic Family Medicine Advocacy Committee and its legislative priorities, including identifying new strategies to mobilize STFM members to be advocates for our academic issues

A number of assumptions about key areas of importance to STFM are woven into the plan. As a result, there is not a separate goal or objective for these areas, but they will be incorporated as part of every applicable activity. These assumptions include: diversity, URM definition, strong infrastructure, innovation, collaborations, communications, technology, support for the STFM Foundation, and regular examination of member benefits.

STFM thanks facilitator Stan Kozakowski, MD, and the SPC for its excellent work in drafting the 2020-2025 STFM Strategic Plan. A tremendous amount of research and discussion has gone into this effort, and we appreciate their commitment to this important task. Members of the SPC included Freddy Chen, MD, MSPH; Renee Crichlow, MD; Joe Gravel, MD; Cristy

Page, MD; Heather Paladine, MD; Andrea Pfeifle, EdD; Randall Reitz, PhD; Beat Steiner, MD, MPH (SPC Chair); Stephen Wilson, MD, MPH; Stacy Brungardt, CAE; and Mary Theobald, MBA

Traci Brazelton, CAE, STFM

ADFM Association of Departments of Family Medicine
VISION, VOICE, LEADERSHIP

From the Association of Departments of Family Medicine

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WHAT DOES POPULATION HEALTH MEAN TO YOU IN YOUR INSTITUTION?

A Summary from Academic Family Medicine Departments

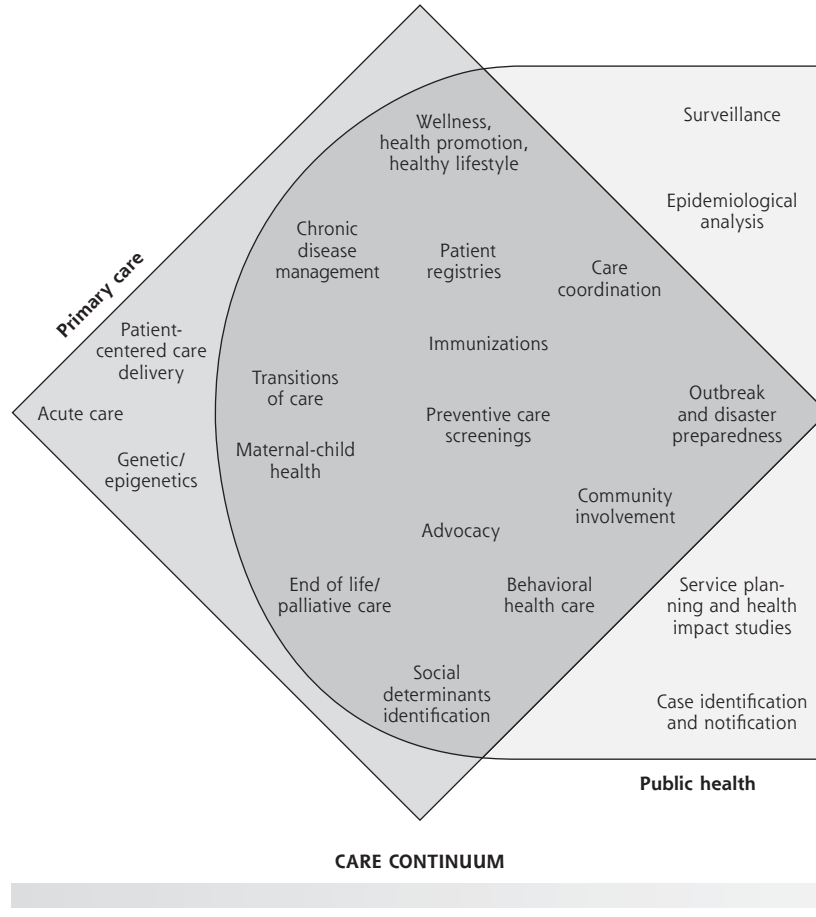
On our 2018 ADFM Annual Survey, we asked the membership, "What does population health mean to you in your institution?" Responses addressed definitions, policies, strategies, processes, and tools related to the clinical, educational, and research implications of population health. Main findings from a simple coding of themes included:

1. The plurality of departments finds a broad definition of population health useful. Attention to the population requires an emphasis on the broader community. Key elements include defining the community, assessing the needs of the community, and improving the health based on commonly agreed upon outcomes. How the broader community is defined is problematic. (Is it payor defined, a geographic entity, or some other construct?) The role of equity and justice is important to some. Attention to the social and structural determinants of health is a key driver for many. Some say population health efforts require advocacy around policy change to be authentic. Additionally, some suggest the rigor of research is necessary.

2. Some departments see their institutional efforts focusing inward on their practices; this is also called population health management or population medicine. A key part of the efforts within these institutions and departments involves community-based multidisciplinary outreach to patients who have poorly controlled chronic conditions or at-risk behaviors aligning with broader efforts to improve the health of all in the community. Advocating for improved resources within the community served by the practice may also include collaboration with public health entities, NCQA certification and alternative payment models such as CPC+.

3. A few departments indicated that their institutions relate population health to the shift to value-based payment. These departments see population

Figure 1. Integration of primary care and public health: the care continuum.



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