From the American Board of Family Medicine

Ann Fam Med 2022;20:287-289. https://doi.org/10.1370/afm.2840

BUILDING PRIORITIES IN HEALTH & HEALTH CARE INTO ABFM'S KNOWLEDGE ASSESSMENTS

In January 2021, the Board of Directors of the American Board of Family Medicine (ABFM) decided that emerging priorities in health and health care should become an explicit component of knowledge assessment in the future. ABFM examinations and self-assessment activities are comprised of a balance of items representing the competencies within family medicine. The composition of these self-assessments and the examinations is guided by a "blueprint" that reflects current knowledge expected of every family physician regarding diagnosis and treatment in daily practice. These items are written and reviewed by volunteer family physicians who practice in a wide variety of settings across the country; the topics come from their clinical practice along with recent evidence and practice guidelines.

The Board is now adding a new explicit and proactive process to ensure that broad trends impacting the clinical practices of family physicians are reflected in the certification examination. It is not enough for family physicians to have knowledge to practice today. As the largest and most widely distributed group of primary care physicians, and as leaders in responding to emerging health problems, family physicians must address future challenges in practice. Mastery of the specific clinical knowledge will be an important foundation of that work. In this editorial, we describe the process, review the topics chosen, and describe the implications for Diplomates.

Identifying the most important emerging trends is difficult in a generalist specialty like Family Medicine. The list of possible topics is inevitably long, and prioritization is important. Our goal was to identify the most important trends in health and health care for the next 3 to 5 years which will influence clinical decisions in the office, at the bedside, or wherever family physicians practice, and which are appropriate for assessment by multiple choice questions.

We used an iterative evidence-informed process. ABFM senior staff identified possible trends in health and health care, and the ABFM Board of Directors and a national blueprint advisory panel added additional topics to identify a total of 15 options, listed alphabetically in Table 1. Staff then developed brief evidence summaries supporting each one, based on current trends and burden of suffering—prevalence, incidence, morbidity, mortality, and cost. Then, over 2 meetings, the ABFM Board narrowed the list to 7 topics, taking the input and prioritizations of the national blueprint panel and ABFM executive staff into account. There was good concordance across the groups, and the final list was approved by the ABFM Board of Directors in January 2022.

All the proposed topics in Table 1 are important: the final priorities represent a clinical judgement, balancing what is known about burden of suffering and near-term trends in health care with constraints inherent in the process of writing multiple choice questions for the examination. Table 2 lists the final ABFM priorities, in order of the voting, with definitions and a brief rationale for their selection: Health Equity,[1-4] Social Determinants of Health,[3] and Structural Racism[4]; Value Based Care[5] and Population Health[6]; Behavioral Health including Adolescent Suicide[7,8]; Multimorbidity[9-11]; Opioid Abuse and Addiction[12,13]; Embracing Technology (Point of Care Ultrasound,[14] Genomics in Primary Care,[15] and Artificial Intelligence/Machine Learning); and Obesity and Activity.[16,17]

What are the next steps for ABFM and for Diplomates? The initial task will be to review our existing multiple-choice questions and explore how well these topics are currently addressed; we will likely need to create new questions for some of these topics. Of note, it will be difficult to write questions for some of these topics, such as social determinants of health: it is easy to write questions, hard to write *good* questions! These topics will then be distributed throughout the knowledge assessments in the ABFM certification portfolio—longitudinal assessment, the one-day certification exam, the In-Training-Exam for residents, Continuous Knowledge Self-Assessment and potential future Knowledge Self-Assessment modules. Of course, it is important to keep in mind that cognitive expertise is only one of the major requirements for Board Certification: commitment to professionalism, lifelong learning and performance improvement are also critical.

Table 1. Possible Priorities in Health and Health Care

Behavioral health including adolescent suicidality
Impact of climate change on health and illness
COVID prevention, diagnosis, prognosis and treatment
Functional medicine
Genomics to guide diagnosis and treatment
Health equity, social determinants of health, and structural racism
Integrated behavioral health
LGBTQ+ health and health care
Lifestyle medicine
Rising maternal mortality and morbidity
Multimorbidity
Obesity, including nutrition and inactivity
Opiates, addiction, and pain management
Integration of point-of-care ultrasound in clinical practice
Value-based care and population health

Table 2. ABFM Priorities in Health and Health Care, 2022

ABFM priorities in health and health care	Definitions and selected rationale
Health equity, social determinants of health, and structural racism	• Health inequities exist when health outcomes differ between populations, including factors such as race or ethnicity, gender, sexual identity, age, disability, socioeconomic status, and geographic location.[1] • Unequal care across race and other factors has long been recognized in the United States, and manifests in differences in access, care process, and outcomes;[2] COVID-19 provides another example. • Social determinants of health include economic status, education access and quality, health care access and quality, neighborhood and built environment, social isolation, and community context.[3] • Structural racism in health care includes differential access and financing of care and extends to specific clinical knowledge based on a false assumption of racial genetic differences, such as in pulmonary function tests (PFT), estimated glomular filtration rate (GFR), or pain tolerance.[4]
Value-based care and population health	• The US health care system is the most costly in the world. • Value-based care is a "health care delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes."[5] Promised for many years, it is becoming more common in many marketplaces. • Potential assessment topics: empanelment, principles of population health, evidence-based performance measures and patient centered outcomes, team-based care and the role of primary care, health systems and payers in improving outcomes.[6]
Integrated behavioral health, including adolescent suicide	• Integration of behavioral and physical health improves outcomes; the new standards for residency training will require it. • Before pandemic, 7% of adolescents had a depression diagnosis, 13% had anxiety, and 19% of high schoolers had considered suicide[7]. Post pandemic, the proportion of mental health-related emergency department visits among adolescents increased 31% in 2020 compared with 2019.[8]
Multimorbidity	• Multimorbidity is the co-occurrence of 2 or more chronic conditions.[9] • Older adults with multimorbidity utilize 2-5 times more physician appointments than patients without multiple conditions.[10] Overall, multimorbidity causes the majority of mortality, morbidity, and cost in the United States. • Over the last generation, there has been a rapid and accelerating rate of multimorbidity. According to the 2018 National Health Interview Survey, nearly 30% of US adults have multiple chronic conditions. Prevalence has grown from 21.8% in 2001 to 27.2% in 2018.[11]
Opioids, addiction, and pain management	• An estimated 10.1 million people in the United States misused opioids in 2019[12], and nearly 100,000 people died from opioid overdoses in 2020. From March 2020 to March 2021, overdose deaths across the country increased nearly 30%.[13]
Embracing technology (POCUS, genomics, artificial intelligence/ machine learning)	• Point-of-care ultrasound can improve care and be learned by family physicians[14]; the new ACGME standards highlight point-of-care ultrasound (POCUS) training. • Genomic medicine uses individual genomic information in clinical care and addresses the health outcomes and policy implications of that clinical use."[15] • The rapid spread of AI/machine learning presents opportunities for deeper knowledge use by physicians.
Obesity, including nutrition and inactivity	• Between 1999 and 2018, US prevalence of obesity increased from 30.5% to 42.4%, and morbid obesity increased from 4.7% to 9.2%. • Obesity increases risk of heart disease, stroke, type 2 diabetes, and certain types of cancer.[16] • The US Preventive Services Task Force (USPSTF) recommends that physicians promote behavioral interventions such as physical activity as the primary focus of effective interventions for weight loss in adults.[17]

Beyond our examination, we hope that setting these priorities will support the clinical evolution of our specialty as it recovers from the pandemic. The proposed ACGME residency standards[18] represent a bold vision of community engagement and emphasize that the practice is the curriculum, including integrated behavioral health and POCUS. The ABFM priorities align well with the draft residency standards.

ABFM will revisit the priorities in 3 years: given the dramatic changes in health and health care that are taking place, the priorities will likely evolve over time. We encourage suggestions for the future.

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STFM SOCIETY OF TEACHERS OF FAMILY MEDICINE **From the Society of Teachers of Family Medicine**

Ann Fam Med 2022;20:289-290. https://doi.org/10.1370/afm.2839

STFM TASK FORCE RELEASES A STANDARDIZED FAMILY MEDICINE SUB-INTERNSHIP CURRICULUM

An STFM task force has released a standardized STFM Family Medicine Sub-Internship Curriculum with a set of flexible guidelines for providing a high-quality advanced clinical rotation for medical students.

The sub-internship is an advanced clinical rotation that provides students with advanced training in the knowledge, skills, and attitudes that are foundational to family medicine. By the end of the sub-internship, students should be ready to assume the role of a family medicine intern.

Sub-internships are an important transition-point from student to resident. Students are challenged to perform at a higher level than what is expected during their clerkship rotations, at the level of an intern. Through immersion in residency programs, students gain firsthand exposure to the breadth and culture of the specialty, which can help confirm interest in the field. A family medicine sub-internship often serves as an "audition rotation," where both the student and the residency program evaluate each other for performance and fit. For medical schools, a sub-internship rotation is a valuable opportunity to measure whether students have achieved a level of competence that will allow them to graduate school and start clinical training as physicians.

Curriculum Design

In 2019, the STFM Medical Student Educators Collaborative identified a need to have a unique sub-internship curriculum specifically for family medicine. A diverse task force of UME and GME educators, residents, and students, was charged with developing and maintaining a standardized curriculum with support by STFM.

"By creating a sub-I curriculum that is specifically for family medicine, it made us consider what it means to be a family physician, and how we are very different from every other specialty," said Tomoko Sairenji, MD, MS, task force chair.

The task force solicited data and voices of the family medicine education community through collecting CERA Clerkship survey data, running focus groups at the STFM Conference on Medical Student Education in 2020, and using the STFM Connect listserv. As a result of both the survey and the focus groups, the following conclusions were drawn and used to inform the curriculum's development:

- Family medicine is practiced differently across the country, so a national sub-internship curriculum needs to allow flexibility