Family Medicine Updates

From the Association of Departments of Family Medicine

From the North American Primary Care Research Group

From the Association of Family Medicine Residency Directors

From the Society of Teachers of Family Medicine

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ORGANIZING OUR ACADEMIC ORGANIZATIONS FOR THE FUTURE OF FAMILY MEDICINE

Introducing the Council of Academic Family Medicine (CAFM)

Unless there are changes in the broader health system and within the specialty, the position of family medicine will be untenable in a 10-20 year timeframe.

–Future of Family Medicine Report, 2004

How should academic family medicine organize to help make the future of family medicine a reality? The paradox is that the Association of Departments of Family Medicine (ADFM), the Association of Family Medicine Residency Directors (AFMRD), the North American Primary Care Research Group (NAPCRG), and the Society of Teachers of Family Medicine (STFM) are all individually thriving, but the discipline is not. About 20 years ago, the Academic Family Medicine Organizations (AFMO) was organized to facilitate coordination of efforts among our various groups, but its added value has been primarily limited to legislative advocacy. Therefore, about 2 years ago, the leadership of ADFM, AFMRD, NAPCRG, and STFM began to explore how they can work together more effectively. The result is the Council of Academic Family Medicine (CAFM), which was launched in January 2008. What follows summarizes key questions about CAFM: (1) Why CAFM, and what are its goals? (2) How does CAFM do its work? (3) How does CAFM relate to its constituent organizations and to the AAFP and ABFM? (4) What is CAFM working on now and how should we measure success?

Why CAFM?

Our discipline is the heart of primary care in America; however, without fundamental changes both in the broader health system and in our discipline, our survival is in doubt, and the health of the public is at even greater risk. We believe that our academic organizations have important contributions to make to the discipline. In order to do this, however, we need to change the way we work together. Our multiple organizations have brought forth ideas and activity in abundance, but we have also missed opportunities, and duplication of effort has resulted in inefficiency. CAFM aspires to be a new way of working together, coordinating activities where there is overlap, and moving strategically on behalf of academic family medicine and the discipline.

What Are the Goals of CAFM?

- To provide a unified voice for academic family medicine. All too often our voices have not harmonized, lessening our impact and impeding our mutual progress.
- To provide a unifying influence for working together more effectively. Each of our academic organizations is very active; CAFM hopes to provide a forum for communication among organizations and to coordinate initiatives to increase speed and impact.
- To provide a place for outside organizations to come to collaborate. Over the years, our discipline has lost opportunities because outside organizations got mixed messages or did not know whom to approach.

How Does CAFM Work?

CAFM consists of the leadership of ADFM, AFMRD, NAPRCG, and STFM (generally the President, President Elect, Past President, and Executive Director). Whereas individual organizations are the foundation of CAFM, our common commitment is that each of us brings to CAFM a focus on the common good of academic family medicine, the discipline, and the patients we serve.

The leaders of 7 family medicine organizations (AAFP, ABFM, and AAFP Foundation, along with ADFM, AFMRD, NAPCRG, and STFM) meet at the

Working Party in January and August. CAFM also meets face-to-face immediately before each Working Party, in addition to monthly conference calls. In addition, in January of each year CAFM conducts an environmental scan from the perspective of academic family medicine and then uses this scan to prioritize common projects. We use a multi-step nominal group process to develop and select new projects while reviewing the progress of current projects.

CAFM is designed to be a task-oriented group: the aim is that you will know us by what we accomplish. Each project represents a strategic initiative on behalf of academic family medicine that has been prioritized by the group. Each project has lead organizations, typically 2, along with identified leaders, specified products/outcomes, and an anticipated timeline; in most cases there are working committees with representation pulled from all organizations as appropriate to the topic.

The Chair of CAFM facilitates the face-to-face and telephone meetings, working closely with staff to manage ongoing projects. Most decisions are made by consensus. Election of Chairs takes place in January, with assumption of office at the August meeting. Warren Newton, MD, MPH, has served as the founding chair, and Perry Dickinson, MD, takes over in August 2008. Ardis Davis, MSW, provides staff services. Reflecting CAFM's coordinating role and reliance on the volunteer time of the members, costs are modest—an extra day at the 2 meetings for each person, conference calls, and 0.05 of a staff member—and are shared equally.

What is the Relationship Between CAFM and Its Constituent Organizations?

The foundation of CAFM is its 4 constituent organizations—ADFM, AFMRD, NAPCRG, and STFM. Their ongoing activity is critical to academic family medicine. The intent of CAFM is not to override constituent organizations but rather to coordinate work and launch new strategic initiatives.

How CAFM proceeds depends on the specifics of the issue. A first step is to identify which organizations should take leading roles. For example, as the group considered the goal of developing an Internet-accessible core curricula for family medicine residencies, it seemed clear that both AFMRD (through specific projects in Washington and South Carolina), and STFM (through the Family Medicine Digital Resource Library [FMDRL]) were vitally involved, and so they were assigned as the leads to the project. In pursuing the issue further, we consulted with AAFP leaders in the process, because electronic access to their enduring materials seemed to be critical. CAFM's role is to select initiatives, identify leaders and key partners, and then to support the leaders and manage the process.

Some issues require input of the boards of the constituent organizations. For example, one of our initial projects has been to develop a joint recommendation for changes in the obstetrics requirements in the family medicine RRC document. Given both the importance and the potential divisiveness of the issue, we judged that it was critical to get broad input from all the boards (and beyond).

Other less weighty issues have begun to come to CAFM, and we have addressed them ad hoc. For example, when NIH requested input on the peer-review process, NAPCRG invited the other CAFM organizations to participate, and individuals from NAPCRG, ADFM, and STFM wrote the document. The comments were not controversial; when the response was developed, CAFM organizations approved the document so that it would carry the voice of all of academic family medicine.

What Is the Relationship Between CAFM, the AAFP, and the ABFM?

Our intent is that CAFM will help academic family medicine partner more effectively with our colleagues in the AAFP and the ABFM for the common good of the discipline. Having partners from the AAFP and ABFM involved has been critical in many of our projects. For example, the AAFP's political clout is critical to access on Capital Hill and the NIH. We have invited representatives of the AAFP as liaison to the process of creating CAFM and kept the leadership of the ABFM informed; we also have involved each of them in specific projects as appropriate—for example, both the AAFP and the ABFM have contributed key data for the hospitalist task force. At the same time, we believe that there are distinctive contributions that the academic organizations can make to the discipline, and look forward to dialog with our partner organizations.

Our hope is to work with the AAFP and the ABFM to better coordinate our joint activities. The Working Party itself provides a valuable information-sharing opportunity, but is not designed for action. The best models for collaborative action across our discipline have been the coordinated activities around the Future of Family Medicine and the *Annals of Family Medicine*. We believe that, as a discipline, we face many challenges that could benefit from joint action—and that improved coordination can be attained through CAFM without losing the value of information sharing at the Working Party.

What is CAFM Working on Now?

Our current projects include:

1. Developing a high-quality national board exam for family medicine—As medical schools emphasize shelf exams as key outcomes of their programs, the

lack of a quality board exam has disadvantaged family medicine clerkships across the country. Historically, family medicine has not had a coordinated voice when interacting with the NBME. The purpose of this task force is to build on STFM's earlier work with ADFM and engage the NBME to develop a good-quality board exam; this effort, in turn, is leading to the development of a consensus core curriculum for the family medicine clerkship.

2. Developing a new RRC requirement for maternity care—RRC requirements for maternity care are controversial. Believing that change is necessary, CAFM has committed to developing a common recommendation for change, building on the survey of residency directors about this issue.

3. Addressing the implications of the hospitalist movement—Over the last decade, the hospitalist movement has reshaped our discipline and had an extensive impact on our training programs, without substantial response from the discipline. A CAFM task force is conducting a formal evidence review of the effectiveness and spread of hospitalists, and will develop consensus recommendations regarding how the discipline should respond in both the academic and clinical realms.

4. Disseminating opportunities for revenue enhancement across academic family medicine—In a time of cuts in clinical reimbursement, Title VII, and other lines of federal grants, generating new revenue from a wide variety of sources is critical for our residencies and departments to thrive. This task force has collected a variety of best practices and will disseminate them through annual meetings of each of our organizations.

5. To develop a core residency curriculum and make it available on the Internet—Residency and clerkship directors now create many curricular materials in isolation: would it be possible for faculty to share curricula across sites, spreading their creativity and lowering the cost for teaching programs? This project will start with residency curriculum and explore the feasibility of such an initiative, building on the success of the FMDRL and pilot projects at the Swedish Family Medicine Residency Program in Washington and at the Medical University of South Carolina. The AAFP has been involved, and an initial focus was intellectual property. Now the group is developing and market testing a sample module and overall business plan.

6. To develop our residencies and medical student teaching practices as patient-centered medical homes—The last year has seen increasing recognition of the importance of the framework patient-centered medical homes. The purpose of this task force is to partner with our residencies and medical student teaching practices to promote their development as patient-centered medical homes. The first phase is to ascertain how well our teaching practices are functioning now as patient-centered medical homes and to catalog current efforts across the discipline to develop our teaching practices as medical homes.

How Will We Know if CAFM Is Successful?

We believe that CAFM has shown early success. As a council, we developed a unified response to the NIH in their evaluation of the peer-review process, facilitated involvement of family medicine departments and researchers in the CTSA process, and have stimulated more program content on revenue generating across our organizations' annual conferences. With regard to working together more effectively, CAFM's involvement with the NBME has helped lead to a significant improvement in the exam and laid the foundation for ongoing collaboration.

How should we judge the value of CAFM to academic family medicine and to the discipline in the longer term? Fundamentally, our success will be reflected in improvement in the health of academic family medicine and in the discipline overall. For example, have we helped create a high-quality board examination for our clerkships? Have we responded to the hospitalist movement in our residency curriculum and practice? Will the next revision of RRC requirements reflect evolving realities of practice? Have departments and residencies developed new funding streams?

How Will We Continue to Communicate About CAFM?

If CAFM is to be successful, it must be integrated into the ongoing work of each of the organizations. Each will need to develop a strategy for communication. The boards of each organization have been extensively involved in the development of CAFM and are now considering how to publicize it within their membership. A key first step is the integration of CAFM projects into the work of standing committees and task forces in each of the organizations. Beyond that, direct communication about CAFM in articles like this, as well as at meetings, will be necessary.

If you have questions or comments about CAFM, feel free to contact your own organization's leadership (President, President-Elect, Immediate Past President, or Executive Director), or you can contact Ardis Davis at ardisd7283@aol.com or (425) 423-0922.

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