2025 Confab Agenda - January 15-17, 2025

Hyatt Andaz Napa, Napa Valley (Downtown), CA

CA:	**Lisa Folberg**	**NC:**	**Greg Griggs and Shawn Parker**
FL:	**Jay Millson & Lucille Killgore**	**OH:**	**Kate Mahler (supporting presentation only)**
IL:	**Gordy Krkic and Jennifer O'Leary**	**TX:**	**Tom Banning and Kathy McCarthy**
MD:	**Becky Wimmer**	**WI:**	**Brandon Wimmer**

Wednesday, January 15	
6:00pm – Dinner	Compline - 1300 First Street #312, Napa (2 blocks from Andaz – 6pm&6:15 res, 2 tables for 6)
Thursday, January 16	
8:00 – 8:30am	Breakfast – In Meeting Room
8:30 – 9:45am	Internal: Tips, Hacks, Tricks & Shits– Roundtable Discussion – Moderator Jay
9:45 – 10:30am	P1: AAFP Election Nomination Process: Good, Bad, or Indifferent- Greg
10:30 – 10:45am	Break
10:45– 11:30am	P2: ACLF, CELP Fostering Positive Chapter and National Relationships- Lisa
11:30 – 12:15pm	P3: AAFP's CME Reporting Tool: Member Benefit or Administrative Burden- Lucille & Kate
12:15 - 1:00pm	Lunch – in meeting room at hotel
1:15 – 1:45pm	P4: Member Advocacy: Latest & Greatest Value Propositions- Brandon
1:45 – 2:15pm	P5: New Physician Programing- Gordy & Jen
2:15 – 2:45pm	P6: New Physician Retention Pilot Update – Kathy
2:45 – 3:15pm	P7: Role of the International Medical Graduate: State Perspectives- Shawn
3:15pm	Wrap-up – option to leave early to enjoy Yountville
6:30pm - Dinner	Bottega - 6525 Washington Street, Yountville, CA 94599 15 min drive – 6:30pm res, 2 tables for 7)
Friday, January 17	
8:00 – 8:30am	Breakfast - In Meeting Room
8:30 – 9:30am	Roundtable: Chapter Staffing, Flat Ceilings, Challenging Issues Workforce – Moderator Shawn
9:30 – 10:00am	P8: Communications and Good Governance Working with your Board – Gordy & Jen
10:00 – 10:30am	P9: Primary Care Investment – ROI in Maryland and Elsewhere – Becky
10:30 – 11:00am	P10: Association Loyalty - A Global Perspective- Jay
11:00 – 11:30am	P11: Future of Family Medicine 20 Years Later: For Better or Worse - Tom
11:30 – 12:00pm	Wrap up – takeaways and plans for next year
12:00pm	Lunch On Your Own, Departures, and Safe Travels

AAFP Election Nomination Process: Good, Bad, or Indifferent

Background – What Was Approved

- 2023 Congress of Delegates adopted a new process for elections.
- Nominating Committee created and charged with identifying annual leadership needs of the AAFP, potential candidates, soliciting applications and providing a slate of qualified candidates by March 31.
- Nominating Committee composed of a chair (appointed by Speaker and Board chair), 3 non-voting ex-officio members (Board Chair, Resident Board Member and Chair of Commission on DEI); 3 voting members selected from past and current COD Delegates and Alternates; 3 members selected from past AAFP Directors; 3 members at large, directly nominated by the Chapters; 3 members from the past three years of NCCL Advisory Group members. (Staggered terms). No nominating committee member shall run for office for at least 2 years after their service on the committee.
- Chapter can nominate someone who was submitted but not included in the slate, but at expense of nominating chapter.
- Any member can self-nominate or be nominated from the floor of the COD.
- No candidate activities shall be permitted prior to the release of the Nominating Committee Slate.
- AAFP provides the following support for all candidates nominated by the Nominating Committee other support by AAFP entities (chapters, MIGs, etc.) is discouraged:
    - Candidate orientation and development program
    - Candidate website
    - Campaign email to all Delegates/Alternates
    - Online Q&A session for any announced candidates
    - Meet the Candidates session at the COD
    - Candidate hospitality event at the COD
    - Candidate form at the COD
    - Reimbursement for travel to AAFP Leadership Conference and COD.
- Much of this now included in Standing Rules of the Congress.

Candidate Campaign Activities and Rules (Approved by Board in Feb. 2024)

- Campaign website available in late May includes: photo, personal statement, bio, CV, listing of candidates' social media (if desired), and a link to a virtual Candidate Q&A forum
- AAFP facilitates one mass email from each candidate to all delegates/alternates.
- Candidates will also receive contact list for all delegates/alternates but are limited to **one** unsolicited outreach per delegate/alternate via **each** modality (direct mail, email, and phone call.) NOTE: most candidates did a mailing, but I am not sure if they used other modalities at all. AAFP did not allow them to get the chapter presidents' list or the chapter executives' list, which you were able to do in the past.
- Candidate hospitality event funded entirely by AAFP. Any gifts or handouts must be of a trivial expense.
- Candidates can attend caucus meetings and reference committee meetings and discuss issues but must refrain from campaigning or soliciting votes.
- No chapter or individual outside of the candidate themselves may provide direct or financial support to a candidate beyond what is described in campaign rules and includes making available resources for speech writing/coaching, meeting attendance, mailings, giveaways, etc.
- Attendance at chapter or regional meetings should be for the sole purpose of participating in the meeting and should not entail any campaign activities.

Other Developments

- At some point, each candidate was given a budget of $1,000 from AAFP for their campaign activities, including giveaways at hospitality booth, any mailings they did, signage at hospitality booth, etc. This is all a candidate could spend on the campaign. AAFP did pay for candidates to go to Annual Leadership meeting and COD separate from this.

- For candidate hospitality event:
    - Any candidate gifts, giveaways, or handouts may not be made available until the Candidate's Hospitality Event.
    - Giveaways must be of a trivial expense, purchased solely with funding provided by AAFP.
    - Any booth décor had to come out of AAFP funding.
    - Additionally, candidates are allowed to purchase an individually customized banner with their name, chapter, and desired office from a standardized offering of options (cost also comes from AAFP funding).

Overall Results

- Generally positive.
- Had six candidates for the first time in a very long time (close to a decade). And had a competitive election for the first time in at least three years. Note: Some candidates were not moved forward by Nominating Committee so more than six candidates applied for the Board.
- It was clear that some candidates did not truly know AAFP COD processes, etc.
- One non-delegate/alternate did win.

Chapter Perspective

- AAFP allowed chapter staff to go to a candidate orientation at ACLF/NCCL this year. Do not think they will in the future. Some chapters did, and some did not.
- Chapters did not get information about rules of engagement, etc. That only went to candidates directly.
- Odd position this year, particularly for President-Elect candidates, because chapters had been involved with them throughout the process in the past.
- There were some things that the Nominating Committee and the Board probably just had not considered going into this. As a result, there were some things that were decided on the fly.
- The change also impacted regional meetings – two of the three were before nominees were named.
- At times, I wondered if it would be good to have a one-pager indicating whether the chapter knows the person, etc., like they do for a commission candidate, but that too could put chapters in a tough position.
- It is fairly clear that chapters will still be involved in some way in certain circumstances. But it does cut down on the cost pretty extensively. However, if a chapter has a leader that they want to run, it is hard to imagine the chapter not providing any guidance at all.

AAFP'S CME REPORTING TOOL: Member Benefit or Administrative Burden

Lucille Killgore (Florida) & Kate Mahler (Ohio)

Napa, California where you are…

Buffalo, NY where I am…

Missing you all terribly…
for many reasons!

AAFP'S CME REPORTING TOOL AS A PRIMARY MEMBER BENEFIT

- The AAFP's recent membership report noted that the CME Reporting Tool is considered by members one of the AAFP's most valuable member benefits.
  - Serves as a vehicle for members to report CME to both the AAFP and the ABFM, as well as other licensing Boards through CE Broker
  - Because of its perceived convenience, this member benefit is considered a "golden handcuff" of membership (a reason to belong to the Academy.)

CME REPORTER TOOL: Current Limitations

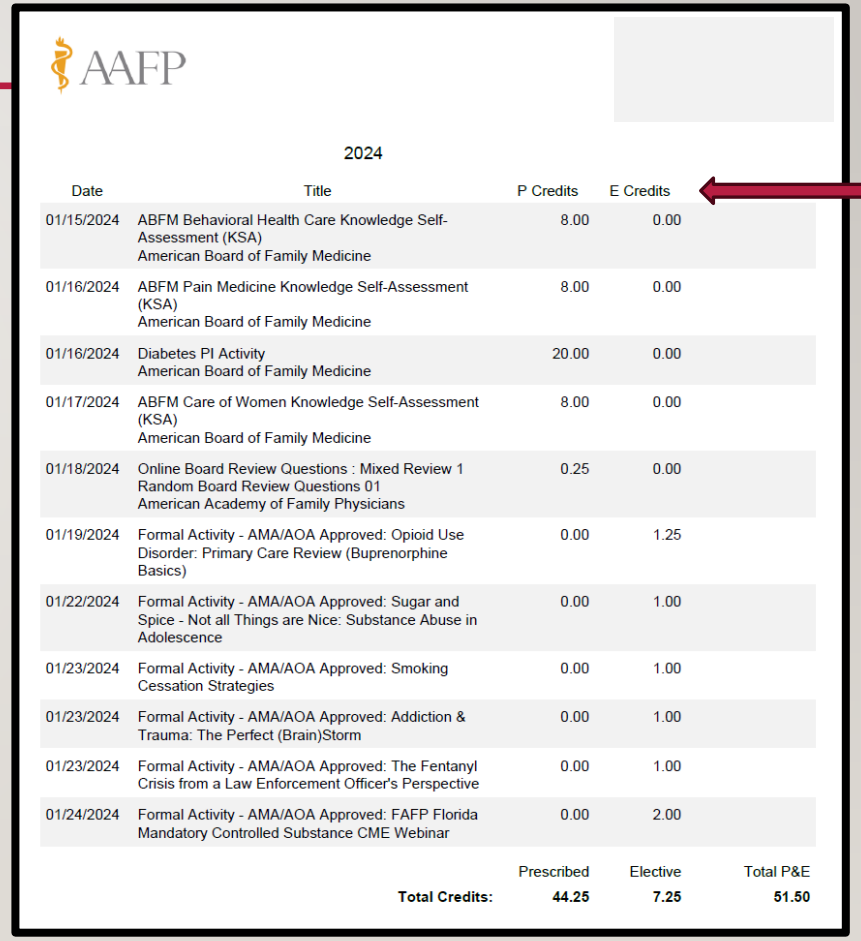
The Core Problem

CME credit submitted via the AAFP Reporting Tool does not recognize CME for its full value which is a problem when the credit is transmitted to the ABFM and to CE Broker.

- A member who submits their CME credit using the AAFP's CME Reporting Tool must either report it as "Prescribed" or "Elective."

Credits that are Prescribed are those approved by the AAFP; all other credits not approved by AAFP are Elective, including those approved by the American Medical Association (AMA) and the American Osteopathic Association (AOA).

How the AAFP CME Transcript Looks Like



AAFP

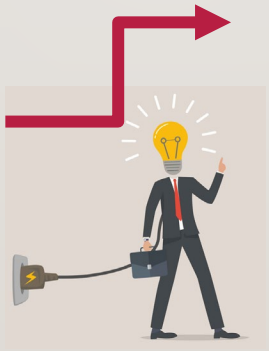
2024

Date	Title	P Credits	E Credits
01/15/2024	ABFM Behavioral Health Care Knowledge Self-Assessment (KSA) American Board of Family Medicine	8.00	0.00
01/16/2024	ABFM Pain Medicine Knowledge Self-Assessment (KSA) American Board of Family Medicine	8.00	0.00
01/16/2024	Diabetes PI Activity American Board of Family Medicine	20.00	0.00
01/17/2024	ABFM Care of Women Knowledge Self-Assessment (KSA) American Board of Family Medicine	8.00	0.00
01/18/2024	Online Board Review Questions : Mixed Review 1 Random Board Review Questions 01 American Academy of Family Physicians	0.25	0.00
01/19/2024	Formal Activity - AMA/AOA Approved: Opioid Use Disorder: Primary Care Review (Buprenorphine Basics)	0.00	1.25
01/22/2024	Formal Activity - AMA/AOA Approved: Sugar and Spice - Not all Things are Nice: Substance Abuse in Adolescence	0.00	1.00
01/23/2024	Formal Activity - AMA/AOA Approved: Smoking Cessation Strategies	0.00	1.00
01/23/2024	Formal Activity - AMA/AOA Approved: Addiction & Trauma: The Perfect (Brain)Storm	0.00	1.00
01/23/2024	Formal Activity - AMA/AOA Approved: The Fentanyl Crisis from a Law Enforcement Officer's Perspective	0.00	1.00
01/24/2024	Formal Activity - AMA/AOA Approved: FAFP Florida Mandatory Controlled Substance CME Webinar	0.00	2.00

	Prescribed	Elective	Total P&E
Total Credits:	**44.25**	**7.25**	**51.50**

Reporting Credit From The AAFP to the ABFM

- When the AAFP transmits reported credits to the ABFM, they are sent with no course detail – only as a Prescribed total and an Elective total.
- The ABFM recognizes Prescribed credits as Division I and Elective credits as Division II.
- AMA Category 1 credit and AOA Category 1A activities not approved by the AAFP are only recognized as Elective credit.



The ABFM requires that 50% of the CME submitted for Board certification be Division 1 certified.

Why is this a problem:

- Diminishes the credit options available to members; undermines the value of AMA and AOA accredited activities by excluding these educational activities from being counted toward Division 1 requirements, thereby reducing the total CME credits physicians can apply toward fulfilling Division 1 credits
- Physicians can directly report to ABFM the AMA or AOA credits taken to count towards Division 1, but this defeats the purpose of streamlining the reporting process for members

ADMINISTRATIVE BURDEN

OHIO CASE

- The glitch in the AAFP's CME Reporting Tool came to light for the Ohio chapter in 2024 when two members contacted our office to seek assistance when they received notice from the ABFM that they were losing their Board certification due to lack of CME.

  In both cases, the members had more than enough CME in all categories; however, because there is no detail provided to the ABFM from the AAFP, all of the Elective credits were recognized as Division II – even those that were accredited as AMA Category 1 and AOA Category 1A. The solution by OAFP staff was to work outside of the AAFP CME Reporting tool and resubmit the AMA Category 1 credit to the ABFM as Division I and it worked!

  Although the result was positive, the solution caused administrative burden for the physician, the staff, and rendered the AAFP's CME Reporting Tool nearly useless.

Working outside the current AAFP CME credit reporting system imposes duplicate efforts in tracking CME categories and creates unnecessary barriers for physicians striving to meet their professional development obligations.

AAFP & ABFM: WORKING TOGETHER TO ADDRESS THE ISSUE

The AAFP & ABFM recognize that there is a significant issue with their reporting process, and have been working to rectify the issue. The OAFP staff has been working with Brian Edwards and members of the Education and Membership teams at the AAFP as well as contacts at the ABFM to move this issue forward.

Brian Edwards shared the following about changes/plans between AAFP & ABFM:

- AAFP staff had their second meeting with ABFM staff about the Division I & Division II reporting issue (10/29/24).
- In the meeting, the teams identified a possible reporting system improvement that they believe would go a long way toward addressing the CME reporting issues raised.
- The identified system improvement will require back-end IT work for both the AAFP and ABFM, and will necessitate close coordination between both orgs to bring online.
- The plan is to have this work completed, or at least ready for an update, by late January/early February, 2025.
- The plan is to make a broader announcement to chapters about the system update closer to when the changes are ready to be implemented.
- In the meantime, AAFP and ABFM staff agreed they are able to continue to resolve member issues on a case-by-case basis as they arise.
- The staff from both organizations agreed to make progress toward alleviating this issue a standing item in the Dyad meetings (ongoing cross-org meeting), with a goal of measuring overall success a year from now.

AAFP REPORTING CME TO CE BROKER

CE BROKER

- A platform that helps track, manage, and report CE requirements for licensure. It connects licensing/state medical boards and licensees to streamline compliance and ensure up-to-date credentials.
- CE Broker and the AAFP have an agreement to transmit CME to certain state medical boards – Ohio and Florida being two of them

CURRENTLY REPORTED

- AAFP only shares a transcript of Prescribed CME that was completed by the reporting physician within a specific time period. The CME on the transcript must be produced by the AAFP or a state chapter only.
- **No** AMA Category 1, **NO** AOA Category 1A (Physicians have to report this CME on their own.)

CE BROKER: AAFP'S ACTION

Brian Edwards shared the following regarding the issues related to CE Broker:

- We are working to expand our web service for six additional states. We're expecting CE Broker to sign with a couple more states in 2025. At this time, CE Broker will only accept CME from the AAFP that is "primary source verified" which limits us to reporting only AAFP and AAFP chapter CME.
- We are having ongoing conversations with CE Broker about accepting additional credit reporting information from the AAFP.
- To date CE Broker has been unable to accommodate this request, citing that they are unable to accept additional information due to system limitations on their end. (Ohio's CE Broker representative says that their company is able to accept the required information, which is inconsistent with AAFP's claim.)
- We are prioritizing transmitting local regional CME completion information as a next step in our conversations with CE Broker and will keep chapters informed as we have any information to report. *(In the case of Ohio regional chapter, Prescribed credits are not reported by AAFP to CE Broker)*

CHANGE IN 2025 & OUR CALL TO ACTION

- Continue to monitor for change in 2025; Encourage members to share feedback CME reporting tool's usability; Advocate for improvements that reduce unnecessary administrative tasks.
- OAFP has prepared a resolution for the 2025 Congress of Delegates if the problem is not resolved to our members satisfaction. (*Draft attached*). We would love your feedback and support.

SUMMARY:

- While the current AAFP CME reporting tool remains a valuable member benefit, there is a clear need to reduce the administrative burden on members.
  - Simplifying the reporting process, recognizing/labeling courses as AMA Category 1 credits as Division 1 (for ABFM), and offering customizable tracking options (for CE Broker) that could enhance usability.

THANK YOU

Aligning the Continuing Medical Education (CME) Reporting Tool with Members' Needs

WHEREAS the American Academy of Family Physicians (AAFP) requires members to report at least 150 credits of approved CME every three calendar years and at least 75 of those credits must be AAFP Prescribed credits, and

WHEREAS the AAFP has a CME reporting tool through which members can enter their CME credit; and

WHEREAS the AAFP's CME reporting tool is rated by members as one of the AAFP's "most-valued service[1];" and

WHEREAS the majority of family physicians in the United States are board certified by the American Board of Family Medicine (ABFM) [2], and

WHEREAS the AAFP has a long-standing agreement with the ABFM to transmit CME entered into the AAFP CME Reporting Tool as a mechanism to assist members in meeting their ABFM certification requirements, and

WHEREAS the AAFP CME Reporting Tool categorizes CME credits[3] as "Prescribed" and "Elective," while the ABFM categorizes CME credit as "Division 1" and "Division 2", and

WHEREAS the AAFP "Elective" credit includes activities that have been designated by the American Medical Association (AMA) Physician's Recognition Award (PRA) Category 1 Credit™ or have been approved by the American Osteopathic Association (AOA) as Category 1 credit, and

WHEREAS only AAFP Prescribed credit is reported to the ABFM as equivalent to the ABFM's Division 1 credit, and

WHEREAS a minimum of 50% of the total required CME credits reported for ABFM-certified physicians must be Division I credit which should include AMA and AOA approved credits[4], and

WHEREAS the AAFP's agreement with the ABFM that "Prescribed" credits count for "Division I" credit and "Elective" credit count for "Division 2," results in valuable member CME credit being transmitted to the wrong "Division" resulting in physicians becoming board-ineligible, and

WHEREAS this discrepancy is not clearly communicated to members on the CME reporting dashboard, and

WHEREAS this discrepancy has the significant potential to cause members to jeopardize their ability to practice medicine and increases members' administrative burden, and

WHEREAS the AAFP also has an agreement with several state medical boards, through its agreement with CE Broker, to transmit only AAFP Prescribed CME activities produced by the AAFP or state chapter for state licensure requirements, and

WHEREAS, similar to the miscategorization of CME that is taking place at the ABFM, CE Broker categorizes CME credit as either Category 1 or Elective credit respectively, and

WHEREAS the AAFP includes as part of its mission statement that it strives to "reduce administrative complexity that detracts from patient care"[5], therefore, be it

RESOLVED that the AAFP transmit members' CME information to the AFBM in a format that allows the ABFM to correctly place Prescribed and Category 1 CME credits in their correct Division; and be it further

RESOLVED that the AAFP work with CE Broker to transmit from the AAFP CME reporting tool, AAFP Prescribed credit along with AMA PRA Category 1 Credit™ or CME credit that has been approved by the AOA as Category 1 credit as proof of completion.

Fiscal Note: ?

1. https://www.aafp.org/membership/welcome-center/get-started/report-cme.mem.html
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3090428/#:~:text=Eighty-five%20percent%20of%20all,were%20participating%20in%20MC-FP
3. https://www.aafp.org/cme/about/types.html#elective
4. https://www.theabfm.org/continue-certification/cme/
5. https://www.aafp.org/about/who-is-the-aafp/vision-mission.html

Member Value Propositions of Advocacy

In professional associations, a compelling value proposition demonstrates the unique benefits an association has to offer, how it can help members find the solutions they need most, and why choosing to be part of the community will benefit them. It should provide solutions to your members' biggest pain points**.**

In advocacy, we use the same tools as in the development of overall membership value proposition identification to bring our value A.L.I.V.E.

Ask the right questions. This helps you discover our members' highest pain points.
Listen intently. Listen for reoccurring themes from members.
Innovate with solutions. Come up with new ways to solve the problems members express.
Value creation. This happens when we provide good solutions to what members need.
Engage with excellence. Once these steps are in place, start communicating about your value, getting members' feedback on your value, and continuing to engage them.

In our communications about the issues that we prioritize we give the promise to amplify their voice, influence policy makers' decision-making, and achieve positive change on issues our members care about by effectively communicating their concerns to relevant stakeholders, leveraging collective power to advocate for our desired outcomes.

How Advocacy Puts ALIVE into Action

- **A-** Advocacy consistently rates as #1 area of member value in WAFP surveys
- **L-** Legislative Committee and biennial member survey to determine member value and member priorities
- **I-** Innovate with solutions
    1. Build a network of supporters
    2. Use data to support the case
    3. Gain the attention of local media and spread your story to a wider audience.
    4. Trying different strategies and test what works and what doesn't. Be open to adapting our approach as needed.
- **V-** Value is created on multiple fronts:
    1. We hear our members
    2. Putting resources into what members tell us is most important
    3. Advocacy efforts achieve results that affect their practice/lived experience
- **E-** Engage
    1. Advocacy Day
    2. Speak Out
    3. Advocacy training opportunities for students & residents
    4. Testimony
    5. Share your wins and put losses into perspective.

NEW PHYSICIAN PROGRAMMING

Napa Confab

January 16, 2025

1:45 – 2:15 pm

ILLINOIS ACADEMY of FAMILY PHYSICIANS

TASK FORCE ON NEW PHYSICIANS

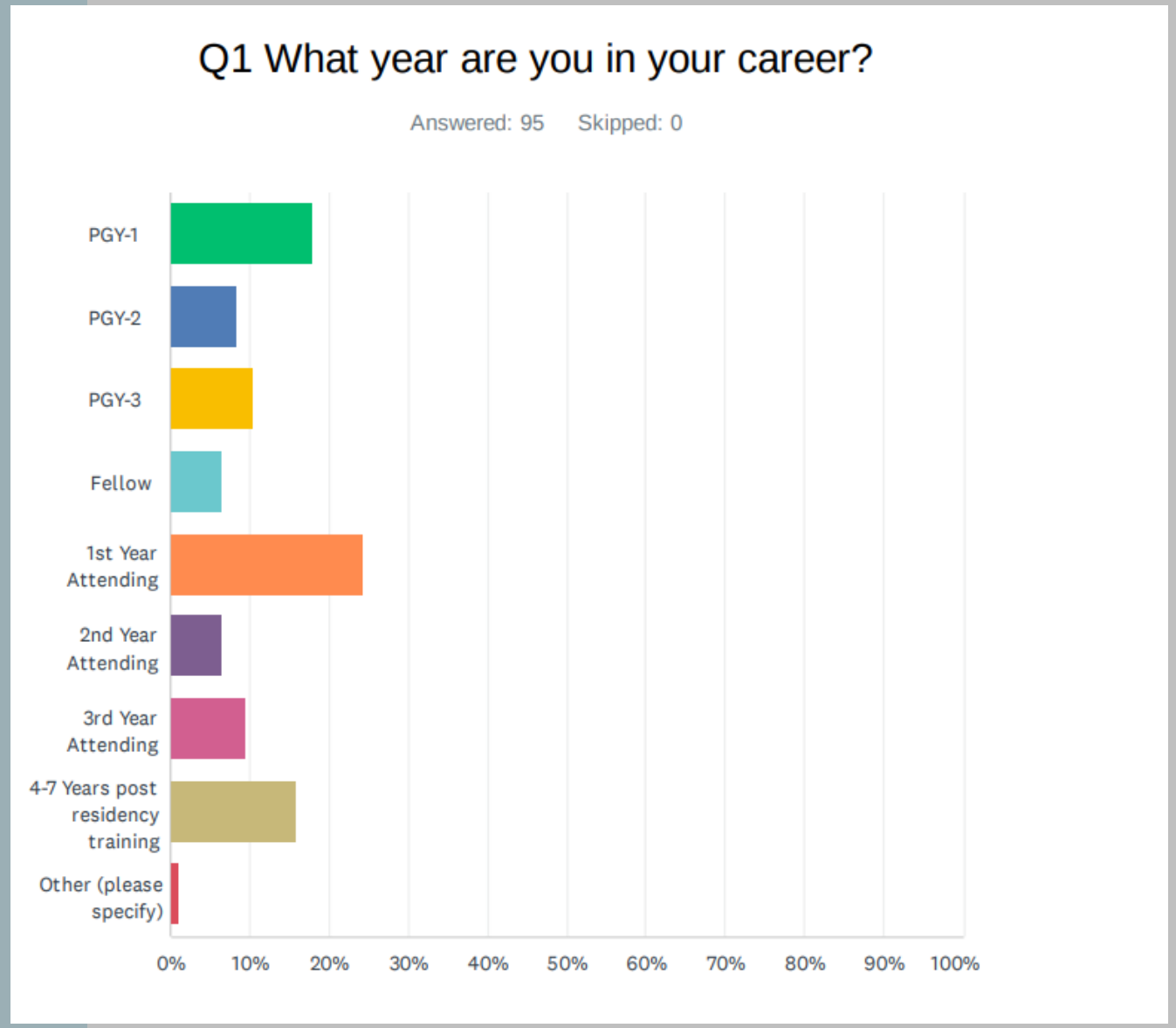
Created March 2024

Purpose: to promote interest and raise awareness of membership among new physicians and residents.

ACTIVITIES/ENGAGEMENT

- Develop Survey for Residents and New Physicians.
- Offer feedback on overall recruitment and retention efforts.
- Serve as focus group for communications/membership marketing campaigns.
- Facilitate learning track at Annual Meeting.
- Sounding board for improved website.

NEW PHYSICIAN SURVEY



KEY TAKEAWAYS

Survey Dashboard

Most interested in:

- **Advocacy** on practice concerns: non-physician scope, administrative burden, and burnout.
- **Advocacy** on health policies such as Medicare for All, reproductive health, and drug pricing.
- **Networking** with potential employers and local physicians.
- **Networking** with other residents and new physicians in a social setting.
- **Career Guidance** on compensation models.
- **Mentorship** based on professional interest.
- **Educational Programming** on licensure requirements and state-mandated CME.

BOOT CAMP FOR NEW PHYSICIANS

Registration fee $100

Received 1.5 prescribed CME credits

Parallel track to Active Members' CME during Annual Meeting

Allowed for participation with Cte/MIG meetings, AAFP Update, Annual Business program, Board installation, and President's Address

BOOT CAMP AGENDA

Finding Your Dream Job

- Recognize various practice models, including utilizing additional post-residency training, available to Family Physicians
- Examine advantages and disadvantages to different practice settings
- Identify additional resources for how to make a career transition

Contract Negotiations

- Develop a negotiating plan prior to engaging an employer on your contract
- Identify which areas are likely to be most and least negotiable in a contract
- Recognize red flag conditions in a contract and contract negotiations

15-minute Time Management Tricks

- Identify key time management strategies specific to the demands of residency and early medical practice, allowing for increased productivity and reduced stress.
- Demonstrate practical techniques for prioritizing tasks and managing clinical and administrative responsibilities efficiently.
- Develop a personalized action plan for maintaining work-life balance and preventing burnout through effective time management practices.

Financial Planning Essentials

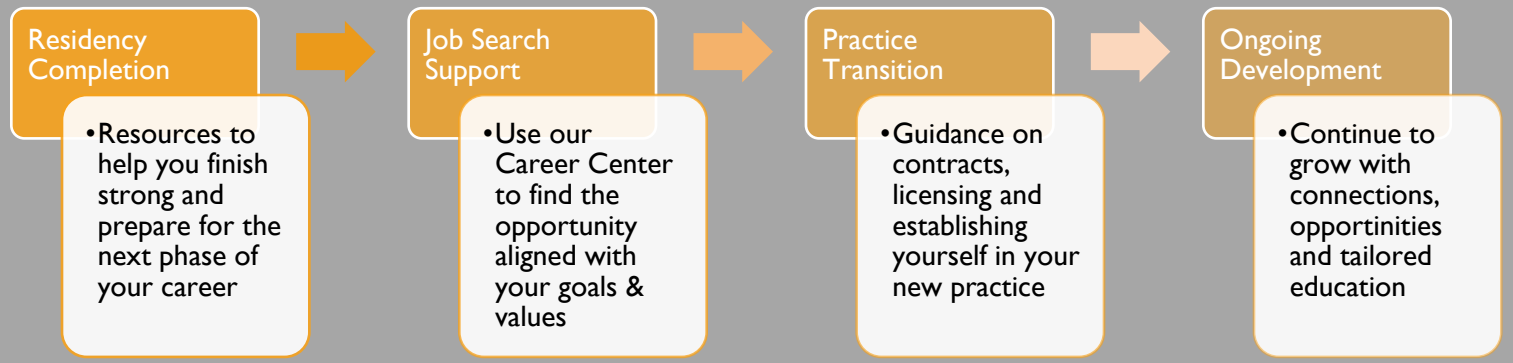
- Develop an overall plan for managing finances regardless of income
- Examine various savings options from retirement, IRAs, stocks and more
- Strategize options for student loan debt repayment including Public Service Loan Forgiveness (PSLF)
- Identify at least three discrete steps one can take for financial security as a physician

CV and Interview Prep

- Modify your CV to convey your strengths succinctly and effectively
- Develop a plan to be prepared and polished for your interview
- Identify common pitfalls for interviews

YEAR-END MAILING

- Sponsored by Health Care Associates Credit Union (HACU) $3,000 cost
- Two-sided resource guide includes:
  - IAFP and AAFP resources
  - HACU information on financial planning and enrollment



GOING FORWARD

January

- Know Your Worth! Career Benchmark Dashboard Training Webinar
- Wellness Baskets to Family Medicine Residency Programs

February

- ABFM Board Exam Overview Webinar

March and beyond

- Library of webinars geared to FMRs and New Physicians

Happy to share templates, survey, agenda, materials, speakers, etc.!

Thank you,

Gordy & Jen

QUESTIONS??

AAFP Residency Ambassador Pilot Program

Presented by Kathy McCarthy, CAE

States participating in the pilot: California, Pennsylvania, and Texas. We were asked to participate based on the numbers – both the number of residents and our retention of new physicians. As of December 2024, AAFP had 16,013 resident members and almost 24% of them were in one of our three states.

Basics

It is a three-year pilot. Each state selected Ambassadors who will be assigned 10-15 residency programs to visit and deliver both a didactic lecture and a presentation on AAFP/chapter resources for residents and new physicians. The didactic lectures come from an online resource First Year Post-Residency Transition Education Package.

The residents who attend will be invited to join an online community that AAFP added to their communities. For each visit they make, the Ambassadors will be paid $750 and that will include all expenses. AAFP will pay for up to 40 visits per state.

The Ambassadors had training in November and mine will begin presentations this spring. Texas is providing travel reimbursement for programs further away from the Ambassador as they'll involve more travel and expenses.

It will take years to see results in membership retention. AAFP will track participation in an online community and survey data from residents who attend a presentation from the Ambassadors as a way to measure success.

What I've learned so far

Residency programs vary in their willingness/ability to have outside speakers. Having a didactic lecture available to deliver helped with some. There is also variations in who plans their didactics.

AAFP shared analysis they did on those who completed residency in Texas in 2021, 2022, or 2023 regardless of where they are now. One datapoint was conversion as of September 2024. The average was 68.6%, but it was broken down by residency program and the rate ranged from 41.7% to 95%. We are using it to both target programs that have "room for improvement" and to spotlight the ones with the highest conversion to share best practices.

In addition to the analysis AAFP provided, I requested a data file of all residency graduates (regardless of membership status or current state chapter) for 10 years and did some of my own analysis.

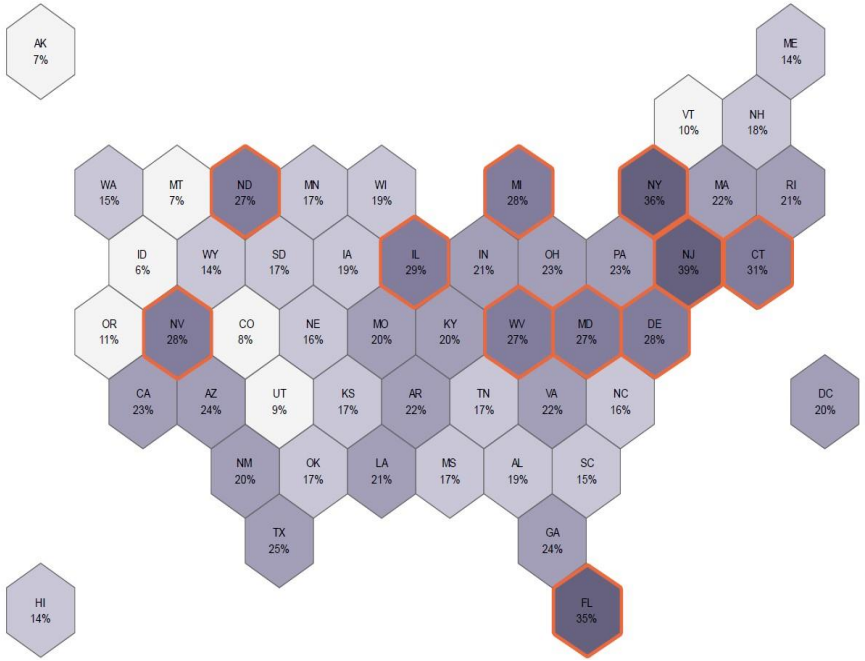
- For the 10-year period, about 58.4% are members and 41.6% are no longer members.
- Approximately 10.4% went on to do a fellowship. Those who completed a fellowship are actually more likely to still be members – 72.2% are still members vs. 56.8% of those who did not complete a fellowship.
- At least 27% of residency grads have an address outside of Texas. It's probably higher as AAFP doesn't update former members consistently.

International Medical Graduates
Alternative Pathways to Licensure

Opportunities and Impacts to Membership

NORTH CAROLINA ACADEMY OF
FAMILY PHYSICIANS

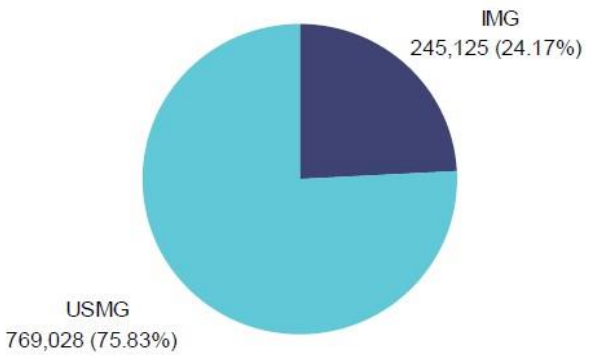
IMGs in Active Practice by State (All Specialties)



States with IMG share of Physicians higher than national average:

- New Jersey (39%)
- New York (36%)
- Florida (35%)
- Connecticut (31%)
- Illinois (29%)
- Michigan (28%)
- Nevada (28)
- Delaware (28%)
- North Dakota (27%)
- Maryland (27%)
- West Virginia (27%)

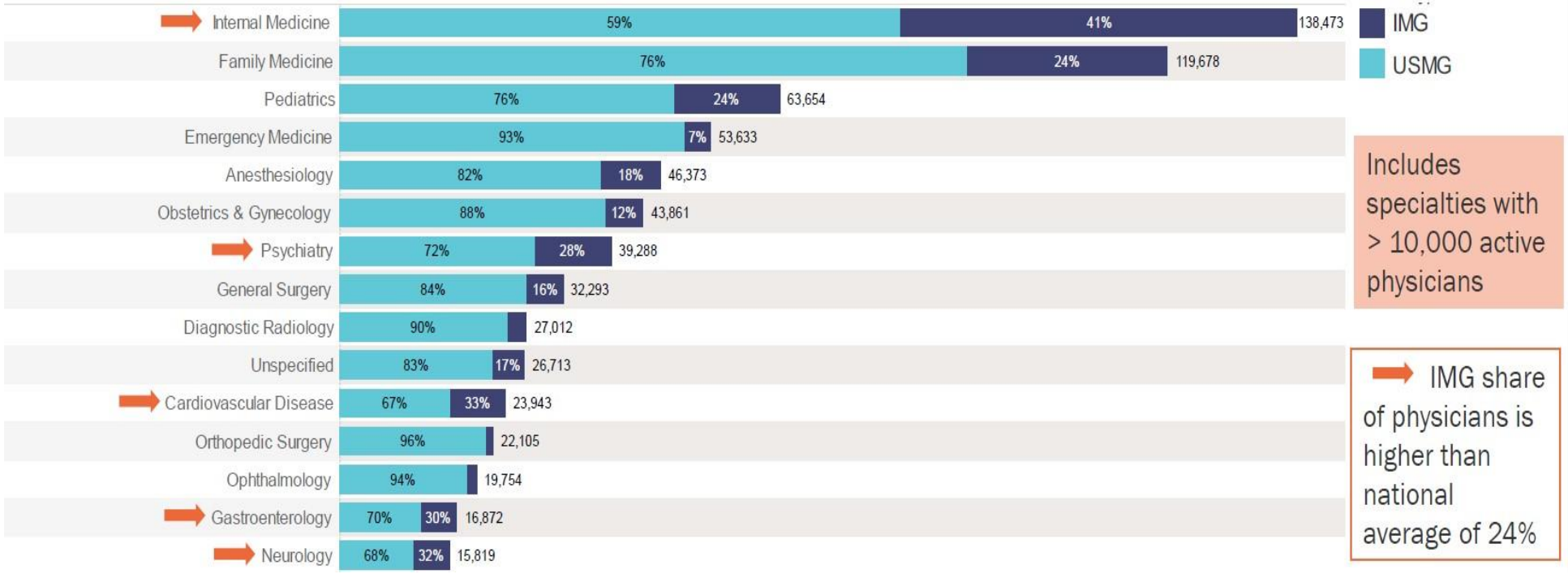
IMG Status



Major Professional Activity

Office-based Practice	USMG	541,356
	IMG	170,478
Hospital Staff	USMG	106,071
	IMG	36,885
Resident/Fellow	USMG	120,516
	IMG	37,287
Locum Tenens	USMG	1,085
	IMG	475

Active Physicians by Specialty and IMG Status



Traditional Pathway to Licensure

- Obtain MD degree or equivalent
- USMLE Steps 1 & 2
- ECFMG certification
- Visa *(if necessary)*

Start U.S./Canadian Residency

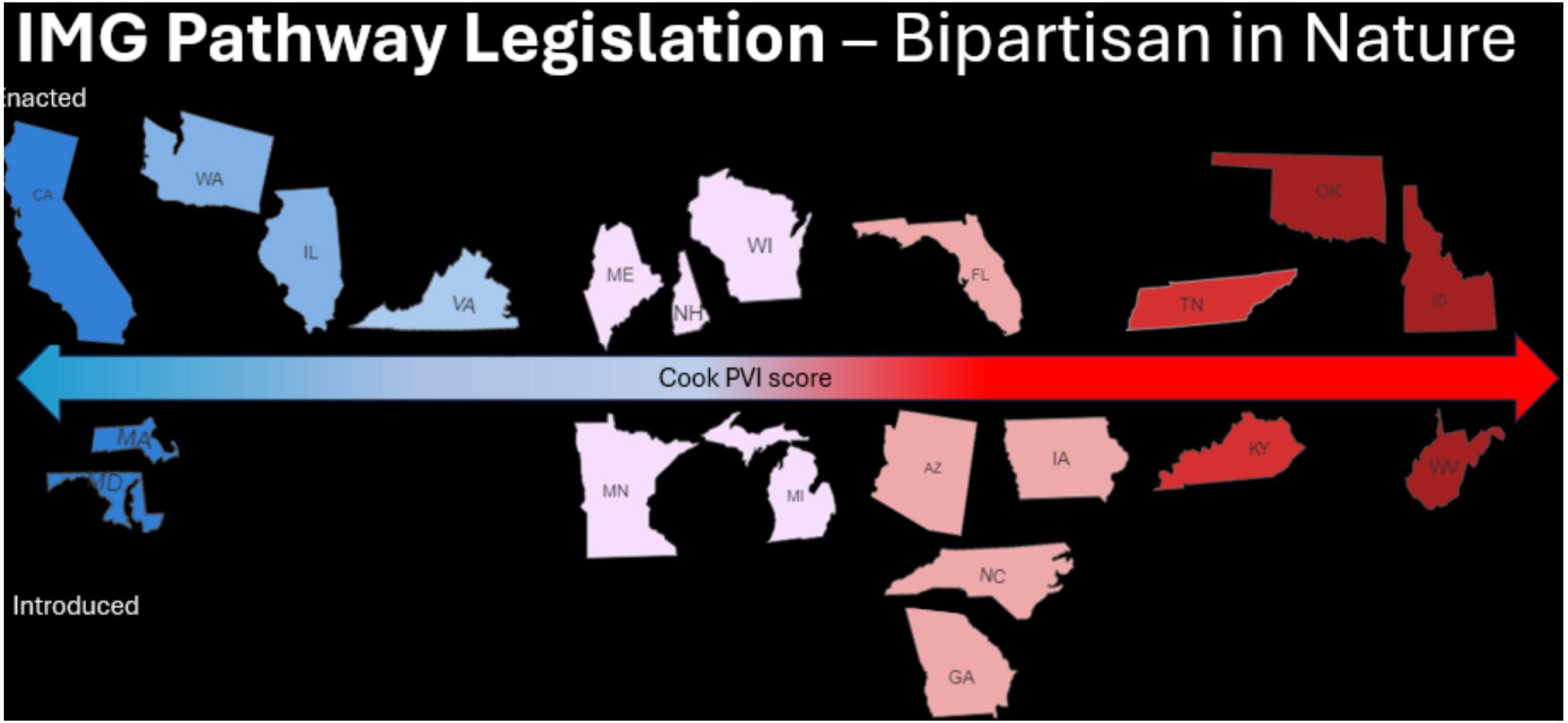
- USMLE/COMLEX Step 3

Before Residency Concludes

- Apply for employment
- Apply for full state license

Fully licensed IMG

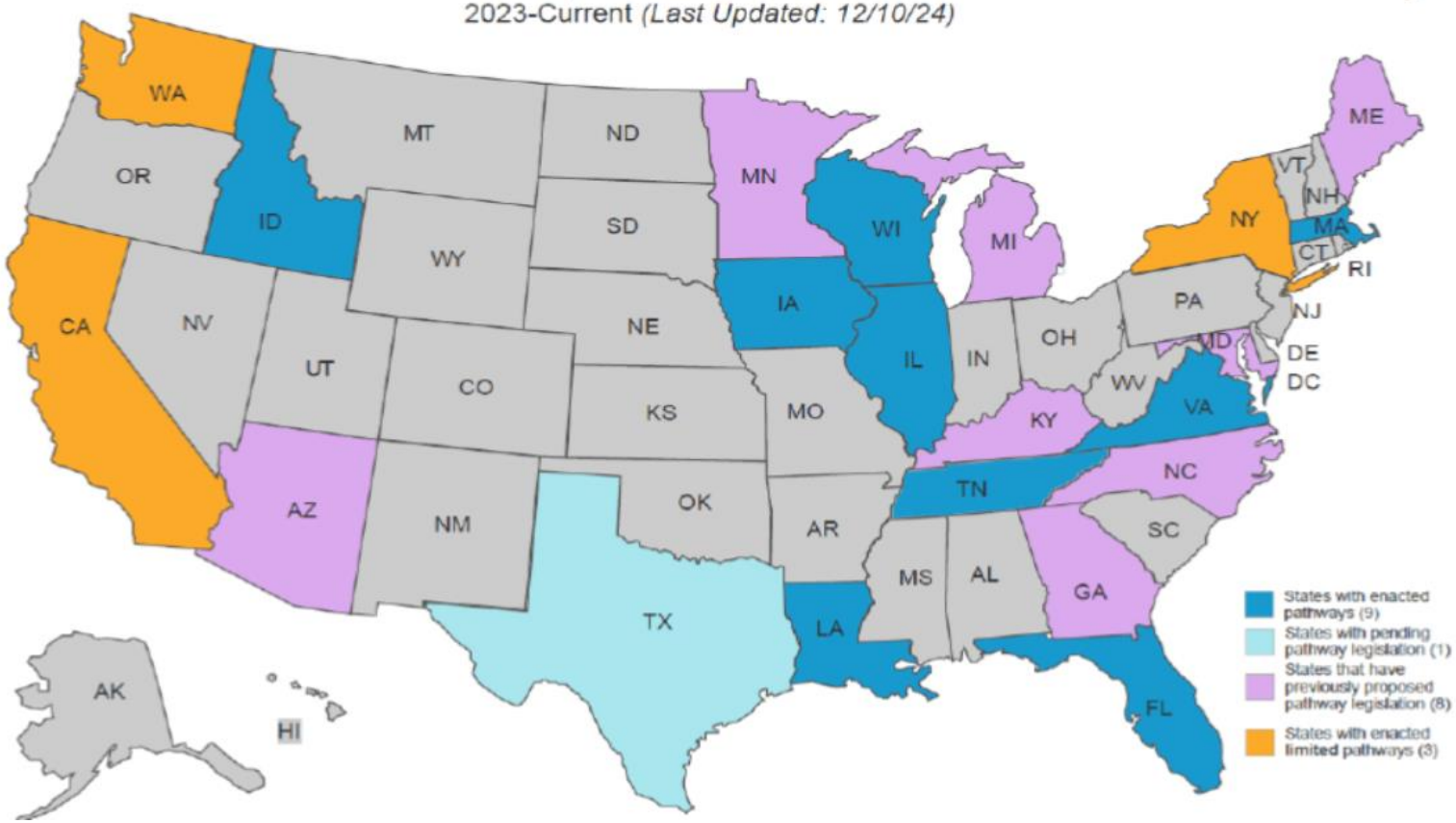
Legislative Trend – New Laws to allow IMGs to Bypass Residency Program Requirements



Cook PVI: Partisan voting Index

States with Enacted and Proposed Additional IMG Licensure Pathways

2023-Current *(Last Updated: 12/10/24)*



Discussion and Considerations

- Advocating for Integrity of the Profession?
  - Two standards of licensure-
  - Distinguish APPs
- More family physicians = more active members?
- How do we reach, recruit, and retain?

NORTH CAROLINA ACADEMY OF FAMILY PHYSICIANS

Communication and Good Governance

- Napa Confab
- January 17, 2025
- 9:30 – 10 am

ILLINOIS ACADEMY of FAMILY PHYSICIANS

Beyond Agendas and Minutes

Meet the Staff Slides

Presence of Staff at Board meetings

Co-CEO message in every *Family Physician* magazine

Brian Wojcicki, JD
State Government Relations

About Brian…

- Began work for IAFP in 2005 as an intern
- Went to Chicago-Kent College of Law in 2006
- Returned to home town Springfield in 2016
- Daily Mantra: The Serenity Prayer
- Go-To TV Show: “West Wing”

Family Physician

Co-CEO Messages

co-ceo insights

Things That Keep Us Up At Night

Gordana Krkic, CAE
Chief Executive Officer and Chief Advocacy Officer

Jennifer O'Leary
Chief Executive Officer and Chief Financial Officer

There are many factors that keep us awake at night; caffeine, poor bedtime habits, medications, or pain. And yes, stress! Without the distractions of the day, stress keeps us awake as intrusive thoughts jolt us up in the middle of the night. Maybe we're consumed by what happened earlier that day or we're constantly thinking about the to-do list that's waiting in the morning.

Here's what keeps IAFP up at night AND what helps us sleep better!

At a Senate Finance Committee hearing in April, AAFP President Steven Furr, MD, FAAFP, testified that "the physician workforce skews heavily toward non-primary care specialists, and we have fewer primary care physicians relative to the population than in other countries. This is having severe impacts on patient access."

According to a study released in March by the Commonwealth Fund, among 10 high-income countries, the U.S. trails its peers in access to and continuity of primary care. The study compares the state of primary care in the U.S. with nine other high-income nations: Australia, Canada, France, Germany, the Netherlands, New Zealand, Sweden, Switzerland, and the United Kingdom. More information about the report is available here. Findings from the analysis show:

1. At least 86% of respondents in all 10 countries reported having a regular physician or place to go for care. However, adults in the U.S. (87%), Sweden (88%) and Canada (86%) had the lowest rates.

2. Only about 2 of 5 adults in the U.S. and Australia reported having been with their primary care physician for five years or more, a significantly lower proportion than in the other countries studied.

3. Less than 4 in 10 physicians in the U.S. reported usually receiving information about changes to their patient's care or medication plans from specialists or hospitals.

4. At the same time, three-quarters of U.S. adults (73 percent) say the health care system is not meeting their needs.

Recent posts and studies show the U.S. saw a net loss in clinicians. Too few physicians are delivering primary care even as patient demand is rising. That's the message of a new report called "The Health of U.S. Primary Care: 2024 Scorecard Report — No One Can See You Now." The Scorecard's Data Dashboard provided a breakdown for both workforce and usual source of care:

- From 2016-2021, the percentage physicians in Illinois practicing primary care decreased from 29.4 to 27. Nationally, the decrease went from 27.9 to 26.6.

- From 2010-2021, the percentage of the adult population without a usual source of care in Illinois remained flat (20.7 to 21.1) while it grew nationally from 23.6 to 28.7. The same held true for the percentage of children without a usual source of care which remained flat in Illinois (4.6 to 4.9), but increased nationally from 10 to 13.6 percent.

As Dr. Furr stated, "…this data is telling. People are losing their trusted relationship with a primary care physician and, in turn, their trust in the health care system."

What helps us sleep better

Relationships matter. Dr. Furr's testimony spoke to the work family physicians do to maintain meaningful relationships with patients, especially those with more complex needs. Evidence continues to suggest this type of longitudinal relationship with their patients leads to better control of chronic conditions, fewer emergency department visits and hospital stays, and improved health outcomes.

According to a Robert Graham Center Policy One-Pager, family physicians continue to offer the most comprehensive care. Again, a usual source of care is associated with better patient satisfaction, enhanced equity, and lower costs.

We continue to use these reports and scorecards at the state level to help inform and shape policies to strengthen primary care.

And there's more… read Dr. Daisy's President's message about the Match in this issue as well as the uplifting medical student stories and promising efforts through our IAFP leaders' conversations with those high school students looking for a career in medicine.

Editor's note:

You can access the Commonwealth Fund State of Primary Care at https://www.commonwealthfund.org/publications/issue-briefs/2024/mar/finger-on-pulse-primary-care-us-nine-countries and The Milbank Fund report at https://www.milbank.org/publications/the-health-of-us-primary-care-2024-scorecard-report-no-one-can-see-you-now/ and the Robert Graham Center One-pager at https://www.aafp.org/pubs/afp/issues/2021/1200/p560.html.

CEO Message

We Need Your Voice

Gordana Krkic, CAE
Chief Executive Officer and Chief Advocacy Officer

Jennifer O'Leary
Chief Executive Officer and Chief Financial Officer

The primary mode of self-expression is our voice. It enables us to share opinions, tell our story, spread awareness, bring forth ideas, and yes, speak up. For many of us, it's easier to advocate for others than it is to speak up for ourselves. Speaking up about something that's on your mind is needed, even if it's a difficult issue. When you speak up, you publicly, assertively, and honestly communicate for the rights and needs of yourself and others. It is at the root of all social change, including within organizations.

For those who spoke up and completed IAFP's all-member survey, THANK YOU. We received many constructive comments and feedback. Look for a synopsis of the results in an upcoming communication. Here are just a few of the open-ended responses that show our members living into their values and speaking their truth:

My biggest professional challenge is…
- Increasing administrative burden and declining reimbursement to physicians.
- Being respected by corporate medical groups.
- Balancing work/life demands in context of increasing patient's needs and decreasing workforce to meet those needs.
- Inbox management and the pressures for productivity within a broken system.
- Keeping independent and dealing with staffing issues.
- Accessing behavioral health for patients.
- Keeping current educationally.
- Getting it all done.

*I believe IAFP could serve our members **even** better if we….*
- Were more effective in our lobbying efforts.
- Connected to members in more ways.
- Stayed out of social activism.
- Engaged more medical students and residents.
- Helped members prepare for retirement.
- Became more proactive in advocating for patient-focused issues as strongly as we do for physician-focused issues.
- Supported the need for universal, equitable access to high-quality health care.
- Provided more in-person or easier online access to CME at no cost to easily obtain mandatory state requirements.

Do these resonate? Each voice gifts us with perspective and knowledge on things that matter to our members. Please continue to use your voice and share your brilliant ideas and burning questions! Your Board of Directors wants to hear from you: your email can be about IAFP's strategic plan, policy, an action item request, or suggestions to improve service to our members. Send your email to iafp@iafp.com. Please include a preferred phone number in your email.

Next up: Plan to attend the IAFP Celebration where all new board members will be installed from 12-3 p.m. on October 27th at the Marriott Marquis McCormick Place alongside the AAFP FMX activities. Our members will gather in celebration of our new leaders and IAFP awards honorees. Learn more and RSVP at www.iafp.com/iafp-annual-meeting.

IAFP's mission is to be the **voice** of Illinois family physicians by promoting the value of the specialty of family medicine in Illinois and improving health for all through advocacy, education, and professional growth. Our goal is to hear your powerful voice and work to accomplish the strategic plan's vision of family physicians thriving in a health care environment that enables them to provide safe, quality, equitable care for every person in Illinois.

Thank you for being a member,
Gordana and Jennifer

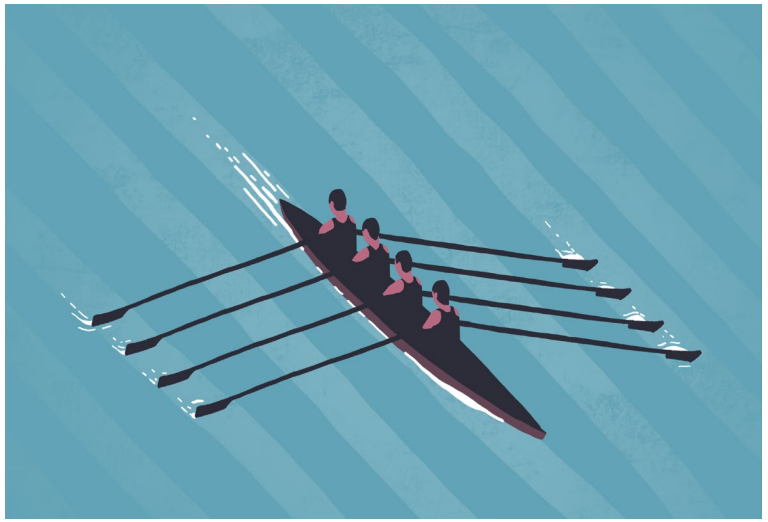
In Sync

It’s essential that a Board understand:

*** who their staff are**

*** what they do**

*** their unique professional expertise and competencies**



EVERYONE thrives on strong relationships and open communication with those who support their efforts.

A Journey Balancing Innovation and Practicality

As Co-CEOs from December 2020 and careers spanning 28 and 32 years with IAFP, we are happy to reflect on a transformative shift in programming at IAFP. While honoring where we started, we appreciate how far we've come. We're shaping our path forward by asking:

- How do we use our core strengths to forward IAFP's mission and vision?
- What opportunities can we pursue, and what tasks can we let go of to create room for them?
- How can we streamline our operations for greater efficiency and impact?

Together with our staff of professionals, we remain committed to embracing new possibilities.

Co-CEO Domains of Practice: In the world of association management, the American Society of Association Executives (ASAE) helps associations grow, excel and achieve. As the premier source of learning, knowledge, and future-oriented research, it is our higher standard of professionalism. The ASAE identified 8 essential domains of practice that reflect the role of a chief staff executive of an association. They're listed here with select highlights from our scope of work that have advanced our transition.

Governance
- ✓ Created continual leadership development topics for the second half of each Board meeting.
- ✓ Offered a Governance Workshop for the Chair, President, President-elect, and Co-CEOs.
- ✓ Provided a narrative to the Executive Committee delineating our roles among these organizations: IAFP, Family Health Foundation, and Family Medicine Midwest.

Executive Leadership
- ✓ Implemented a regular "update" to the Board.
- ✓ Adapted during the pandemic by hosting a virtual rural health summit, virtual Annual Meeting, and increasing member communications with COVID resources to remain relevant to our membership.
- ✓ Established a diversity policy.

Organizational Strategy
- ✓ Increased transparency on Delegate and Alternate Delegate processes, Board term limits, and listing of IAFP members serving on AAFP Commissions.
- ✓ Improved Cloud preservation of institutional knowledge (manuals, recurrent calendar tasks, etc.).
- ✓ Conduct quarterly Deep Dives with staff which include problem-solving and concept-mapping.

Operations
- ✓ Paid off outstanding debt $340k.
- ✓ Conducted legal review of Employee Handbook, Conflict of Interest, and Anti-Trust statements. Suggestions were adopted and all are in compliance.
- ✓ For FY2025 budget, earmarked a $50k line item for Residents/New Physicians and a $50k line item for a new website and new membership software.

Business Development
- ✓ Strengthened relationships with professional organizations and state agencies.
- ✓ Shifted grant writing for projects and education within our scope and of impact to the specialty of family medicine: vaccines, dementia, behavioral health, lifestyle medicine, obesity, diabetes, antimicrobial stewardship, substance use disorder, etc.
- ✓ Created Podcasts and YouTube CME.

Member and Stakeholder Engagement
- ✓ Started the President's Member Message to increase touchpoints with membership.
- ✓ Recognized a need for new physician engagement and created a Task Force on New Physicians.
- ✓ Provided a New Physicians and Residents learning track at Annual Meeting addressing their specific needs.

Advocacy and Public Policy
- ✓ Dedicated a website for advocacy, including legislative tracking, legislator advocacy, and background briefs.
- ✓ Developed an Advocacy Elective for resident physicians.
- ✓ Improved synergy with AAFP on issues transcending state impact like scope of practice and importance of primary care.

Marketing and Communications
- ✓ Improved presence on social media and among partner organizations.
- ✓ Increased awareness with the public on family physicians' role in improving health outcomes.
- ✓ Trusted voice for investigative journalism on stories impacting members and their patients.

Charting the Transition: Our Report to Leadership
December 2024

Looking Ahead: Our work continues. In the coming year, you'll see a new website, robust additions to our CME library, greater offerings for our resident and new physicians to help them grow and connect to peers and the family medicine community, a virtual Essential Evidence Update in the spring, and Spring Into Action returns in the non-election year.

As our Board, your role will include updating the strategic plan, identifying and mentoring upcoming leaders, recruiting new and lapsed members, weighing in on our financial strength, sharing your accomplishments so others may learn and grow from your experiences.

Excited to continue this journey,

Gordana Krkic, CAE
Jennifer O'Leary
Chief Executive Officers

Keeping Them Apprised

President, President-Elect, and Board Chair:

- Monthly Meeting with Co-CEOs

Executive Committee:

- On an as-needed basis with Co-CEOs
- In-person at AAFP Congress of Delegates

Full Board of Directors

- Secure Board home page of resources
- Quarterly Co-CEO Update
- On an as-needed basis

Leadership Development Programming

Dedicated time during every Board meeting

- Homework and Follow-up Activities

Topics include:

- DISc Assessment for Leaders
- Take the Test – Eagle Center for Leadership
- Facilitated Discussion on:
  - New Physician Engagement and Recruitment Strategies
  - Advocacy Case Studies

Formula for Success

Building Mutual Trust:

- A Board should familiarize themselves with staff roles and contributions.

- When the staff feels valued and understood, the Board gains confidence in the team's ability to execute initiatives and provide reliable insights.

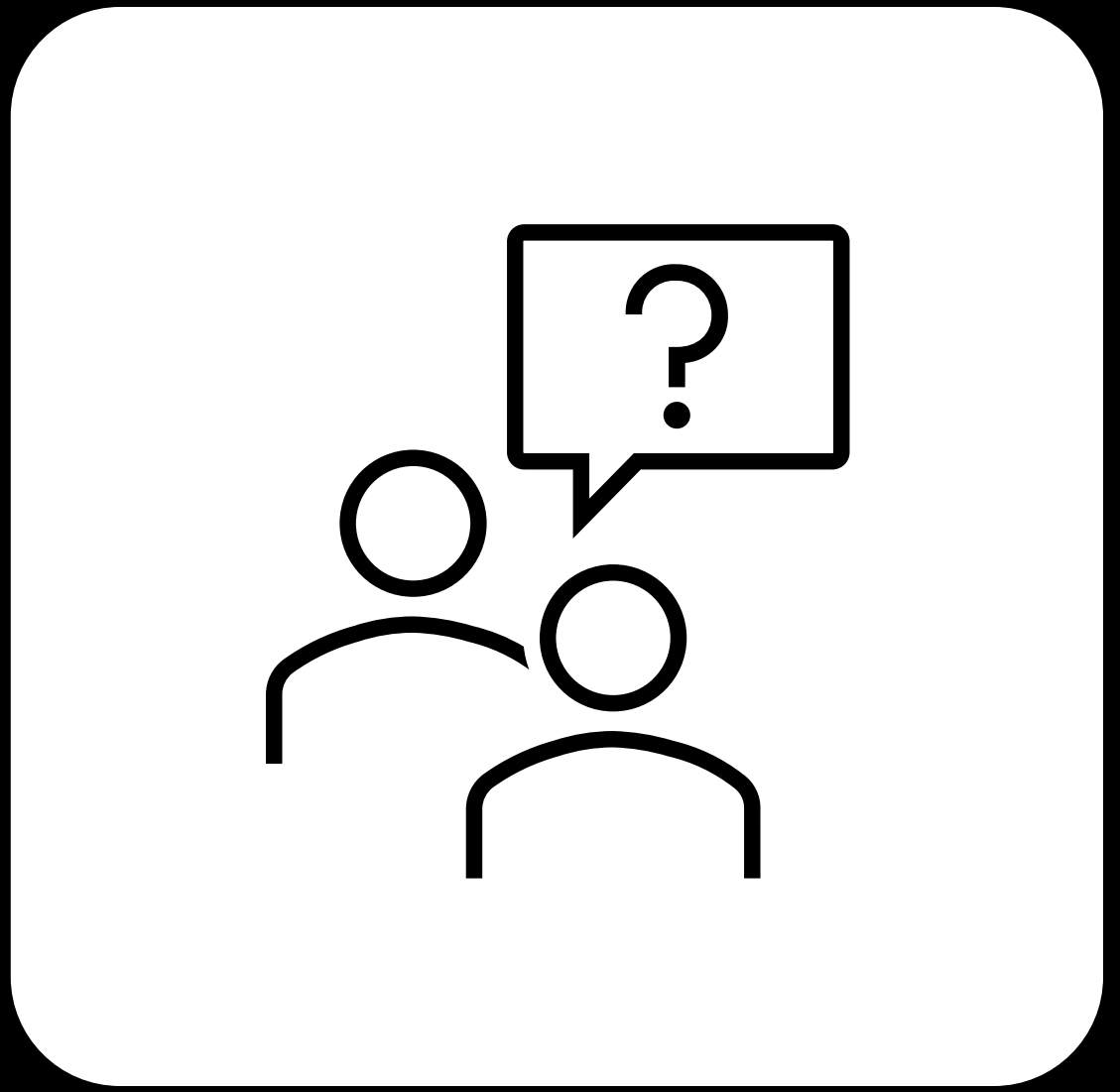
Result:

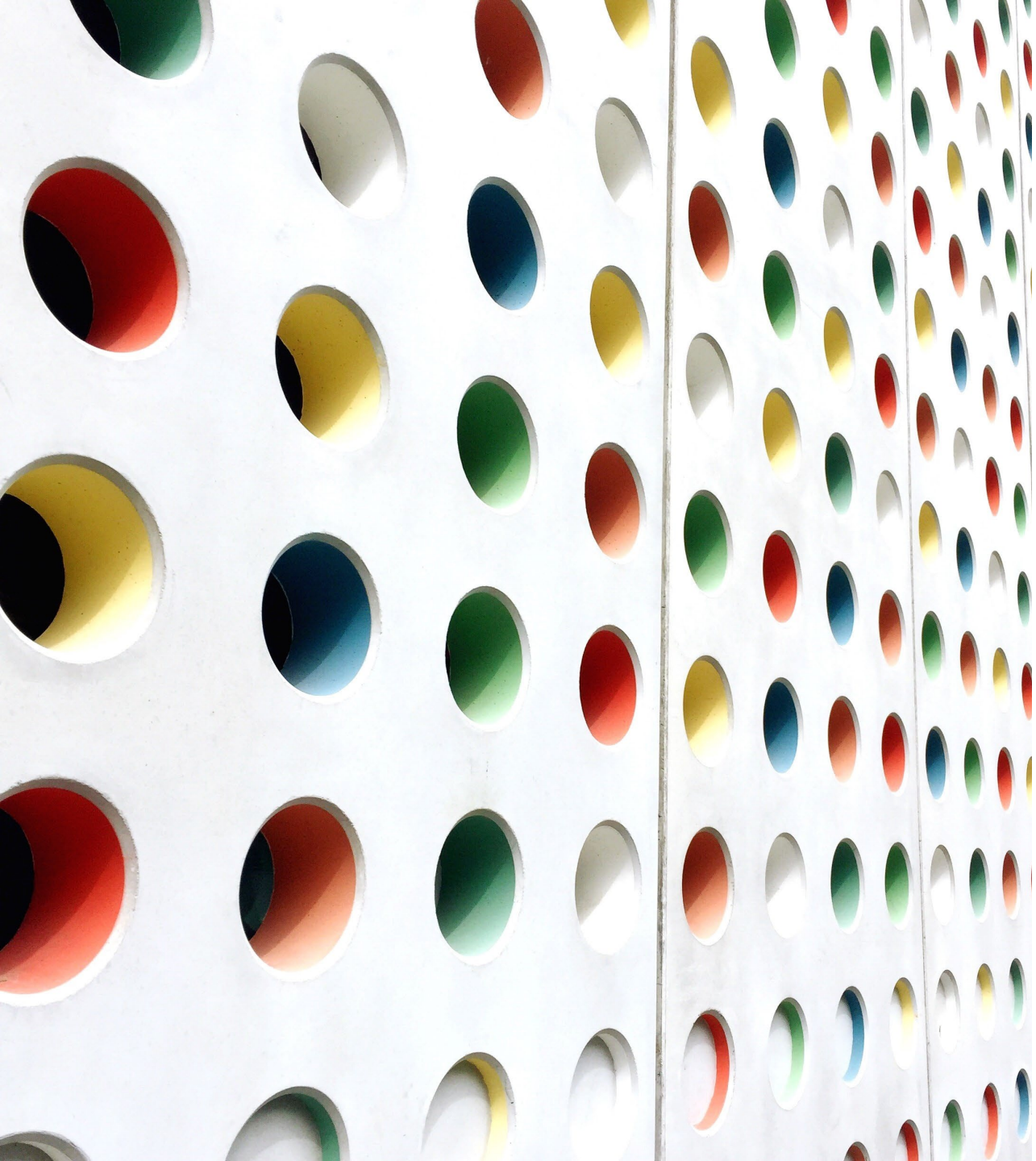
- A foundation of trust ensures that everyone is aligned in achieving the organization’s goals.

- A well-informed Board is an empowered Board – and **knowing the staff is a key part of that empowerment**.

Thank you!

Gordy & Jen





Association Loyalty – A Global Perspective

JAY MILLSON - FAFP

Workforce is changing in every way…

Internal:
Staffing/employees

External: Family Physicians and medical students & associations in general

"What if we don't change at all ...
and something magical just happens?"

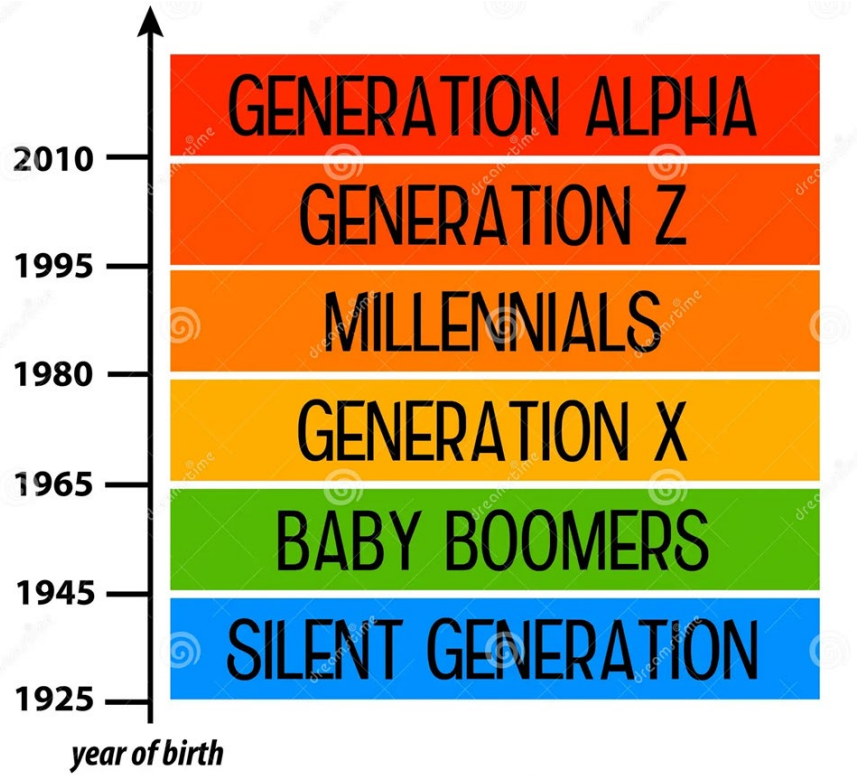
Young Millennials & Gen Z: 1989-2001	Older Millennials: 1980-1988	Gen X: 1965-1979	Baby Boomers: 1946-1964
1. The organization cares about employees' wellbeing.	1. The organization cares about employees' wellbeing.	1. The organization's leadership is ethical.	1. The organization's leadership is ethical.
2. The organization's leadership is ethical.	2. The organization's leadership is ethical.	2. The organization cares about employees' wellbeing.	2. The organization cares about employees' wellbeing.
3. The organization is diverse and inclusive of all people.	3. The organization's leadership is open and transparent.	3. The organization's financial stability.	3. The organization's financial stability.

GALLUP

What employees look for in their employers, by generation

Interesting Data…

- In 2016, Millennials overtook Baby Boomers to become the largest generation in the workforce.
- According to Gallup, as of 2021, 46% of all employees within the workforce are millennial or Generation Z.
- On average, 71% of an association's member base is comprised of members over the age of 40.

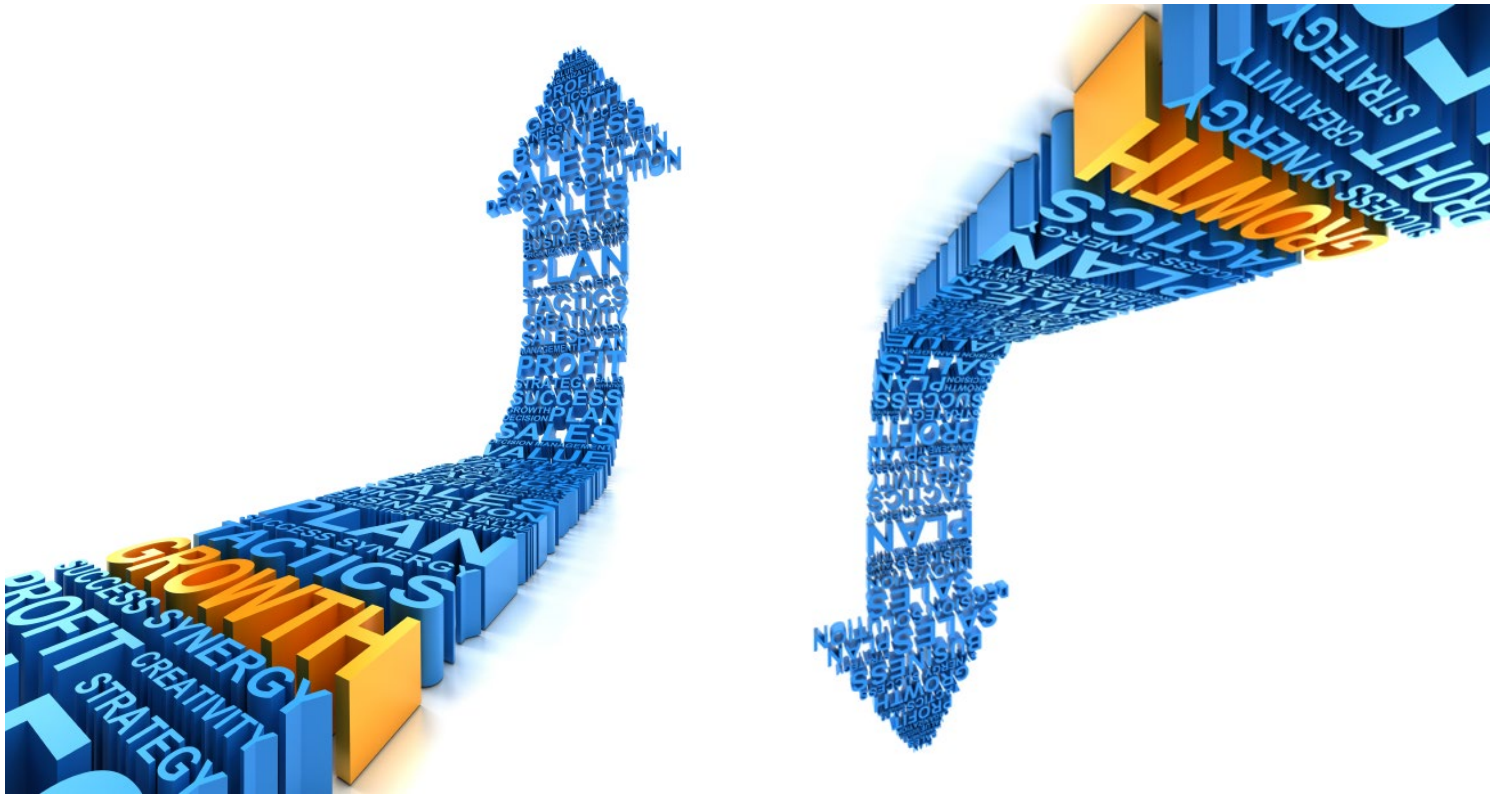


What staffing challenges are you dealing with?

- Unrealistic compensation and benefit expectations
- Work-Life balance beyond reason
- Disinterest in the type of work, don't enjoy the association routine – burnout?!?
- What others: _____?

What are you doing to address these dynamics in your workplace?

So, are membership associations growing or contracting?



Association Membership *Trends*

While the pandemic had an obvious impact on membership, what are the current driving forces influencing individuals or trade organizations in membership recruitment and retention?

IMO: Individual Membership Organization

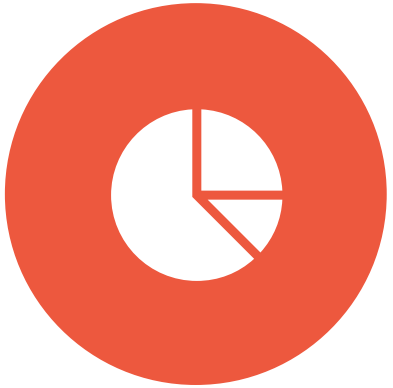
HOW HAS YOUR MEMBERSHIP CHANGED IN THE PAST ONE YEAR PERIOD?

MEMBERSHIP CHANGE IN PAST YEAR (TREND)				
	Increased	Decreased	Remained the same	Not sure
2024	47%	21%	31%	2%
2023	49%	22%	29%	1%
2022	38%	33%	29%	1%
2021	26%	47%	26%	1%
2020	42%	27%	30%	2%
2019	45%	26%	28%	1%
2018	48%	25%	26%	2%
2017	46%	25%	28%	1%
2016	49%	22%	27%	1%
2015	46%	24%	28%	2%
2014	53%	27%	16%	4%
2013	52%	31%	16%	1%
2012	52%	29%	16%	3%
2011	49%	34%	16%	2%
2010	36%	48%	14%	3%
2009	45%	35%	16%	5%

CHANGE IN MEMBERSHIP OVER PAST FIVE YEARS				
	Total (n = 636)	IMO (n = 278)	Trade (n = 220)	Combination (n = 138)
Increased	49%	48%	46%	55%
Decreased	29%	30%	29%	27%
Remained the same	19%	17%	24%	16%
Not sure	3%	5%	1%	2%

Top 3 Reasons Members Join IMOs

(how are we/your chapter doing in these areas?)

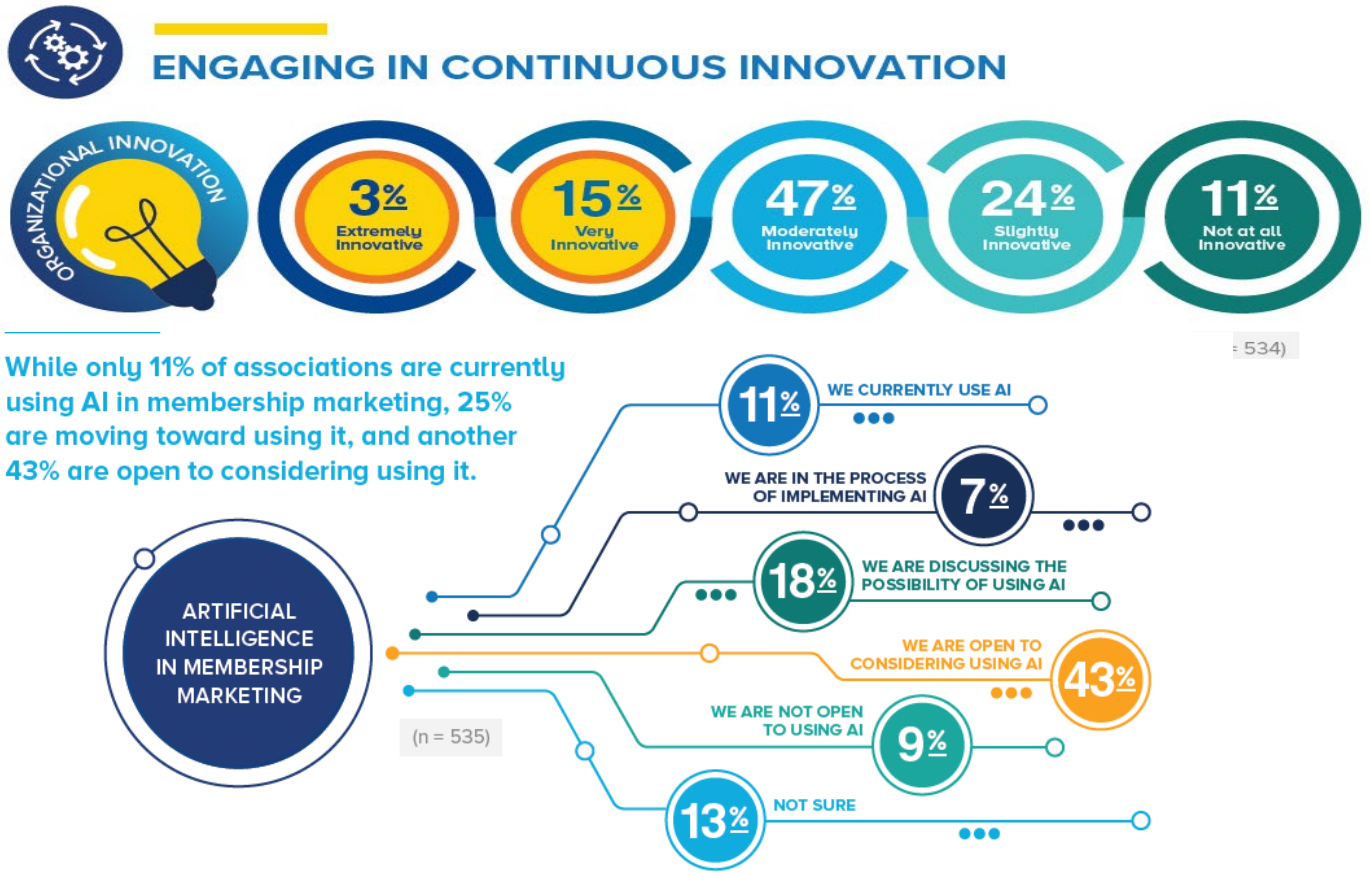


NETWORKING WITH PEERS (67%)

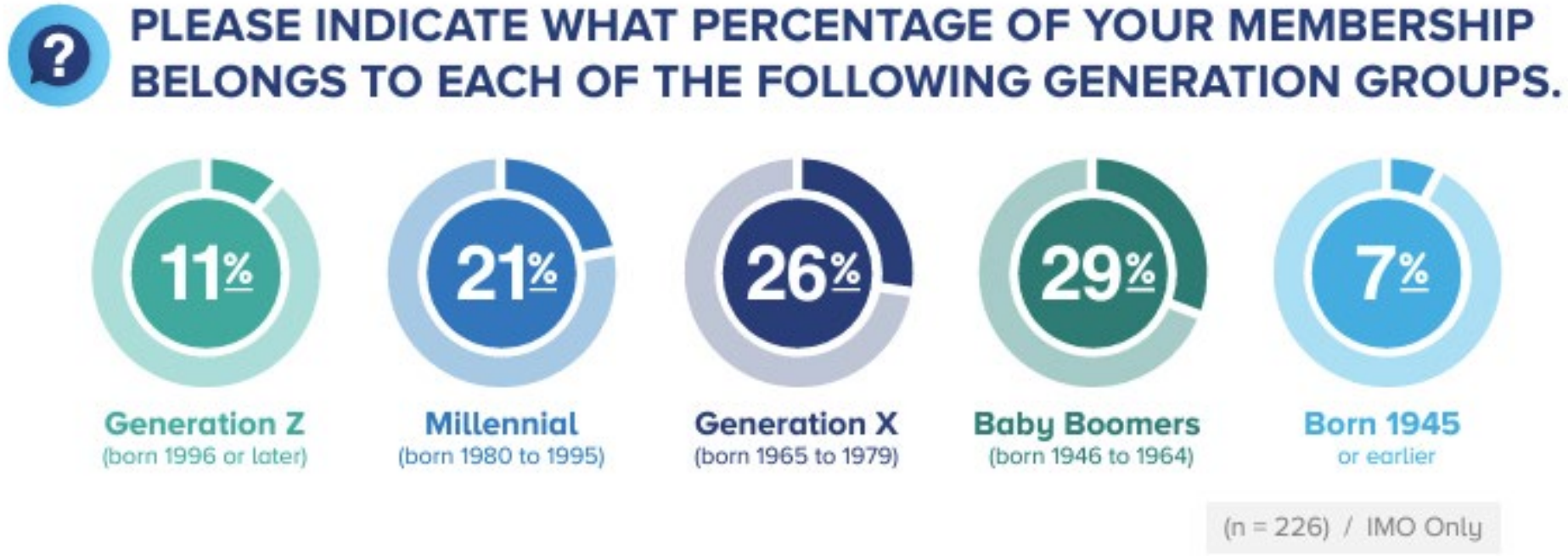
CONTINUING EDUCATION (42%)

ACCESSING SPECIALIZED & CURRENT INFORMATION (32%)

Associations that consider their organization innovative are more likely to report membership growth



Are we evolving and responding to the new generations?



Why Associations Can't Recruit and Retail Millennials & Gen Z?

1. You're not meeting them where they are

2. You aren't supporting their nuanced career trajectories

3. You're not creating the experiences they want

4. You haven't proven the value matches the price point

5. Your communications aren't personalized

Things to consider…

- In your state, how is membership within county medical societies, state specialty societies, and state medical association: growing, declining, about the same?
- Is your chapter distinguishing itself between these organizations effectively?
- Is it important to inform our leadership of state and national membership trends?
- Are the AAFP member strategies making a difference?
- Where do you think FM chapters and AAFP will be membership-wise in 3-5-10 years?