FMLC Virtual Meeting

Friday August 13, 2021 Time: 9:45am – 3:30 pm CENTRAL
Start: 10:45 am edt / 8:45 am mdt / 7:45 pdt

Saturday August 14, 2021 Time: 9:00am – 12:15 pm CENTRAL
Start: 10 am edt / 8 am mdt / 7 am pdt

Join Zoom Meeting BOTH days
https://us02web.zoom.us/j/85346683752?pwd=NXZJVitzVmNtSWViUXRSY2JQeHl0QT09

Meeting ID: **853 4668 3752**
Passcode: **FMLC2021**

FAMILY MEDICINE LEADERSHIP CONSORTIUM – DRAFT AGENDA
Virtual Meeting - August 13-14, 2021

Friday, August 13	
9:45-10:15 am CDT	**Welcome and Introductions** • Aaron Michelfelder, MD, STFM President • Ice breaker
10:15-11 am CDT	**Wicked Problem 1: Advancing the Recommendations from the NASEM High-Value Primary Care Report – <u>Update Since the Announcement (Part 1)</u>** **Overview of Activities Since the Report's Announcement (30 min)** – Bob Phillips, MD, Lauren Hughes, MD **Brief Presentation and Discussion (15 min)** – Shawn Martin, CAE Share ideas on how the NASEM report aligns with other key reports, ie, the new paradigm for primary care financing, PC for America, and the Commonwealth Fund Task Force policy recommendations on payment and delivery system reform
10 minutes	**Break**
11:10-12:20 pm CDT	**Wicked Problem 1: Advancing the Recommendations from the NASEM High-Value Primary Care Report – <u>External Perspectives (Part 2)</u>** **Introduction of the Presenters and Goals for This Section (10 min)** – Aaron Michelfelder, MD **Presentations (20 min each) 3 groups** *Presenters will share ideas and examples of how their organization is or is planning to advance the recommendations from the report.* • 11:20-11:40 Melinda Abrams, MS, Commonwealth Fund • 11:40-12:00 David Skorton, MD, Association of American Medical Colleges • 12:00-12:20 Peter Long, Blue Shield of California
30 minutes	**Lunch Break 12:20-12:50**
12:50-2 pm CDT	**Wicked Problem 1: Advancing the Recommendations from the NASEM High-Value Primary Care Report – <u>External Perspectives (Part 2 cont'd)</u>** **Presentations (20 min each) 3 groups** *Presenters will share ideas and examples of how their organization is or is planning to advance the recommendations from the report.* • 12:50-1:10 Marcus Plescia, MD, Association of State and Territorial Officers • 1:10-1:30 Liz Fowler, PhD, JD, Center for Medicare and Medicaid Innovation • 1:30-1:50 Susan Hassmiller, PhD, RN, Robert Wood Johnson Foundation **Wrap Up –** Aaron Michelfelder, MD
10 minutes	**Break**

2:10-3:30 pm CDT	**Wicked Problem 1: Advancing the Recommendations from the NASEM High-Value Primary Care Report – <u>Ideation and Harmonizing Family Medicine's Efforts (Part 3)</u>** **Breakout Groups (35 minutes)** *Participants break into five groups according to their organization's interest in these areas (payment, access, workforce, digital health, and accountability). The structure will be a modified world café format with a focus on building on the tactics planned by the organizations, generating ideas from these activities for new ideas and collaborations. across groups. Each group will have a facilitator who will serve as a reporter.* *Breakout Discussions: First round 20 minutes. Second round 15 minutes. Participants choose their own breakouts.* 1. **Payment:** Pay for primary care teams to care for people, not doctors to deliver services – *Facilitator - Stephanie Quinn* 2. **Access:** Ensure that high-quality primary care is available to every individual and family in every community – *Facilitator - Nicole Bixler, DO, ACOFP* 3. **Workforce:** Train primary care teams where people live and work – *AFMRD facilitate* 4. **Digital Health:** Design information technology that serves the patient, family, and interprofessional team – *Facilitator - John Franko, MD* 5. **Accountability:** Ensure the high-quality primary care is implemented in the US – *Facilitator - Warren Newton, MD* **Breakout Discussions** • Discuss what each family medicine organization is doing or plans to do to advance the actions within the report. Focus on harmonizing ideas and identifying potential areas for collaboration among the family medicine organizations. **Large Group (45 minutes)** • Small groups report out to the large group – 5 minutes each • Discussion of ideas – 20 minutes *Facilitator – Aaron Michelfelder, MD*
3:30 pm CDT	**Day 1 Wrap-up**
Saturday, August 14	
9-9:50 am CDT	**Wicked Problem 2: Addressing Antiracism and DEI in Family Medicine: <u>Approach for Collective Action</u>** • Discuss Family Medicine Committee on Antiracism (FM-CAR) Antiracism Charter and Scope of Work --- Danielle Jones, MPH, AAFP Director of Diversity and Health Equity (15 min overview) *Facilitator: Aaron Michelfelder, MD*
9:50-10:30 am CDT	**Duration of Family Medicine Residency Training –** *Karen Mitchell, MD, Warren Newton, MD*
15 minutes	**Break**
10:45 am-Noon CDT	**Government Relations Update** **Michael Park**, Partner & Brian Lee, Senior Associate – Alston & Bird – ACOFP **Hope Wittenberg, MA,** CAFM Government Relations Director **Bob Phillips, MD,** ABFM, Exec Dir, Center for Professionalism & Value in Health Care **Stephanie Quinn,** Senior VP – Advocacy, Practice Advancement & Policy, AAFP
Noon-12:15 pm CDT	**Debrief and Closing Remarks** Ideas for January 2022 agenda

FMLC August 2021 Meeting List of Attendees and Presenters and Guests

AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP)	
Margot Savoy, MD, Senior VP for Education at the AAFP	msavoy@aafp.org
Sterling Ransone, MD, FAAFP, President-Elect	Sterling.Ransone@rivhs.com
Gary LeRoy, MD, Board Chair	marvelmoon@earthlink.net
Shawn Martin, CEO/EVP	smartin@aafp.org
Stephanie Quinn, Sr. VP	squinn@aafp.org
Ada Stewart, MD, FAAFP, President	adstewmd@aol.com
Julie Wood, MD, Sr. VP	JWood@aafp.org
Karen Mitchell, MD, Dir, Med Education Division	kmitchell@aafp.org
AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP-Foundation)	
Martin Devine, MD, FAAFP – Treasurer	martindevinemd@gmail.com
Rebecca Jaffe, MD, MPH, FAAFP – President	rjaffedocmom@gmail.com
Heather Palmer, Executive Director – AAFP Foundation/Vice President – Developr	hpalmer@aafp.org
David R. Smith, MD, MPH, FAAFP – President-elect	drstharseo@gmail.com
Tomas Owens, MD, FAAFP – Vice President	tomas.owens@integrisok.com
AMERICAN BOARD OF FAMILY MEDICINE (ABFM)	
Elizabeth "Libby" Baxley, MD - Executive Vice President	EBaxley@theabfm.org
Andrew Bazemore, MD, MPH - Senior VP of Research and Policy	abazemore@theabfm.org
Wendy Biggs, MD, Treasurer	wendy.biggs@cmich.edu
John Brady, MD, Immediate Past Chair	thevillagedoctor1@gmail.com
Roger Bean, CPA, Chief Financial Officer	rbean@theabfm.org
Daniel Spogen, MD, Member at Large Executive Committee	dspogen@med.unr.edu
Michael Magill, MD, Chair	Michael.magill@hsc.utah.edu
Lauren Hughes, MD, Chair Elect	laurenshughes@gmail.com
Warren Newton, MD, MPH, President and Chief Executive Officer	WNewton@theabfm.org
Bob Phillips, MD, MSPH, Ex. Dir., Center for Professionalism & Value in Health Ca	bphillips@theabfm.org
Kevin Rode, Vice President, Operations	krode@theabfm.org
AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS (ACOFP)	
Nicole Bixler, DO, FACOFP, President	nickbixdo@gmail.com
Bruce Williams, DO, FACOFP, President-elect	drwms87@gmail.com
Robert DeLuca, DO, FACOFP dist., Immediate Past President	docrockindo@yahoo.com
Bob Moore, MA, CAE, Executive Director	bobm@acofp.org
ASSOCIATION OF DEPARTMENTS OF FAMILY MEDICINE (ADFM)	
Amanda Weidner, Ex Dir.	aweidner@adfm.org
Allen Perkins, MD, MPH, Outgoing President	perkins@health.southalabama.edu
Chelley Alexander, MD, President	ALEXANDERCH14@ecu.edu
John Franko, MD , Incoming President	John.Franko@towerhealth.org
ASSOCIATION OF FAMILY MEDICINE RESIDENCY DIRECTORS (AFMRD)	
Steve Brown, MD, FAAFP, immediate Past President (Also representing CAFM re	Steven.Brown@bannerhealth.com
Wendy Barr, MD, MPH, MSCE, President	wbarr@glfhc.org
Kim Stutzman, MD, AFMRD President-Elect	KimStutzman@FMRIdaho.org
Kathleen Ingraham (represents/attends CAFM only)	KIngraham@aafp.org
Deanne St. George, CAE	DStGeorge@aafp.org
NAPCRG	
Julie Sutter, Ex Dir.	jsutter@napcrg.org
Gillian Bartlett-Esquillant, PhD, President	gillian.bartlett@health.missouri.edu

Jack Westfall, MD, MPH (represents CAFM)	Jwestfall@aafp.org
SOCIETY OF TEACHERS OF FAMILY MEDICINE (STFM)	
Stacy Brungardt, CAE, Ex. Dir.	SBrungardt@stfm.org
Aaron Michelfelder, MD, President	amichel@lumc.edu
Linda Myerholtz, PhD, President -Elect	linda_myerholtz@med.unc.edu
Tricia Elliott, MD, Past- President	Telliott@jpshealth.org
Hope Wittenberg, MA STFM Dir. Government Relations	hwittenberg@stfm.org
Emily Walters, STFM Dir. Education and Special Projects	ewalters@stfm.org
Melissa Abuel, CMP, STFM Mgr. Conf. and Special Projects	mabuel@stfm.org

Guests	
Melinda Abrams, MS, Commonwealth Fund **(Presenter)**	
David Skorton, MD, Association of American Medical Colleges **(Presenter)**	
Peter Long, Blue Shield of California **(Presenter)**	
Marcus Plescia, MD, Association of State and Territorial Officers **(Presenter)**	
Liz Fowler, PhD, JD, Center for Medicare and Medicaid Innovation **(Presenter)**	
Susan Hassmiller, PhD, RN, Robert Wood Johnson Foundation **(Presenter)**	
Danielle Jones, PhD, MPH, AAFP Dir of Diversity and Hlth Equity **(Presenter)**	
Scott Shipman, MD, MPH Association of American Medical Colleges	
Mary Theobald, MBA, STFM Chief of Strategy and Innovation	mtheobald@stfm.org

Additional Guests
Stacy Potts, MD, Med, Vice Chair of Education, University of Massachusetts Medical School
Leah Hendrick, JD, Center for Medicare and Medicaid Innovation
Nick Minter, MPP, Center for Medicare and Medicaid Innovation

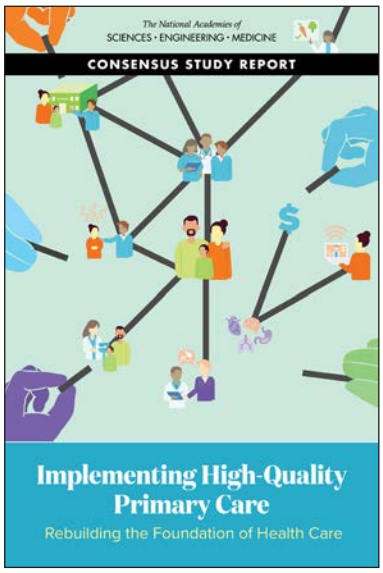
Wicked Problem 1

Advancing the Recommendations from the NASEM High-Value Primary Care Report

Background materials

Implementing High-Quality Primary Care

Rebuilding the Foundation of Health Care



High-quality primary care is the foundation of a high-functioning health care system. When it is high-quality, primary care provides continuous, person-centered, relationship-based care that considers the needs and preferences of individuals, families, and communities. Without access to high-quality primary care, minor health problems can spiral into chronic disease, chronic disease management becomes difficult and uncoordinated, visits to emergency departments increase, preventive care lags, and health care spending soars to unsustainable levels.

Unequal access to primary care remains a concern, and the COVID-19 pandemic amplified pervasive economic, mental health, and social health disparities that ubiquitous, high-quality primary care might have reduced. Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes. For this reason, **primary care is a common good,** which makes the strength and quality of the country's primary care services a public concern.

The National Academies of Sciences, Engineering, and Medicine formed the Committee on Implementing High-Quality Primary Care in 2019. Building on the recommendations of the 1996 Institute of Medicine report *Primary Care: America's Health in a New Era*, **the committee was tasked to develop an implementation plan for high-quality primary care in the United States.**

The committee's definition of high-quality primary care (see Box 1) describes what it *should be*, not what most people in the United States experience today. To rebuild a strong foundation for the U.S. health care system, **the committee's implementation plan includes objectives and actions targeting primary care stakeholders and balancing national needs for scalable solutions while allowing for adaptations to meet local needs.**

The committee set five implementation objectives to make high-quality primary care available to all people living in the United States:

1. Pay for primary care teams to care for people, not doctors to deliver services.

2. Ensure that high-quality primary care is available to every individual and family in every community.

3. Train primary care teams where people live and work.

4. Design information technology that serves the patient, family, and the interprofessional care team.

5. Ensure that high-quality primary care is implemented in the United States.

The committee's implementation plan—comprising recommended actions under each objective—calls for appropriately scaled actions by public- and private-sector actors at the macro, meso, and micro system levels (see the full report for details) and creates accountability structures. Below are the implementation objectives with summaries of the recommended actions to achieve them.

BOX 1. WHAT IS HIGH-QUALITY PRIMARY CARE?

The provision of whole-person,* integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.

* Whole-person health focuses on well-being rather than the absence of disease. It accounts for the mental, physical, emotional, and spiritual health and the social determinants of health of a person.

OBJECTIVE ONE: PAY FOR PRIMARY CARE TEAMS TO CARE FOR PEOPLE, NOT DOCTORS TO DELIVER SERVICES

- Payers[1] should evaluate and disseminate payment models based on the ability of those models to promote the delivery of high-quality primary care, not on achieving short-term cost savings.
- Payers using a fee-for-service (FFS) model should shift primary care payment toward hybrid (part FFS, part capitated) models, and make them the default over time.
- The Centers for Medicare & Medicaid Services (CMS) should increase the overall portion of spending going to primary care.
- States should implement primary care payment reform by facilitating multi-payer collaboration and by increasing the overall portion of health care spending in their state going to primary care.

Implementing high-quality primary care begins by committing to pay primary care more and differently because of its capacity to improve population health and health equity for all of society, not because it generates short-term returns on investment for payers. High-quality primary care is a common good promoted by responsible public policy and supported by private-sector action.

OBJECTIVE TWO: ENSURE THAT HIGH-QUALITY PRIMARY CARE IS AVAILABLE TO EVERY INDIVIDUAL AND FAMILY IN EVERY COMMUNITY

- All individuals should have the opportunity to have a usual source of primary care. Payers should ask all covered individuals to declare a usual source of primary care annually and should assign non-responding enrollees to a source of care. When community health centers, hospitals, and primary care practices treat people who are uninsured, they should assume and document an ongoing clinical relationship with them.
- The U.S. Department of Health and Human Services (HHS) should target sustained investment in creating new health centers (including federally qualified health centers, lookalikes, and school-based health centers), rural health clinics, and Indian Health Service facilities in areas with a shortage of primary care.
- CMS should revise and enforce its FFS and managed care access standards for primary care for Medicaid beneficiaries. CMS should also provide assistance to state Medicaid agencies for implementing and attaining these standards, and measure and publish state performance.
- CMS should permanently support the COVID-era rule revisions and interpretations of Medicaid and Medicare benefits that have facilitated integrated team-based care, enabled more equitable access to telephone and virtual visits, provided equitable payment for non-in-person visits, eased documentation requirements, expanded the role of interprofessional care team members, and eliminated other barriers to high-quality primary care.
- Primary care practices should move toward a community-oriented model.

The COVID-19 pandemic forced payers to enhance the ability of patients to access their primary care teams virtually by video and telephone. These forms of care provide many benefits and CMS should minimize the payment and regulatory barriers to their use. Efforts by primary care teams to build relationships with community organizations

[1] Medicaid, Medicare, commercial insurers, and self-insured employers.

and public health agencies should place patients, families, and community members at the center of the design and accountability of these endeavors.

OBJECTIVE THREE: TRAIN PRIMARY CARE TEAMS WHERE PEOPLE LIVE AND WORK

- Health care organizations and local, state, and federal government agencies should expand and diversify the primary care workforce, particularly in areas that are medically underserved and have a shortage of health professionals, to strengthen interprofessional teams and better align the workforce with the communities they serve.
- CMS, the U.S. Department of Veterans Affairs, the Health Resources and Services Administration (HRSA), and states should redeploy or augment funding to support interprofessional training in community-based, primary care practice environments.

Organizations that train, hire, and finance primary care clinicians should ensure that the demographic composition of their primary care workforce reflects the communities they serve and that the care delivered is culturally appropriate. Developing a workforce able to deliver high-quality care that meets the committee's definition of primary care requires reshaping what is expected of training programs and the clinical settings where the training occurs. The committee recommends adopting alternative financing sources for HRSA-developed, community-based primary care training and that federal support be available to trainees of a broad array of primary care professions.

OBJECTIVE FOUR: DESIGN INFORMATION TECHNOLOGY THAT SERVES PATIENTS, THEIR FAMILIES, AND THE INTERPROFESSIONAL PRIMARY CARE TEAM

- The Office of the National Coordinator for Health Information Technology (ONC) and CMS should develop the next phase of electronic health record certification standards to
  - align with the functions of primary care;
  - account for the user experience of clinicians and patients to ensure that health systems are interoperable;
  - ensure equitable access and use of digital health systems;
  - include highly usable automated functions that aid in decision making;
  - ensure that base products meet certification standards with minimal need for modification; and
  - hold health information technology (HIT) vendors and state and national support agencies financially responsible for failing to meet the standards.
- ONC and CMS should plan for and adopt a comprehensive aggregate patient data system to enable primary care clinicians and interprofessional teams to easily access comprehensive patient data needed to provide whole-person care.

HIT creates opportunities to improve care coordination and person-centeredness. The committee supports federal standards-setting but has determined that current certification requirements are a barrier to high-quality primary care. Creating and implementing these changes require new policies and authorizations as well as innovation by vendors and state and national support agencies. However, these changes will greatly assist primary care teams to deliver high-quality care.

OBJECTIVE FIVE: ENSURE THAT HIGH-QUALITY PRIMARY CARE IS IMPLEMENTED IN THE UNITED STATES

- The HHS Secretary should establish a Secretary's Council on Primary Care to achieve the vision of high-quality primary care captured in the committee's definition.
- HHS should form an Office of Primary Care Research at the National Institutes of Health and prioritize funding of primary care research at the Agency for Healthcare Research and Quality, via the National Center for Excellence in Primary Care Research.
- Primary care professional societies and consumer groups at the national and state level should assemble, regularly compile, and disseminate a "high-quality primary care implementation scorecard," based on the five key implementation objectives to track progress in achieving this report's objectives. (View Appendix E of the report for the committee's proposed scorecard.)

CONCLUDING REMARKS

To increase the chances for successful implementation of high-quality primary care, actors should be held publicly accountable for their responsibilities. Evidence abounds for what is needed to achieve high-quality primary care for all, but primary care lacks a unified voice advocating for change. Organizing primary care clinicians, consumer groups, employers, and other stakeholders to assess the implementation of the committee's recommended actions will hold the named actors accountable, increase the likelihood of successful implementation, and catalyze a common agenda to achieve a vital common good—high-quality primary care.

Committee on Implementing High-Quality Primary Care

Linda McCauley (*Co-Chair*)
Emory University

Robert L. Phillips, Jr. (*Co-Chair*)
American Board of Family Medicine

Asaf Bitton
Ariadne Labs

Tumaini Coker
University of Washington

Carrie Colla
Dartmouth College

Molly Cooke
University of California, San Francisco

Jennifer DeVoe
Oregon Health & Science University

Rebecca Etz
Virginia Commonwealth University

Susan Fisher-Owens
University of California, San Francisco

Jackson Griggs
Heart of Texas Community Health Center, Inc.

Shawna Hudson
Rutgers University

Shreya Kangovi
University of Pennsylvania

Christopher Koller
Milbank Memorial Fund

Alex Krist
Virginia Commonwealth University

Luci K. Leykum
The University of Texas at Austin

Benjamin Olmedo
Dignity Health

Brenda Reiss-Brennan
Intermountain Healthcare

Hector Rodriguez
University of California, Berkeley

Mary Roth McClurg
University of North Carolina at Chapel Hill

Robert Weyant
University of Pittsburgh

Study Staff

Marc Meisnere
Program Officer, Study Director

Tracy A. Lustig
Senior Program Officer

Sarah K. Robinson
Research Associate

Samira Abbas
Senior Program Assistant

Micah Winograd
Senior Finance Business Partner

Sharyl Nass
Senior Director, Board on Health Care Services

Study Sponsors

Academic Pediatric Association

Agency for Healthcare Research and Quality

Alliance for Academic Internal Medicine

American Academy of Family Physicians

American Academy of Pediatrics

American Board of Pediatrics

American College of Physicians

American Geriatrics Society

Blue Shield of California

The Commonwealth Fund

Family Medicine for America's Health

Health Resources and Services Administration

New York State Health Foundation

Patient-Centered Outcomes Research Institute

Samueli Foundation

Society of General Internal Medicine

U.S. Department of Veterans Affairs

Fellows

Kameron Matthews
U.S. Department of Veterans Affairs

Lars Peterson
American Board of Family Medicine

Jennifer Puthota
Christine Mirzayan Science & Technology Policy Graduate Fellow (*until April 2020*)

Dima Qato
University of Southern California

Consultants

Joe Alper
Science Writer

Robert Berenson
Urban Institute

Richard G. Frank
Harvard Medical School

William Miller
University of South Florida

Kurt Stange
Case Western Reserve University

To read the full report, please visit
http://www.nationalacademies.org/primarycare

The National Academies of
SCIENCES • ENGINEERING • MEDICINE

The nation turns to the National Academies of Sciences, Engineering, and Medicine for independent, objective advice on issues that affect people's lives worldwide.
www.nationalacademies.org

The National Academies of SCIENCES ENGINEERING MEDICINE

Implementing High-Quality Primary Care
Rebuilding the Foundation of Health Care

PAYMENT REFORM

High-quality primary care that is team-based, relationship-oriented, and broadly accessible is critical to improving the health of the nation's population and reducing health disparities. Yet, primary care in the United States is fragile and weakening. The cause is two-fold: systemic underinvestment and a fragmented payment system that reimburses individual clinicians for providing specific services instead of teams for delivering whole-person care.

Due to its direct benefits to society, primary care deserves to be treated as a common good and should be promoted by responsible public policy and supported by the private sector. The report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* outlines objectives to make high-quality primary care available for everyone in the United States.

Any effort to implement high-quality primary care must begin with a commitment to **pay for primary care teams to care for people, not doctors to deliver services.** To improve payment for primary care to better meet people's needs, payment should be increased to reflect the outsized benefit primary care has on the health and well-being of society and flexible enough to allow practices to meet the specific needs of the population they serve.

RECOMMENDED ACTIONS

Change the Standard for Evaluating and Supporting Payment Models

Primary care payment models to date have largely been judged based on their ability to generate cost savings. Payment models that support integrated, interprofessional primary care teams working in sustained relationships with patients and families will ensure that high-quality primary care is possible to implement and sustain.

ACTION: Medicaid, Medicare, commercial insurers, and self-insured employers should **evaluate and disseminate payment models** based on the ability of those models to promote the delivery of high-quality primary care and not on their ability to achieve short-term cost savings.

Shift to a Hybrid Payment Model

At present, most primary care in the United States operates under a **fee-for-service (FFS)** model in which insurers pay a given fee for each service. Capitated payment models are less common but provide a fixed amount of money per patient paid in advance to the practice for the delivery of health care services.

ACTION: Medicaid, Medicare, commercial insurers, and self-insured employers should **shift primary care payment toward hybrid (part FFS, part capitated) models,** making them the default method for paying for primary care teams over time. For risk-bearing contracts with population-based health and cost accountabilities, such as those with accountable care organizations, payers should ensure that sufficient resources and incentives flow to primary care.

The hybrid reimbursement model (part FFS, part capitated) should:

- **Pay prospectively** for interprofessional, integrated, team-based care. This includes incentives for incorporating non-clinician team members and for partnerships with community-based organizations.
- Be **risk-adjusted** for medical and social complexity.
- Allow for **investment** in team development, practice transformation resources, and the infrastructure to design, use, and maintain necessary digital technology; and
- **Align with incentives** for measuring and improving outcomes for patient populations assigned to clinicians.

Increase Overall Primary Care Spending

Only a small and declining portion of health care spending is directed to primary care. Underinvestment has perpetuated a system that in most cases is unable to provide high-quality primary care by restricting the ability of interprofessional teams to address the whole-person health needs of individuals and families they serve.

ACTION: The Centers for Medicare & Medicaid Services should increase the overall portion of spending going to primary care by:

- Accelerating efforts to improve the accuracy of the Medicare physician fee schedule by **developing better data collection and valuation tools** to identify overpriced services; and
- **Restoring the Relative Value Scale Update Committee to an advisory nature** by developing and relying on additional experts and evidence.

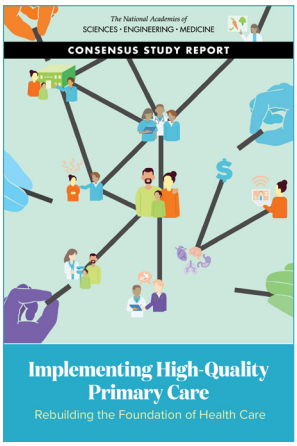
Facilitate Primary Care Payment Reform at the State Level

States play an important role in implementing payment reform through policy and action.

ACTION: States should implement primary care payment reform by using their authority to **facilitate multi-payer collaboration** and by **measuring and increasing the overall portion of health care spending going to primary care.**

CONCLUSION

Most primary care delivered today is transactional in nature, with payment rendered for services provided. Payment reform that supports and encourages high-quality primary care is fundamental to improving the health of the nation. While primary care payment reform may not result in short-term cost savings, it is a long-term investment that can improve population health and create greater health equity.



What Is High-Quality Primary Care?

High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.

To download a free copy of the full report and other resources, please visit nationalacademies.org/primarycare.

nationalacademies.org/primarycare

The National Academies of SCIENCES ENGINEERING MEDICINE

Implementing High-Quality Primary Care
Rebuilding the Foundation of Health Care

ENSURE ACCESS

High-quality primary care should be person-centered, family-centered, and community-oriented. The nation must also overcome barriers to ensure access to primary care for all communities, particularly underserved populations. The COVID-19 pandemic further highlighted pervasive economic, mental health, and social health disparities that might have been reduced with better access to high-quality primary care.

The report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* outlines objectives to make high-quality primary care available to everyone in the United States. Community-oriented primary care models that are able to meet the specific needs of the population they serve and that partner with public health and community-based organizations—influenced by policy changes and innovative payment models—are central to **ensure that high-quality primary care is available to every individual and family in every community.**

RECOMMENDED ACTIONS

Provide Access to Everyone

Successfully implementing high-quality primary care means everyone should have access to a regular source of primary care. While this is more likely to happen when everyone has adequate health insurance, there are ways to improve and reinforce access to primary care and support relationships for both the insured and uninsured.

ACTION: To facilitate an ongoing primary care relationship, all individuals should have the opportunity to have a usual source of primary care.

- Medicaid, Medicare, commercial insurers, and self-insured employers should ask all covered individuals to **declare a usual source of primary care annually and should assign non-responding enrollees** to a source of care using established methods, track this information, and use if for payment and accountability measures.
- When health centers, hospitals, and primary care practices treat people who are uninsured, they should assume and document an ongoing clinical relationship with them.

Create New Health Centers

Health centers are a reliable source of high-quality primary care in underserved communities around the country. It is a model worthy of expansion to improve access to high-quality primary care to more underserved populations and facilitate providing a usual source of high-quality primary care to the uninsured.

nationalacademies.org/primarycare

ACTION: The U.S. Department of Health and Human Services should **target sustained investment in creating new health centers** (including federally qualified health centers, look-alikes, and school-based health centers), rural health clinics, and Indian Health Service facilities in areas with a shortage of primary care.

Revise Access Standards

Medicaid is the second-largest payer in the country, with disproportionate numbers of children and high-needs beneficiaries. Medicaid needs a new strategy to address its documented low rates for primary care paid by state Medicaid agencies and their contractors that limit children's access to high-quality primary care.

ACTION: To improve access to high-quality primary care services for Medicare beneficiaries, the Centers for Medicare & Medicaid Services (CMS) should **revise and enforce its fee-for-service and managed care access standards.** CMS should also provide technical assistance to state Medicaid agencies to implement and attain these standards, and measure and publish state performance.

Eliminate Barriers to Primary Care

The COVID-19 pandemic quickly illustrated that primary care can be delivered outside a traditional office setting, creating options to help eliminate barriers to care and forcing Medicare and other establishments to quickly scale their ability to access primary care teams virtually by video and telephone.

ACTION: CMS should **permanently support COVID-era rule revisions** and Medicaid and Medicare benefits interpretations that have facilitated integrated team-based care, enabled more equitable access to telephone and virtual visits, provided equitable payment for non-in-person visits, eased documentation requirements, expanded the role of interprofessional care team members, and eliminated other barriers to high-quality primary care.

Build Relationships

Having primary care teams embedded within communities and partnering with public health and community-based organizations are crucial to build health-improving relationships with patients, families, and community members.

ACTION: Primary care practices should **move toward a community-oriented model** of primary care by including community members in their governance and practice design and partnering with community-based organizations.

CONCLUSION

Everyone in the country should have access to high-quality primary care that is person-centered, relationship-oriented, and responsive to the needs of the community.

Personalized, prioritized, and coordinated care for all people and families in communities will require a system that develops and sustains strong relationships in primary care with community organizations and public health agencies, and works to ensure universal access to high-quality primary care.

What Is High-Quality Primary Care?
High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.

To download a free copy of the full report and other resources, please visit nationalacademies.org/primarycare.

nationalacademies.org/primarycare

The National Academies of SCIENCES ENGINEERING MEDICINE

Implementing High-Quality Primary Care
Rebuilding the Foundation of Health Care

TRAIN PRIMARY CARE TEAMS

High-quality primary care is critical to addressing the unique needs and preferences of individuals, families, and communities but the current number of trainees entering primary care professions is inadequate. In recent years, the proportion of health care trainees choosing to enter primary care has decreased. In addition, funding for training the primary care workforce is inconsistent and insufficient, with training tending to occur in hospital settings instead of in the communities where most primary care takes place.

The report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* outlines objectives to make high-quality primary care available to everyone in the United States. For primary care teams to address race- and ethnicity-based treatment disparities, their members should reflect the lived experience of the people and families they serve. Organizations that train, hire, and finance primary care clinicians should ensure that the demographic composition of their primary care workforce reflects the communities they serve and that the care delivered is culturally appropriate. High-quality primary care is also best done by a professionally diverse team whose members each bring unique skills in addressing the needs of the patients, families, and communities they serve.

It is essential to **train primary care teams where people live and work**. This will require reshaping training programs and aligning a payment and financial system that provides incentives and rewards to create effective, integrated primary care.

RECOMMENDED ACTIONS

Expand and Diversify the Primary Care Workforce

Black, Hispanic, American Indian and Alaska Native, and Native Hawaiian and other Pacific Islander people are currently underrepresented in nearly every clinical primary care occupation. To provide everyone with high-quality primary care, care teams should reflect the diversity of the communities they serve.

ACTION: Health care organizations and local, state, and federal government agencies should **expand and diversify the primary care workforce,** particularly in areas that are medically underserved and have a shortage of health professionals, to strengthen interprofessional teams and better align the workforce with the communities they serve.

- Public and private health care organizations should ensure inclusion, support, and training for family caregivers, community health workers, and other informal caregivers as members of their interprofessional primary care team.

- The U.S. Department of Education and the U.S. Department of Health and Human Services (HHS) should partner to expand educational pipeline models that would encourage and increase opportunities for students who are underrepresented in health professions
- The Health Resources and Services Administration (HRSA), state and local government, and health care systems should redesign and implement economic incentives, including loan forgiveness and salary supplements, to ensure that interprofessional care team members, especially those who reflect the diverse needs of the local community, are encouraged to enter primary care in rural and underserved areas.
- Health systems and organizations should develop a data-driven approach to customizing interprofessional teams to meet the needs of the population they serve.

Increase Funding and Expand Settings for Training

While training individual primary care clinicians in inpatient settings is commonplace, it is not where primary care occurs and will not develop a workforce able to deliver high-quality primary care to everyone. Current funding to support the training of interprofessional primary care teams is inconsistent and insufficient.

ACTION: The Centers for Medicare & Medicaid Services, the U.S. Department of Veterans Affairs, HRSA, and states should **redeploy or augment funding to support interprofessional training** in community-based, primary care practice environments. The revised funding model should be sufficient in size to improve access to primary care and ensure that training programs can adequately support the primary care needs of the future.

- HRSA funding, via Title VII and VIII programs, for other health professions training should be increased and prioritized for interprofessional training.
- HHS should **redesign the graduate medical education (GME) payment** to:
  - Support training primary care clinicians in community settings.
  - Expand the distribution of training sites to better meet the needs of communities and populations, particularly in rural and underserved areas.
  - Prioritize effective HRSA models for existing GME funding redistribution and sustained discretionary funding.
  - Modify GME funding to support training all members of the interprofessional primary care team, including nurse practitioners, pharmacists, physician assistants, behavioral health specialists, pediatricians, and dental professionals.

CONCLUSION

The ability to deliver high-quality primary care depends on the availability, accessibility, and proficiency of interprofessional primary care teams to meet the health care needs of all individuals, families, and communities.

Those who train, hire, and finance primary care teams should ensure that the demographic composition of their interprofessional primary care workforce reflects the communities they serve. Developing a workforce able to deliver high-quality care requires reshaping what is expected of training programs and the clinical settings where the training occurs.

What Is High-Quality Primary Care?
High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.

To download a free copy of the full report and other resources, please visit nationalacademies.org/primarycare.

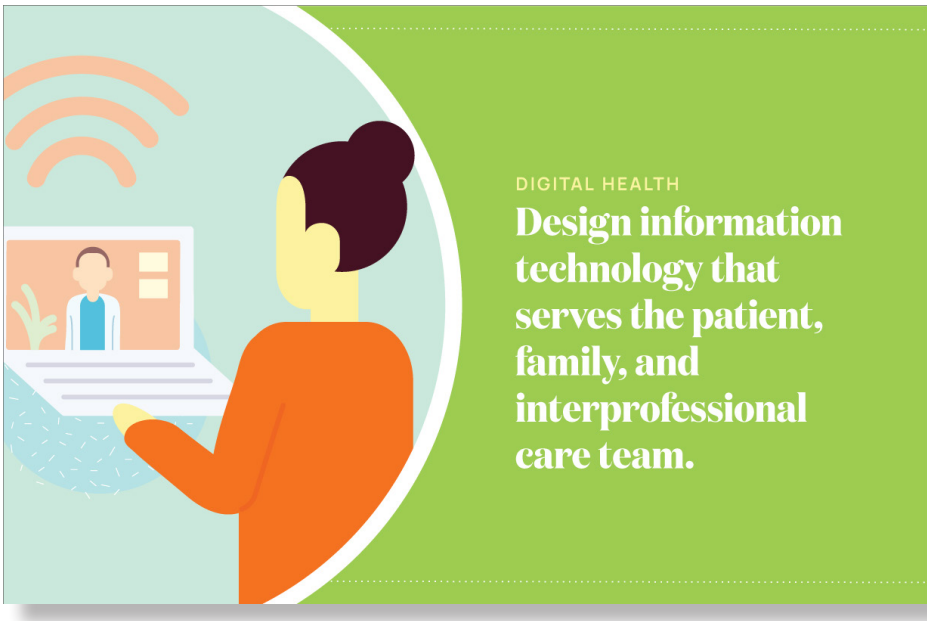
nationalacademies.org/primarycare

The National Academies of SCIENCES ENGINEERING MEDICINE

Implementing High-Quality Primary Care
Rebuilding the Foundation of Health Care

ADVANCE DIGITAL HEALTH

Well-designed health information technology (HIT) is essential to making high-quality primary care more accessible, convenient, and efficient for patients, families, and interprofessional care teams. The digital tools routinely used in primary care, such as electronic health records (EHRs) and patient portals, collect health information to help primary care teams make diagnoses, coordinate and deliver care, track progress, and communicate among team members. Despite their potential, today's electronic health data present challenges. Primary care teams must spend long hours documenting care and reviewing and gathering information from specialists, hospitals, pharmacies, and other sources.



The report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* outlines objectives to make high-quality primary care available to everyone in the United States. To improve care coordination and advance HIT for primary care, changes are needed to **design digital health that serves patients, their families, and the interprofessional primary care teams**.

RECOMMENDED ACTIONS

Develop the Next Phase of Digital Health

Well-designed digital health tools should improve the care delivery experience of patients and primary care teams. For example, EHRs should serve as the hub of patient information, make it easier for people to receive care, and seamlessly provide clinicians with the information they need to deliver the right care at the right time, but there is room for improvement. Vendor policies, inconsistent data storage and architecture, and limited mechanisms for efficient data transfer limit EHRs interoperability and the current dominance of the market by a few informatics vendors has locked clinicians and practices into existing systems and stifled innovation.

ACTION: The Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) should **develop the next phase of digital health**, including EHR, certification standards to:

- Align with the functions of primary care, supporting the relationship among clinicians, care teams, and patients;
- Account for the user experience of clinicians and patients to ensure that health systems are truly interoperable;
- Ensure equitable access and use of digital health information systems that support equitable care and deliver national standards;
- Include highly usable automated tools that make sense of data, identify clinically important data, and inform care;

- Ensure that base products meet certification standards with minimal need for local modification to meet requirements; and
- Hold HIT vendors and state and national support agencies financially responsible for failing to meet the standards.

Comprehensive Patient Data System

A national, comprehensive, and aggregated patient data system would enable primary care clinicians, teams, patients, and families to easily access the comprehensive data needed to provide whole-person care. Creating and implementing this change will require new policies and authorizations as well as innovation by vendors and state and national support agencies.

ACTION: ONC and CMS should **plan for and adopt a comprehensive aggregated patient data system** to enable primary care clinicians and interprofessional teams to easily access comprehensive patient data needed to provide whole-person care.

- This data source needs to be usable by any certified digital health tool for patients, families, clinicians, and care team members.
- ONC and CMS could accomplish this through a centralized data warehouse, individual health data card, or distributed sources connected by a real-time, functional health information exchange.

CONCLUSION

Digital health technology creates opportunities to improve care coordination and support primary care relationships among individuals, families, clinicians, and communities.

The use of telemedicine and other technologies during the COVID-19 pandemic highlighted the benefits of digital health, improving primary care access and offering more scheduling flexibility. However, changes to the marketplace, aggregated comprehensive patient data, and revised federal standards are needed to strengthen the role of HIT to support the implementation of high-quality primary care.

What Is High-Quality Primary Care?
High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.

To download a free copy of the full report and other resources, please visit nationalacademies.org/primarycare.

The National Academies of SCIENCES ENGINEERING MEDICINE

Implementing High-Quality Primary Care
Rebuilding the Foundation of Health Care

ENSURE IMPLEMENTATION

The report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* outlines objectives to make high-quality primary care available to everyone in the United States.

Successfully implementing a plan to create high-quality primary care requires assigning accountability. No federal agency currently has oversight of primary care, and no dedicated research funding is available. The current measures applied to primary care are not aligned with its purpose and function and fail to adequately assess its quality and ensure accountability.

Clear and meaningful measures of care, ongoing research, and leadership from the federal government are all necessary to **ensure that high-quality primary care is implemented in the United States**.

RECOMMENDED ACTIONS

Assign Accountability

The federal government plays an active but uncoordinated role in primary care. The COVID-19 pandemic further highlighted this lack of coordination. Congressional COVID-19 relief did not specifically support primary care and primary care was not included in federal epidemic strategies before or during the pandemic. Senior secretary–level coordination of federal primary care activity in workforce training, safety net funding, payment and benefits policy, health information technology, quality measurement, and research is necessary to ensure the implementation of the report's recommendations with the goal of achieving high-quality primary care for everyone in the United States.

ACTION: The Secretary of the U.S. Department of Health and Human Services (HHS) should **establish a Secretary's Council on Primary Care** to enable the vision of primary care captured in the committee's definition.

- Council members should include the Centers for Medicare & Medicaid Services Administrator; the Directors of the Center for Medicare & Medicaid Innovation, the Health Resources and Services Administration, and the Agency for Healthcare Research and Quality (AHRQ); the Assistant Secretary for Planning and Evaluation at HHS; and the National Coordinator for the Office of the National Coordinator for Health Information Technology.
- The council should coordinate primary care policy across HHS agencies with attention to the following responsibilities:
  - Assess federal primary care payment sufficiency and policy;
  - Monitor primary care workforce sufficiency, including training, financing, production, and preparation; incentives for federally designated shortage areas; and federal clinical assets/investments;

- Coordinate and assess the adequacy of the federal government's research investment in primary care;
- Address primary care's technology, data, and evidence needs, including interagency collaboration in the use of multiple data sources;
- Promote the alignment of public and private payer policies in support of high-quality primary care; and
- Establish meaningful metrics for assessing the quality of primary care that embrace person-centeredness and health equity goals. Additionally, the council should coordinate implementing the committee's recommended actions that target federal agencies.

- As part of its coordination role, the council should verify adequate budgetary resources are allotted in respective agencies for filling these responsibilities.
- The council should annually report to Congress and the public on the progress of its implementation plan and performance.
- The council should be informed through regular guidance and recommendations provided by a Primary Care Advisory Committee created by the HHS Secretary under the Federal Advisory Committee Act that includes members from national organizations that represent significant primary care stakeholder groups.

Create a Primary Care Research Agenda

While primary care research is instrumental to address questions that are critically important for primary care outcomes and a population-based understanding of illness and disease, it is in need of a significant boost in support and funding. At present, no federal agency is funded to advance a robust primary care research program. While AHRQ was designated by Congress to steward primary care research, no funding was allocated for this task. Similarly, primary care research currently receives less than 0.4 percent of the National Institutes of Health's (NIH's) research funding.

ACTION: HHS should **form an Office of Primary Care Research at NIH and prioritize funding of primary care research at AHRQ** via the National Center for Excellence in Primary Care Research.

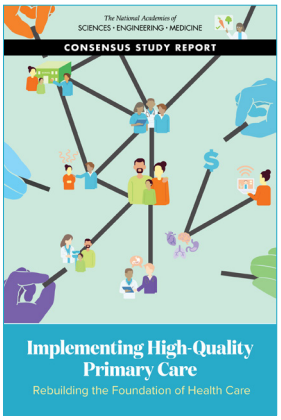
Track Implementation Progress

An implementation plan needs a set of metrics to track its progress and assess whether its objectives are achieved over time. To that end, the report proposes a scorecard (see Appendix E) of selected measures that could be managed by one or more of the sponsoring organizations, federal agencies, or other interested stakeholders.

ACTION: To improve accountability and increase the chances of successful implementation, primary care professional societies and consumer groups at the national and state level should **assemble and regularly compile and disseminate a "high-quality primary care implementation scorecard,"** based on the five key implementation objectives to track progress in achieving this report's objectives. One or more philanthropies should assist in convening and facilitating the scorecard development and compilation.

CONCLUSION

Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes, making it a common good. The strength and quality of the country's primary care rely on having a plan that accounts for the complexity of the U.S. health care system in both the public and private sectors and affirms the fundamental responsibility of the federal government to lead this process. Ensuring that the nation can successfully implement this plan for high-quality primary care requires coordinating primary care activities at the federal level, assigning accountability, establishing effective measurement, and prioritizing funding of primary care research.



What Is High-Quality Primary Care?

High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.

To download a free copy of the full report and other resources, please visit nationalacademies.org/primarycare.

NASEM Report Speaker Bios

Melinda K. Abrams, MS, is executive vice president for programs at the Commonwealth Fund, where she has responsibility for the development and management of the Fund's grant programs. Since coming to the Fund in 1997, Ms. Abrams has worked on the Fund's Task Force on Academic Health Centers, the Child Development and Preventive Care program, led the Patient-Centered Coordinated Care Program, and most recently was the senior vice president of the Delivery System Reform and International Health Policy programs. Ms. Abrams has served on many national committees and boards for private organizations and federal agencies and is a peer-reviewer for several journals. Ms. Abrams was the recipient of a Champion Award from the Primary Care Development Corporation and a Primary Care Community/Research Leadership Award from the Patient-Centered Primary Care Collaborative. Ms. Abrams holds a BA in history from Cornell University and an M.S. in health policy and management from the Harvard School of Public Health.

David J. Skorton, MD, a cardiologist, is president and CEO of the Association of American Medical Colleges, a not-for-profit institution that represents the nation's medical schools, teaching hospitals and health systems, and academic societies. Previously, he was the 13th secretary of the Smithsonian Institution, president of Cornell University and president of the University of Iowa. He has published hundreds of original research papers, opinion pieces, blogs, public policy reports, and book chapters, and edited two major texts in cardiology. He earned his BA from Northwestern University and his MD from Northwestern University Feinberg School of Medicine. He completed his medical residency and fellowship in cardiology at the University of California, Los Angeles.

Peter Long, PhD is senior vice president and chief healthcare transformation & affordability officer at Blue Shield of California. Peter leads collaborations with healthcare providers, community leaders, and other stakeholders to design innovative clinical and community programs, and healthcare delivery and payment systems that provide all Californians access to value-based, high-quality, and affordable care.

Previously, Peter was president and CEO of Blue Shield of California Foundation for nearly nine years, focusing on building lasting and equitable solutions to make California the healthiest state and end domestic violence. He helped launch the California Accountable Communities for Health Initiative in 15 communities across the state in partnership with California Department of Public Health and other philanthropies. Under his leadership in partnership with the Center for Care Innovations, the Foundation supported successful implementation of the Affordable Care Act among the safety-net providers for Californians who had been excluded from health care. Peter earned a Bachelor's degree from Harvard University, a Master's degree from Johns Hopkins Bloomberg School of Public Health, and a doctorate from UCLA Fielding School of Public Health. He serves an adjunct professor at the UCLA Fielding School of Public Health. He currently serves on the Integrated Healthcare Association Board and California Quality Collaborative, among other health advisory councils.

Marcus Plescia, MD, MPH is the chief medical officer for the Association of State and Territorial Health Officials (ASTHO). He provides medical leadership and expertise across the agency and oversees ASTHO's portfolio of chronic disease prevention and control programs. During the COVID-19 epidemic he has served as ASHTO's principal spokesperson, and primary liaison to the Centers for Disease Control and Prevention. ASTHO is the national nonprofit organization representing the public health agencies of the United States, US territories, and District of Columbia, as well as the more than 100,000 public health professionals these agencies employ.

Dr Plescia has served in public health leadership roles at the local, state and federal level in North Carolina and at the Centers for Disease Control and Prevention. In these roles he led successful efforts to enact systemic public health interventions including expanded cancer screening coverage, prescription drug and disease reporting requirements, revised clinical guidelines, and state and local tobacco policy. He has been prominent in nationwide efforts to transform public health practice to a more population-based, strategic framework, and led the implementation of the CDC's national colorectal cancer screening program based on this approach.

Dr Plescia received his Medical Degree, Master of Public Health and Bachelor of Science from the University of North Carolina at Chapel Hill. He trained in family medicine at Montefiore Medical Center in the Bronx, NY. He is Board Certified in family medicine and has practiced in a variety of settings serving homeless, urban poor and rural underserved populations. He has published extensively in the public health and family medicine literature.

Elizabeth Fowler, PhD, JD, is the deputy administrator and director of the Center for Medicare and Medicaid Innovation (CMS Innovation Center). Dr Fowler previously served as executive vice president of programs at The Commonwealth Fund and Vice President for Global Health Policy at Johnson & Johnson. Liz was special assistant to President Obama on health care and economic policy at the National Economic Council. In 2008-2010, she was Chief Health Counsel to Senate Finance Committee Chair, Senator Max Baucus (D-MT), where she played a critical role developing the Senate version of the Affordable Care Act. She also played a key role drafting the 2003 Medicare Prescription Drug, Improvement and Modernization Act (MMA). Liz has over 25 years of experience in health policy and health services research. She earned her bachelor's degree from the University of Pennsylvania, a PhD from the Johns Hopkins Bloomberg School of Public Health, where her research focused on risk adjustment, and a law degree (J.D.) from the University of Minnesota. She is admitted to the bar in Maryland, the District of Columbia, and the U.S. Supreme Court. Liz is a Fellow of the inaugural class of the Aspen Health Innovators Fellowship and a member of the Aspen Global Leadership Network.

Susan Hassmiller, RN, PhD, FAAN, is serving as the senior scholar-in-residence and senior adviser to the president on nursing at the National Academy of Medicine from January 2019 through August 2021. In this role, she serves as a key member of the leadership team for the report, *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*. She is also the Robert Wood Johnson Foundation Senior Adviser for Nursing, and in partnership with AARP, she directs the Foundation's Future of Nursing: Campaign for Action. This national

initiative advances the recommendations of the Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health*. Hassmiller served as the report's study director.

Hassmiller has worked in public health settings at the local, state and national levels, including the Health Resources and Services Administration. She taught community health nursing at the University of Nebraska and George Mason University.

Hassmiller is an elected member of the National Academy of Medicine, a fellow in the American Academy of Nursing and sits on other advisory committees and boards, including the Hackensack Meridian Health System, UnitedHealth, Carrier Clinic, NursesEverywhere, and the American Red Cross. She is the recipient of many awards and four honorary doctorates, but most notably the Florence Nightingale Medal, the highest international honor given to a nurse by the International Committee of the Red Cross.

NASEM Actions and plans as of July 2021

Pay: ***Pay for Primary Care Teams to Care for People, Not Physicians to Deliver Services***

• Payers (ie, Medicaid, Medicare, commercial insurers, and self-insured employers) should evaluate and disseminate payment models based on the ability of those models to promote the delivery of high-quality primary care, not on achieving short-term cost savings.
• Payers using a fee-for-service model should shift primary care payment toward hybrid (part fee-for- service, part capitated) models and make them the default payment model over time.
• The Centers for Medicare & Medicaid Services (CMS) should increase the overall portion of spending on primary care.
• States should implement primary care payment re- form by facilitating multi-payer collaboration and by increasing the overall portion of health care spending in their state going to primary care.

AAFP	Verbal
AAFP Foundation	
ABFM	ABFM supports the advocacy goals of the Family, including payment. Our research and activity support payment adjustment for social deprivation.
ACOFP	ACOFP has one specific advocacy priority related to this action (1.2). Preserve the Family Medicine Model of Care (ACOFP Advocacy Priority 6). • Continue to support DPC arrangements through appropriate tax treatment (e.g., allowing DPCs to be paid for using health savings accounts). Regarding action 1.4, ACOFP has three supporting advocacy priorities: 1. Address the Family Physician Shortage (ACOFP Advocacy Priority 3) • Support policies that equalize reimbursement for primary care and specialty care. • Reward care provided by family medicine through reimbursement policies that are proven to ensure high-quality patient outcomes and patient satisfaction. 2. Improve Outcomes and Reduce Costs Through Primary Care and Support for Family Physicians (ACOFP Advocacy Priority 5) • Support primary care models that empower and reward PCPs who focus on prevention of chronic illness, manage those who have progressed and appropriately use specialists. • Ensure physicians earn compensation for activities that are under the heading of "care coordination," which are essential for improved outcomes and reduction of health care costs. • Recognize the clinical value and cost-savings from physician-led care coordination and establish appropriate reimbursement policies for such activities. 3.Focus on Vulnerable Populations and Address Racial Disparities (ACOFP Advocacy Priority 7) • Preserve and enhance Medicare and Medicaid reimbursement for rural and underserved area physicians, including the facilities where they provide care (e.g., Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), Critical Access Hospitals (CAHs) and Disproportionate Share Hospitals (DSHs)). Note: While our advocacy priorities as written appear physician centered, they are predicated on the premise of supporting the full primary care team.
ADFM	1) Support departments in efforts to organize by state for collective action (e.g. advocacy for primary care spend, etc.); 2) Encourage efforts to address payment at health system level, share resources and case examples
AFMRD	• Encourage AFMRD members, by providing tools and resources, to advocate locally on behalf of increased primary care spending. • Work with STFM to ensure the development of health systems management curricula that supports residents being trained to advocate for, develop, and work in these new payment models
NAPCRG	
STFM	1. Developed a proposal for a rural hospital bonus payment for hospitals that host training programs to commit to keeping their programs going in light of financial issues due to Covid, encouraging other orgs such as NRHA to support it. 2. Identify and showcase community partnership models and multi-institutional collaborations that advance health equity in communities. 3. Provide STFM members with training and resources to effectively make the case to health systems leaders and legislators that investment in primary care medical education has financial and patient care benefits.

Access: ***Ensure That High-Quality Primary Care Is Available to Every Individual and Family in Every Community***	
• All individuals should have the opportunity to have a usual source of primary care. Payers should ask all covered individuals to declare a usual source of primary care annually and should assign nonresponding enrollees. Community health centers, hospitals, and primary care practices should assume and document an ongoing clinical relationship with the uninsured people they are treating. • The Department of Health and Human Services (HHS) should target sustained investment in creating new health centers (including federally qualified health centers [FQHC], FQHC lookalikes, and school-based health centers), rural health clinics, and Indian Health Service facilities in areas with a shortage of primary care. • CMS should revise and enforce its fee-for-service and managed care access standards for primary care for Medicaid beneficiaries. CMS should also assist state Medicaid agencies with implementing and attaining these standards, as well as measure and publish state performance on standards. • CMS should continue to support the COVID-19–era rule revisions and interpretations of Medicaid and Medicare benefits that have facilitated integrated team-based care, enabled more equitable access to telephone and virtual visits, provided equitable payment for non–in-person visits, eased documentation requirements, expanded the role of interprofessional care team members, and eliminated other barriers to high-quality primary care. • Primary care practices should move toward a community- oriented model.	
AAFP	Verbal
AAFP Foundation	• The Family Medicine Care USA grants for free health clinics focus on those clinics that in particular serve the underserved. • The Family Medicine Cares Resident Service Award creates an opportunity for Family Medicine Residents to address health disparities by tackling the health need the underserved in their local communities.
ABFM	ABFM supports a focus on access. Our work to support payments based on social deprivation will support practices in improving access for vulnerable. Our demographic and certification data will allow monitoring of diversity in our workforce and teams, which are necessary for access and health equity. We are developing collaborations with the CDC and the Census to define and monitor social determinants of care at the community level. PRIME and its extension to social determinants provide tools for addressing key access issues, and we are developing national projects to use to assess the status and vitality of rural primary--a key population of concern with respect to access.
ACOFP	Action 2.4: CMS should permanently support COVID-era rule revisions. In general, this is in line with our advocacy priorities. We may want to spell this out more in our plan given where we are in the pandemic. The current advocacy positions are written in a way that may be more appropriate for the middle of the pandemic, not post. (ACOFP Advocacy Priority 1) Action 2.5: Primary care practices should include community members in governance, design, and delivery, and partner with community-based organizations. While not directly aligned with the above actions, ACOFP has an advocacy priority to Focus on Vulnerable Populations and Address Racial Disparities (ACOFP Advocacy Priority 7) which does support the broader recommendation of ensuring high-quality healthcare for all. • Advocate for federal health program policies that assist and support—rather than financially penalize—physicians for unmet patient needs related to social determinants of health. • Develop and advocate for policies ensuring access to equitable and high-quality healthcare. • Encourage Congress to recognize and act on the racial health disparities in our country to improve health outcomes for minority populations.
ADFM	1) support departments in collaboration and advocacy at state and community levels; 2) encourage sharing/find venues for sharing resources on addressing health of populations at an institution level (led or at least championed by DFMs); 3) DFMs may work within their communities to align efforts with community-based organizations, FQHCs, etc. for collective movement toward access for all
AFMRD	• Develop resources to help program directors demonstrate, to health system leaders, the value and contribution the residency program brings to providing community oriented primary care, caring for underserved populations and sustaining clinical relationships with uninsured patients. • Advocated to continue support for COVID-19 era CMS rule changes. • Support development of new residency programs in FQHCs and rural community settings
NAPCRG	
STFM	1. The GME Committee has created a Leadership Training Track for Residents and Early-Career Faculty at the 2021 Annual Meeting. URM Leadership Workgroup has identified topics for an online course on leadership for URM faculty. 2. The work of the STFM Telemedicine Curriculum Task Force is broadly aligned with the access objective. By developing and disseminating a national curriculum to train medical students and residents to perform high-quality primary care via telemedicine, STFM's efforts will enable and advance the shared vision of delivering effective primary care to every individual and family in every community. 3. Launched Health Systems Initiative with multiple tactics around engaging health system leaders. 4. AFMAC continues to advocate for sustained investment in THCs and continued support for the pandemic rule revisions that have facilitated integrated team-based care and payment for non in-person visits, and the training related to those visits.

Workforce: ***Train Primary Care Teams Where People Live and Work***	
• Health care organizations and local, state, and federal government agencies should expand and diversify the primary care work- force, particularly in federally designated shortage areas, to strengthen interprofessional teams and better align the work- force with the communities they serve. • CMS, the Department of Veterans Affairs, the Health Resources and Services Administration, and states should redeploy or augment funding to support interprofessional training in community- based, primary care practice environments.	
AAFP	Verbal
AAFP-Foundation	Provide leadership development training to residents and students for potential impact in their communities and institutions as future family medicine physicians.
ABFM	ABFM supports residency transformation through ongoing work on re-envisioning the residency education of the future; at this stage, the focus is on the ACGME writing group. The recent special issue of Family Medicine laid out many specific major changes: starting with the obligation of meeting the future needs of society, to an emphasis on the practice being the curriculum, a robust involvement in community, competency-based assessment and a broader system that ensures innovation, better standardization, and more social accountability. We are also continuing to engage the ACGME about core faculty time, which is critical to the specialty's future. We believe that it will be important to develop what we mean by team-based care and a key role for personal physicians--and to involve patients and communities at many levels. The ABFM foundation is committed to supporting a major national collaborative project to support residency transformation, once the outlines of the changes become clear. ABFM's graduate survey shows outcomes of residency education; in collaboration with other researchers and AFMRD, we will contribute to the effort to drive improvement in residencies through the use of outcomes data. ABFM certification and demographic data will help monitor and drive changes in workforce scope of practice, team composition and practice transformation across the country; ABFM research has a major focus on health equity in teams, communities, and other settings. The Center for Professionalism and Value in Health Care will engage other specialties, professions, and the public in both development of models of team-based care as well as development of metrics for care that will help to shape the care environment to make it more friendly to robust primary care and the role of personal physicians. CPV will also advocate for commitment to professionalism as an underlying value, which we see as necessary for the future of the health care system. Finally, ABFM is committed to the long-term development of the family medicine workforce through independent assessment and assessment to support education developed by the AAFP and other partners.
ACOFP	Action 3.2 ACOFP has one advocacy priority related to this recommendation: 1. Address the Family Physician Shortage (ACOFP Advocacy Priority 3) • Increase financial support to hospitals, especially those in rural areas, to establish residency programs in family medicine. • Protect and expand medical education funding, including Direct and Indirect Graduate Medical Education funding, and preserve existing alternative Graduate Medical Education programs, such as the Teaching Health Centers Graduate Medical Education program, Title VII and other medical education programs.
ADFM	1) sharing models of team-based care; 2) sharing innovations in GME (e.g. to address community needs) and encouraging GME expansion; 3) advocating for GME expansion opportunities and opportunities for paying for innovations in team-based care;
AFMRD	• Developed DEI milestones for programs to use to assess the DEI status and progress within their program. • Continue to develop diversity related education and resources for AFMRD members with a focus on encouraging diverse workforce with in FMRPs. • Support programs in developing models for interdisciplinary training through NIPDD and other AFMRD programming • AFMRD supports through AFMAC and CAFM advocacy efforts to fund rural GME and THC expansion and permanence • AFMRD supports new program and new program director development so that more programs can be created in diverse locations and communities
NAPCRG	
STFM	1. Health Systems Initiative has aggregated relevant curriculum and is creating new online and in-person curriculum to fill gaps. 2. Working with the VA to deliver faculty development at VA facilities. Work with NRHA and other organizations in support of a rural GME bill. 3. In the early stages of addressing scope of practice issues. 4. Staff and members participate in ongoing meetings of the 25x2030 campaign steering committee and executive committee. MSE Liaison to the 25x2030 initiative asking group for input and providing updates. 5. The URM initiative has liaisons from the AAMC, AAFP, and the Comprehensive Medical Mentoring Program to share ideas and enhance collaborations. 6. STFM/CAFM support for legislation such as our rural GME bill and THC expansion and permanence help to "expand and diversify the primary care work- force, particularly in federally designated shortage areas, to strengthen interprofessional teams and better align the work- force with the communities they serve.

Digital Health: ***Design Information Technology That Serves Patients, Their Families, and the Interprofessional Primary Care Team***
• The Office of the National Coordinator for Health Information Technology (ONC) and CMS should develop the next phase of electronic health record certification standards to align with the functions of primary care; account for the user experience of clinicians and patients to ensure that health systems are interoperable; ensure equitable access and use of digital health systems; include highly usable automated functions that aid in decision-making; ensure that base products meet certification standards with minimal need for modification; and hold health information technology vendors and state and national support agencies financially responsible for failing to meet the standards. • ONC and CMS should plan for and adopt a comprehensive aggregate patient data system to enable primary care clinicians and interprofessional teams to easily access comprehensive patient data needed to provide whole-person care.

AAFP	Verbal
AAFP Foundation	
ABFM	ABFM has been funded by the ONC to address the current status of EHR use among the prime registry. This represents an opportunity to influence the future development of EHRS, to reduce burden and improve outcomes.
ACOFP	Action 4.2 In general, ACOFP has three advocacy priorities related to this recommendation: 1.To encourage the appropriate use of telehealth (ACOFP Advocacy Priority 2). • Prioritize telehealth services for the patient's primary care physician. • Ensure care is properly coordinated with the primary care physician, and Congress should provide resources for physicians to effectively coordinate care with other providers. • Reduce administrative burden associated with telehealth, including burdensome state licensing requirements. • Use data and evidence to develop telehealth coverage policy that ensures patients are receiving the highest quality care possible. • Ensure that family physicians have sufficient resources to invest in new technologies to provide effective telehealth services. 2.Reduce unnecessary paperwork requirements (ACOFP Advocacy Priority 4). • Promote EHR interoperability and standardize reporting requirements to reduce time spent on EHRs. • Develop meaningful EHR reporting requirements to replace unnecessary requirements that do not contribute to patient outcomes. • Streamline utilization management policies across payers in a way that all stakeholders can quickly and efficiently address patient needs. 3. Improve Outcomes and Reduce Costs Through Primary Care and Support for Family Physicians (ACOFP Advocacy Priority 5). • Equalize reimbursement across settings of care and between primary care and specialty care so that primary care has the resources to provide the newest technology and to obtain health IT that assists with improving quality and reducing costs.
ADFM	1) help to train learners in UME and GME space on telehealth ; 2) support efforts on "measures that matter" and other ways to move this forward by individual DFMs sharing faculty expertise
AFMRD	
NAPCRG	
STFM	1. Advocated for various telehealth changes under COVID public health emergency to aid rural training and supervision.

Accountability: ***Ensure That High-Quality Primary Care Is Implemented***	
• The HHS secretary should establish a Secretary's Council on Primary Care to enable the vision of primary care captured in the committee's definition. • HHS should form an Office of Primary Care Research at the National Institutes of Health and prioritize funding of primary care research at the Agency for Healthcare Research and Quality, via the National Center for Excellence in Primary Care Research. • Primary care professional societies and consumer groups at the national and state levels should assemble and regularly compile and disseminate a "high-quality primary care implementation score- card," based on the 5 key implementation objectives.	
AAFP	Verbal
AAFP Foundation	
ABFM	ABFM supports a secretary's council and a focus of federal effort on primary care research, along with more funding and prioritization for primary care research. We believe that these are critical to the future of family medicine and primary care, along with the other recommendations of the report.
ACOFP	Action 5.1: The HHS Secretary should establish a Secretary's Council on Primary Care to coordinate primary care policy, ensure adequate budgetary resources for such work, report to Congress and the public on progress, and hear guidance and recommendations from a Primary Care Advisory Committee that represents key primary care stakeholders. ACOFP hasn't yet, but can support this recommendation. Action 5.2: HHS should form an Office of Primary Care Research at NIH and prioritize funding of primary care research at AHRQ. ACOFP hasn't yet, but can support this recommendation. ACOFP would encourage there be the ability to specifically study osteopathic family medicine as part of some research.
ADFM	1) support advocacy efforts for creating a federal group for primary care; 2) support advocacy efforts for creating/funding a research center focused on primary care; 3) push forward the discussion of a research agenda for the discipline
AFMRD	• Support and disseminate AFMAC advocacy efforts related to Secretary's Council on Primary Care, Office of Primary Care at NIH, Primary Care Advisory Committee. • Work with ABFM to increase the use and functionality of the AFMRD and ABFM National Graduate Survey to measure residency program outcomes
NAPCRG	
STFM	1. Train faculty to rigorously assess the effectiveness of their educational tools, methods, and programs. New CERA Fellowship supports this work, fellowship starts May 2021. 2. Project from Practice Management Collaborative: creating an educational curricular resource to improve education in practice management. Quality Improvement Assessment Tool, https://www.stfm.org/media/2203/ucsf-qi-project-assessment.pdf 3. Partner with other organizations to share data on health indicators and the value of workforce development and increasing the primary care spend. 4. AFMAC recommends its member organizations support policy to advance the establishment of a Secretary's Council on Primary Care, the formation of an Office of Primary Care Research at NIH, and increased funding of primary care research at the Center for Primary Care at AHRQ. STFM/CAFM has been actively working for funding of the Center for primary care research at AHRQ since 2017.
PCCRT (Primary Care Centers Round Table)	● The Primary Care Centers Round Table (PCCRT) is a volunteer group of primary care research and policy centers across the US that meets regularly, including the Robert Graham Center, the Eugene S. Farley, Jr., Health Policy Center, the Center for Professionalism and Value in Health Care, the Center for Community Health Integration, the UCSF Center for Excellence in Primary Care, the Larry A. Green Center, the Morehouse National Center for Primary Care, and the OHSU Center for Primary Care Research and Innovation. The main purposes of the PCCRT – which first began convening in fall 2018 – are to maintain a continual focus on research and policy necessary for the future of family medicine and primary care and to foment a primary care movement. ● The PCCRT is leading an effort to drive sustained focus on this NASEM report recommendation, ultimately leading to its implementation at the federal level. This effort includes two components: 1) a "private" strategy that connects primary care leaders within and beyond the PCCRT to Administration officials, legislators, and other health care influencers to have targeted conversations emphasizing key messages around the need for and the value of this Council; and a "public" strategy that identifies PCCRT and other primary care leaders who can author lay press and peer-reviewed articles that communicate the same key messages.

Wicked Problem 2

Addressing Antiracism and DEI in Family Medicine

Approach for Collective Action

Family Medicine Committee on Anti-Racism (FM-CAR)
Charter

Background

In 2017, the American Academy of Family Physicians (AAFP) launched the Center for Diversity and Health Equity (CDHE) which created an infrastructure to centralize and operationalize the strategic priorities of the AAFP to advance issues of diversity and health equity within family medicine. The CDHE also lends its support to the other member organizations of the Family Medicine Leadership Consortium (FMLC) to achieve similar goals and objectives. To maximize our collective impact, limit duplication of efforts and synchronize activities, the CDHE began convening the Family Medicine Health Equity Action Team (FM HEAT), an inter-organizational staff workgroup, for the purpose of advancing health equity across the family medicine discipline in 2018. Prior to 2020, FM HEAT met twice a year, in the Spring and Fall, between the Summer/Winter FMLC meeting schedule.

The key objectives of FM HEAT included:

- Providing inter-organizational support for the development and implementation of strategic priorities to advance diversity and health equity
- Cross promotion of organizational events and activities that advance health equity within family medicine
- Identifying opportunities for the co-development and dissemination of products and/or services that meet member needs
- Facilitating communication periodically with executive leadership of the FMLC organizations

During the Winter 2021 FMLC meeting, member organizations shared their current actions (Appendix B) to address antiracism in medicine using the framework (Appendix A) developed by the CDHE. The following guests were invited to provide their expertise in the areas of practice, education and research.

- Monica Hahn, MD, Associate Professor, University of California, San Francisco
- Edwin Lindo, JD, Assistant Dean for Social & Health Justice, University of Washington
- Brittani James, MD, Founding Codirector, The Institute for Antiracism

Following the guest presentations, facilitated breakout discussions focused on barriers, gaps and opportunities for collaboration in the following areas:

- Research
- Undergraduate Medical Education
- Residency training
- Pipeline
- Faculty development
- Practice guidelines
- Advocacy
- Governance

At the conclusion of the meeting, member organizations concurred that a coordinated strategy addressing antiracism across the specialty was needed and recommended the formation of a committee to draft a formal plan for review and approval. The CDHE proposed that the FM HEAT be

repurposed to develop and coordinate the implementation of an antiracism roadmap for the specialty of family medicine.

Since that Winter 2021 meeting, the National Academies of Science released *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* (April 29, 2021 Nationalacademies.org/primarycare). This report examines the current state of primary care in the United States and sets forth an implementation plan to strengthen primary care services in the United States, especially for underserved populations. The report compels collective action. Among the five objectives identified as necessary for high-quality primary care, one aimed at access is particularly relevant and compelling for this FMLC initiative: "Ensure that high-quality care is available to every individual and family in every community."

This charter outlines the organization, objectives and timelines of the FM-CAR.

Guiding Principles

The work of the committee is guided and bound by the following philosophical principles:

- We adhere to the guiding principles of the FMLC, specifically recognizing that the consortium is intended to facilitate information sharing, relationship building, and leadership for coordinated and/or collaborative strategic action on behalf of family medicine, and that we recognize that "From time to time for some issues, it will be important for the specialty to take collective action requiring sustained activity between meetings." This committee is a function of this need for sustained action.

- Diversity, Equity and Inclusion (DEI) Issues: There is mutual understanding that while DEI issues in family medicine are broad, this committee aims to prioritize those identified in the proposed "Anti-Racism in Family Medicine Framework" (Appendix A). These are issues that pertain to activities that significantly impact governance, advocacy, research, medical education, pipeline, faculty and practice. These issues are ones that come under the purview of the committee.

- Autonomy: This committee structure respects the unique contribution of each organization while also considering emerging and ongoing opportunities to take collective action on issues of common priority and interest. We support joint efforts through FMLC as a way to fully engage all stakeholders and achieve maximum impact.

- We believe that each organization brings unique and important perspectives to diversity, equity and inclusion issues. Further, we recognize the good work and ongoing efforts of each family medicine organization in addressing racism and equity issues. Each organization has addressed antiracism through policies and programming within its respective disciplines and will continue to do so. This proposed FMLC initiative is intended to identify needs and target areas where collective effort might create or influence impact. Working together has the potential to achieve more effective solutions than any single organization acting alone.

- Committee members will respect any confidentiality agreements made by the group.

- The sharing of information and openness of intent and action are core values that member organizations and their representatives are expected to uphold. While we may

not agree to support everything we each propose, we can agree, with due diligence, to inform.

- The proposed roadmap and action plan will be developed in concordance with existing policy set forth by each of the participating organizations.

Composition of the Committee

The committee shall consist of representation from each of the following participating FMLC organizations as designated by each organizations' respective senior executive. In addition, member organizations will be expected to share their current and planned actions addressing antiracism in family medicine.

- Association of Departments of Family Medicine (ADFM)
- Association of Family Medicine Residency Directors (AFMRD)
- North American Primary Care Research Group (NAPCRG)
- Society of Teachers of Family Medicine (STFM)
- American Academy of Family Physicians (AAFP)
- American Board of Family Medicine (ABFM)
- American College of Osteopathic Family Physicians (ACOFP)
- AAFP Foundation (Foundation)

Committee Convener and Chair

The AAFP serves as the convener of this committee and appoints the Director of the CDHE as chair (***pending AAFP Board Chair approval***). Each FMLC organization is entitled to appoint up to two representatives to the committee. If one or more designated representative(s) of an organization cannot attend a meeting or phone call, an ad hoc representative from that organization may attend in their place. Any reimbursement for travel, etc. are particular to the policies of each member organization.

The convener shall appoint a designated representative from the committee to assist with scheduling meetings, developing and disseminating the meeting agendas, and other administrative tasks associated with the drafting of the action plan. The Committee will inform the FMLC planning committee of all activities to facilitate coordination with related FMLC discussions, decision making and actions.

Scope of Work of the Committee

This committee exists to support the continued development, operationalization and coordination of an antiracism strategy across the 8 member organizations of the FMLC. This process consists of the following activities:

- Solicit from each member organization current and planned strategic actions to address antiracism, diversity and equity. This includes evaluation measures.

- Conduct a gap analysis of the specialty using the proposed "Anti-Racism in Family Medicine Framework" (Appendix A).

- Develop recommendations that address identified gaps, strengthen the impact of current efforts and monitor progress towards outcomes.

- Provide recommendations to FMLC for feedback and plan approval.

- Develop a coordinated plan to communicate the strategy to key stakeholders.

- Once this strategy has been created and communicated, meet approximately every other month (or at a pace set by the committee) for ongoing check-ins to help hold each other accountable for the efforts of our individual organizations and to assess overall collective impact.

Timeline

The committee proposes the following timeline to complete the scope of work. This timeline may be adjusted by the Chair with approval of the FMLC.

- August 2021 - FM-CAR Charter presented and approved by FMLC organizations
- September 2021 - Committee meeting
- November 2021 - Committee meeting
- January 2022 - plan presented to FMLC organizations for feedback and approval
- 2022 - Tentative plan launch date
- Ongoing - committee meetings to check-in on progress

Process for Decision Making

The committee is an advisory body only and does not have decision making authority. It is only authorized to make recommendations to the FMLC in regard to its scope of work.

Frequency of Committee Meetings

At minimum the committee will meet bi-monthly, not to exceed 12 consecutive months without prior approval from FMLC organizations. These meetings will be held virtually to incur minimal expense for participating organizations. If an in-person meeting is necessary, each organization will be responsible for covering the travel expenses of their designated representative.

Appendix A Draft Anti-Racism in Family Medicine Framework (Not for Distribution)

FMLC Organizational Efforts Toward Anti-Racism, Diversity, Inclusion, and Health Equity Actions and efforts as of July 2021 **UPDATED 7/27/2021**	
Governance: ***Policy; leadership; training***	
AAFP	As directed by the COD, the AAFP has developed policy on Implicit Bias, Institutional Racism, Birth Equity and Race Based Medicine. In addition, starting in 2021 we will annually offer anti-racism training for all office holders and commission members.
AAFP-Foundation	• Annual diversity survey taken by the BoT and reviewed annually. Gaps in diversity are incorporated in governance review and board nomination announcements.
ABFM	• Definition of Diversity established spring of 2020, amended 2021 • Change of Board election procedures to support diversity in the Board, spring 2020 • Public Statement of Anti-Racism (5/20) • Editorial on ABFM Strategy for Health Equity (9/20) • Board Task Force on Governance and Development begun (9/2)—to include education, leadership pipeline development and potentially other interventions… • 2021 Board members elected in the spring include 2 minorities, 4 women, two rural physicians, A DO and a patient. • 2021 Beginning Effort to Diversify Volunteer Representation and to Track/Report Regularly • Helped lead ABMS collection of DEI data, implementation of DIF procedures; shared best practices across Boards
ACOFP	Implemented a Task Force on Racism & Health (now DEI) with the following charge: • Assess the issue of racism and health for 3 subgroups: Governance, Education and Community Outreach • Review ACOFP's current policies, programs and efforts to address this issue. • Make recommendations to the Board on ways ACOFP can help osteopathic family physicians play a role in ending health disparities due to racism and discrimination. A Governance Task Force continues their work with a goal to increase diversity of the Board. Congress Resolution submitted and passed in March 2020 titled Opposition to Patient Discrimination of Osteopathic Family Physicians Because of Race, Color, Religion, Gender, Sexual Orientation, Gender Identity or National Origin - The American College of Osteopathic Family Physicians (ACOFP) supports osteopathic family physicians who act in life-threatening emergencies to have acted ethically and professionally; and, the ACOFP supports the education of the public that osteopathic family physicians should be evaluated by their skill and knowledge rather than by their race, color, religion, gender, sexual orientation, gender identity or national origin ACOFP hosted diversity training for its staff in May of 2021 and conducted implicit bias training for Board Members at the June 2021 Board meeting.
ADFM	Tracking diversity of our membership; considering diversity of our Board; integrate diversity and health equity into each of our strategic areas; invest in a socially responsible fund; **examining all policies for potential bias.**
AFMRD	• Appointed, non-voting, Association Program Director position to the Board of Directors in 2020 with the goal of increasing diversity. • Call for Board of Directors nominees written to encourage diverse representation on the Board of Directors. • Moved from Board members chairing all committees and task forces, to soliciting member at large volunteers to serve as chair of select workgroups and committees. • Diversity of representation is taken into consideration and is prioritized when selecting liaisons, committee chairs, and other leadership positions. • The AFMRD Diversity and Health Equity Task Force has been converted to a standing Committee.
NAPCRG	1) The Board has committed to including diversity/equity/inclusion as a goal within the strategic plan. 2) Board members and the Governance Committee were intentional about reaching out to nominees to encouraged them to apply for board and committee positions. Proactive action supplemented the traditional, more passive NAPCRG Call for Nominations process, which is based on submissions and favors those with prior experience. 3) We hosted a virtual session prior to the submission deadline so that interested members (and nonmembers) could learn more about committee and Board service. 4) Committees were asked to explore how they could advance DEI efforts within the organization; these reports will inform the next version of the strategic plan, 5) exploring policies & programs (awards) that create barriers to URM participation.
STFM	(tactic) Consider diversity first is woven into the process of how STFM selects our Board, committees, and task forces; (tactic) Health equity is one of our strategic priorities; antiracism - created new Antiracism Task Force to drive antiracism initiatives (action) URM initiative, through the task force, prioritizes getting URM faculty in leadership positions. Also emphasizes scholarship, mentorship, and URM faculty pipeline STFM invests in socially responsible funds; (action) Two years ago, began implicit bias conversations with board; (action) Intentionally increasing racial/ethnic diversity of STFM staff including review of STFM policy manual and hiring procedures for unconscious bias.

Advocacy: ***Federal, organizational, communities, patients***	
AAFP	The AAFP continues to advocate on issues it believes advances racial and health equity. Letter to HHS Secretary Azar on COVID-19 Data Collection by Race and Ethnicity (04/03), Letter in Support of COVID-19 Task Force on Racial and Ethnic Disparities (05/28), AAFP Condemns All Forms of Racism (05/31), Letter to Congress on Reducing Maternal Health Disparities (06/09), Letter to Domestic Policy Council (DPC) on Racism as a Public Health Issue (06/10), the Anti-Racism in Public Health Act (06/23).
AAFP-Foundation	
ABFM	• Federal: Unified Voice for Primary Care with Component of Equity—initial statement 12/20; affirmed support of NASEM report • Supported NASEM report—funded planning meeting; Bob Phillips co-lead of report; supporting implementation. Primary Care • Convening of Meetings with federal agencies on Adjustment of Clinical Payments for Social Deprivation; • ABFM research and engagement with the CDC and the Census Bureau about Social Determinants of Health. • Supporting efforts across all specialty boards to address bias in certifying examinations and certification.
ACOFP	ACOFP has a specific advocacy position on this topic: Focus on Vulnerable Populations • Ensure recognition and inclusion of the social determinants of health and their overarching impact on healthcare in policy making • Expand physician knowledge of population health and how it relates to the understanding of patient outcomes • Expand telehealth access and billable codes for vulnerable populations in rural, inner-city and urban areas • Preserve and enhance Medicare and Medicaid reimbursement for rural and underserved area physicians, including the facilities where they provide care (e.g., Rural Health Clinics (RHC), Federally Qualified Health Center (FQHC's), Critical Access Hospitals (CAH's) and Disproportionate Share Hospitals (DSH)
ADFM	Sharing data re: DEI structures in departments and institutions (working on a publication); Supporting advocacy needs of other FM departments and sharing resources
AFMRD	• Strategic Priority: Diversity, equity, and inclusion. Includes providing residency program directors with resources to address equity and inclusion and to ensure a diverse workforce within their programs. • Provided holistic screening and selection guidance to program directors during an AAFP sponsored virtual interviewing webinar in the fall of 2020.
NAPCRG	
STFM	(action) Conference sessions, including plenary sessions on Allyship, Justice, Racism, Diversity, Equity, Micro aggressions. (action) AN20: Blanchard Lecture: Reflections of a Unicorn – Cedric Bright, and Zoom Room Discussions: Antiracism and Health Equity: A Call to Awareness and Action / Health Equity and Implicit Bias in Medical Education (Strategic Priority) Increase the knowledge and skills of family medicine faculty and learners so they can be effective advocates for antiracism policies in their institutions and communities.

Research: ***Define race, name racism, avoid genetic interpretations, cite experts of color***	
AAFP	The FY21-22 Strategic Operational Plan aims to position members and the AAFP to lead on advancing racial equity across the specialty through focused work in research. Led by the National Research Network, the AAFP intends to develop a framework for approaching and evaluating projects, processes and products with a health equity lens. Led by the Robert Graham Center the AAFP aims to develop a research agenda around implicit bias, URM physician well-being and institutional racism.
AAFP-Foundation	
ABFM	• Collection of race/ethnicity data for all Diplomates • Differential Item Function: ongoing testing for bias in test questions, with review committee (submission in process); Analysis of Intraining Examination Results (paper submitted); Analysis of Diversity By States • Reduction of Disparities in Board Certification (Analysis complete, paper in preparation) • We plan to formalize policy on not including race based descriptors in examination questions in 2021. • Our policy research team has set policy that authors of JABFM policy briefs and commentary authors will be diverse. We have instituted this policy this spring.
ACOFP	In February of 2021, ACOFP partnered with the Exeter Group to assess staff and member perceptions of the organization in regard to DEI. The survey took place over the course of two months and resulted in findings on member perceptions of ACOFP, along with recommendations and next steps. The Task Force will use this data to present recommendations to the ACOFP Board of Directors in October.
ADFM	Within new project creating "profiles" with DEI metrics for clinical practice, workforce, and learning environment, considering how to track research through each of these; working with other stakeholders such as ABFM to push research initiatives forward, including how to attract a more diverse workforce to research
AFMRD	
NAPCRG	
STFM	action) STFM member IRB survey to gather baseline data on members' perceptions of racism in their academic environments. 700 members have responded. (action) Leadership through Scholarship Fellowship offers training and mentorship for early-career URM faculty with a focus on developing scholarly writing skills for academic advancement and leadership. Class size expanded in 2021 to 12 fellows with ABFM Foundation funding. (action) Antiracism and Health Equity section on the STFM website. Includes aggregated resources. (tactic) Integrate an antiracist analysis and identity into the work of all STFM resources and programming. (action) Series of URM Scholarship webinars & virtual workshops released by the URM Scholarship workshop over 2020-2021 (action) URiFM Twitter Chats hosted by the URM Scholarship work group on issues of URM scholarship & representation

Education: *Medical school, residency training, curriculum, modeling*	
AAFP	The FY21-22 Strategic Operational Plan aims to position members and the AAFP to lead on advancing racial equity across the specialty through targeted education. This will include engaging with our academic family medicine partners on the development of racial equity curriculum. The Medical Education Division completed the 2020 STUDENT MATCH PREPARATION SURVEY which also asked students about their medical school's response to racism. The CDHE also provides members with education which has included the topics of implicit bias, racism and the pandemic. Impact of the COVID-19 Pandemic on Vulnerable Populations (04/29) The Public Health Impact of Racism (06/22) COVID-19 and Implicit Bias (06/24). Future educational offerings include Overcoming Imposter Syndrome and Anti-Racism in Medicine.
AAFP-Foundation	• Dr. Ada Stewart, AAFP President, to give remarks on diversity and inclusion to the 2021 Family Medicine Leads Emerging Leader Institute Scholars (7/15/21). • Provide leadership training to diverse cohort of students and residents in Family Medicine Leads Emerging Leader Institute program. • NEW STRATEGIC PLAN TACTIC: Expand CHFM's collections to recognize the wide diversity of FPs and their impact to family medicine through oral histories.
ABFM	• Residency Summit/ACGME Major revision process included significant URM voice (20% of participants) and presentations. ABFM-F funded the special Issue of Family Medicine which included commentaries on the current family medicine work force, plans for increasing the diversity of the workforce, engagement in communities and embedding interventions to address health equity in model practices. • Development with AAFP of Health Equity Knowledge Self-Assessment—expected release this fall. • Over the next 12 months, revisions of other knowledge self-assessments (KSAS) will include questions on disparities, social drivers/determinants of health.
ACOFP	ACOFP has offered CME on a variety of topics related to racism and health (i.e. health disparities, social determinants of health, unconscious bias). The redesigned Intensive Osteopathic Update (IOU) that was held in August 2020 offered a few sessions to further the learning and understanding need to help impact change (i.e race and health, unconscious bias). Pre- and Post-Doctoral Education Policy- The ACOFP encourages the development of core curriculum guidelines in cultural diversity to address the issue of cultural competency and healthcare disparities throughout the lifelong continuum of osteopathic medical education, and that these guidelines should be included in the Basic Standards for Residency Training and be forwarded to the AOA for referral to appropriate committees for inclusion into the Basic Standards of Pre-Doctoral and Post-Doctoral Training. In March of 2021, Sekou Andrews presented Power Through the People: Diversity is Disruption as the keynote speaker at the Annual Convention. ACOFP also has a focus on Diversity, Equity, and Inclusion via our content-focused blog which touches on a multitude of diversity dimensions.
ADFM	Creating a "learning environment" profile with DEI metrics for departments to measure; Considering creating/vetting/partnering for shared anti-racism/social justice curriculum for application at any medical school
AFMRD	• Modified (with permission) the FMAHealth Workforce Diversity Toolkit to in resources specifically useful to residency program directors. • The AFMRD Diversity and Health Equity Committee developed DEI milestones. The Milestones were presented at the 2021 AAFP Residency Leadership Summit (formerly PDW-RPS) and have been prepared for publication. • Providing funding support of two AAFP Health Equity Fellows in 2021. • Residency Curriculum Resource curriculum is being updated with lens toward DEI and antiracism. • A DEI domain is being added to the NIPDD curriculum.
NAPCRG	2021 meetings/conferences (Annual Meeting, PBRN, ICPF) have featured or will feature DEI presentations.
STFM	(action item) Create or link to antiracism curriculum for the Family Medicine Residency Curriculum Resource (tactic) Update the Residency Curriculum Resource to integrate antiracism education within existing curricula. (action item) Conduct a summit with Diversity Officers and Health System Senior leaders to Empower participants to work as teams to identify racist structures and behaviors within their academic institutions. (tactic) Enhance the knowledge and skills of family medicine faculty and learners in bestowed power and intercultural humility so they may more effectively serve as allies to BIPOC peers and trainees.

Pipeline: *Expand, reinforce, holistic review, committee diversity*	
AAFP	The AAFP leads the 25x2030 initiative and is developing programs to expand the medical education pipeline. Also, as part of our strategic operational plan, the AAFP aims to grow a diverse family physician workforce by increasing student choice of family medicine especially among URMs. This includes leadership development opportunities for students, residents and other influencers.
AAFP-Foundation	• The application for the Family Medicine Leads Emerging Leader Institute contains the following diversity statement: We encourage all to apply and are committed to the development of future Family Medicine leaders who reflect the rich diversity of the specialty and the patients served. • NEW STRATEGIC PLAN TACTIC: Collaborate with Chapters/Chapter Foundations to identify diverse opportunities for medical students to explore family medicine. • NEW STRATEGIC PLAN TACTIC: Develop and state a diversity statement on all grant and scholarship applications and website for students of all diverse backgrounds. • NEW STRATEGIC PLAN TACTIC: Increase the awareness and appreciation of diversity, equity, and inclusion within family medicine by highlighting diversity of recipients, clinics, and volunteers in all Foundation communication outlets. • NEW STRATEGIC PLAN TACTIC: Provide diversity information/knowledge to medical students volunteering at FMC USA awarded free health clinics by increasing diversity in the Family Medicine pipeline to work in underserved community practice sites.
ABFM	See above for residency training. ABFM has increased funding to the Pisacano Leadership Foundation in order to double the number of Pisacano fellows yearly. Given the track record of diversity in Pisacano fellows, this will represent an increased number of diverse future leaders. With support of collaboration with the Graham Center, and ABFM/CPV, US News and World Report has published the first rankings of medical schools for primary care using actual outcomes of students going into primary care and diversity.
ACOFP	ACOFP announced the new Diversity, Equity and Inclusion Award this March which recognizes osteopathic family physicians who make significant contributions toward enhancing diversity, equity and inclusion within osteopathic family medicine education and practice. The award acknowledges practicing osteopathic family physicians who have completed residency and demonstrated behavior or led initiatives that foster these principles within diverse and underrepresented communities. The award honors those who have demonstrated such commitment not only by engagement but also through initiative and leadership. The DEI Award recipients will serve as a discussion group or symposium leader and author articles on their efforts. The Student Association of the ACOFP features a monthly article in their newsletter called Diversity in Patient Populations - #BlackSkinMatters which shares comparisons of clinical cases and highlights images showing the differences in presentations of diverse patient populations. The Student Association of the ACOFP's national service project, Family Med Tread 5K, was held virtually across campuses in March 2020 to raise awareness and funds for the nonprofit Skin of Color Society, an organization whose mission is to provide information related to all aspects of skin of color in order to educate physicians, residents, scientists, and the general public about the unique properties and diseases of individuals with skin of color. This is done through promoting research studies and dermatologic literature written about these disease processes and by mentoring individuals interested in the field of skin of color.
ADFM	LEADS fellowship emphasis on women and URM; weaving diversity and inclusion through the LEADS fellowship curriculum; Creating a "workforce" profile with DEI metrics for departments to measure
AFMRD	• Launched formal communication campaign to members providing guidance and encouraging utilization of the CAFM Leadership Development Toolkit to foster the professional development of URM in residency programs for both faculty and residents.
NAPCRG	The Board will consider actions it can take to address the pipeline of URM in research in the next version of the strategic plan.
STFM	(action) Scholarships for URM to attend STFM conferences and participate: Emerging Leaders, Behavioral Science fellowships, New Faculty Scholars, and Medical Student Scholarships. (tactic) A virtual half-day workshop in July 2021, led by the Minority & Multicultural Health Collaborative, to help STFM members take action as upstanders, especially for those with different levels of privilege. (tactic) Teach and promote antiracism in family medicine through the development and dissemination of a national curriculum for faculty and learners. (tactic) Podcast to release in Aug/Sept. 2021 - "URM Journey to Academics" a podcast for URM residents & students with key topics to relevant to an academic track and the hidden curriculum (tactic) Online course on URM Leadership under development for release winter 2021/2022

Faculty: ***Develop, promote, eliminate the minority tax, sponsorship/mentorship, empower, allyship***	
AAFP	The AAFP supports CAFM in the development of tools to increase representation of women and minorities in faculty leadership positions. The AAFP also supports faculty by developing educational tools such as the Implicit Bias Training Guide. The AAFP's strategic operational plan includes tactics that prioritize faculty diversity to include development and training.
AAFP-Foundation	The Family Medicine Leads Emerging Leader Institute identifies and recruits diverse pool of FP volunteers for faculty and mentor roles in developing future leaders.
ABFM	ABFM Foundation funds of STFM for Minority Faculty Development, and ADFM for expansion of LEADS program for academic and health system leadership, scholarships for 4 minority faculty. The ABFM has committed to develop a new program to support underrepresented minorities in development of leadership in practice, education, research, and administration. The ABFM Foundation will take responsibility for developing and communicating about this program. A program office will need to be hired.
ACOFP	In February ACOFP held a Virtual Faculty Development and Program Directors Workshop which there were presentations on: Creating a Culture of Inclusion and Diversity as a Component of Wellness in a Residency Program and addressing Diversity, Inclusion and Implicit Bias in Resident Recruitment and Curriculum.
ADFM	Creating a "workforce" profile with DEI metrics for departments to measure; Gathering follow up data on DEI efforts at department level including PAID faculty time for DEI efforts
AFMRD	
NAPCRG	
STFM	(action) STFM Antiracism Task Force created funding proposal for an academic family medicine learning collaborative. Goals: empower and educate participants so they will identify racist structures and behaviors within their academic institutions and become leaders for change, promote allyship, spread effective change strategies (action) STFM's URM Initiative has four teams (leadership, scholarship, mentoring, and URM pipeline) working to develop URM leaders and increase the percentage of URM family medicine faculty. (Funded by ABFM Foundation and STFM Foundation.) (action) 2020-2021 Presidential Podcast Series: Being Black in Medicine, URM Physician Pipeline, URM Women in Leadership. (action) Mentoring Underrepresented Faculty for Academic Excellence (MUFAE) - a longitudinal mentoring program to promote success and advancement for URM faculty members in the early stages of their careers. Year 1 in 2020-2021 matched 25 mentor/mentee pairs and Year 2 is launching in August 2021. (tactic) Partner with AAMC and other organizations to advocate for antiracism curricular changes in UME and GME.

Practice: *Guidelines, protocols, procedures, processes, clinical reasoning*	
AAFP	The AAFP is identifying opportunities to address race-based medicine in its clinical guidelines with tools and resources to support members in practice. This work is being supported by the Commission on the Health of the Public and Science. The AAFP plans to launch new curriculum, Anti-Racism in Medicine, which is developed into a 4 part series by body system. We intend to facilitate it's dissemination broadly at FMX, STFM and AFMRD conference events.
AAFP-Foundation	• Annual grant of $100,000 to the AAFP Center for Diversity and Health Equity since its inception three years ago. • Annual grant of $100,000 to the AAFP familydoctor.org. • The Family Medicine Care USA grants for free health clinics focus on those clinics that in particular serve the underserved. • The Family Medicine Cares Resident Service Award creates an opportunity for Family Medicine Residents to address health disparities by tackling the health need the underserved in their local communities.
ABFM	ABFM has made health equity a major focus of its performance improvement program evolution. In June 2020, we posted a health equity module which allowed Diplomates to address a variety of projects with respect to health equity, from assessment and intervention with implicit bias among staff, to qi focusing on improving health equity, to community interventions. Uptake has been modest, but many Diplomates have done excellent work. We will promote this work and best practices this this fall. We will also build a health equity component into many of our existing modules this fall. In the longer term, we have begun exploring with the USPTF and other organizations an evidence-based approach to define a smaller set of the most important health disparities with a goal of using this list to prioritize our work going forward. Of note, approximately 30,000 family physicians do performance improvement and get credit for it each year: if many focus on health equity, practice by practice and community by community, we will make progress.
ACOFP	In cooperation with the ACOFP Task Force on Racism & Health – Governance Subcommittee, the ACOFP Constitution and Bylaws/Policy and Organizational Review Committee will begin to conduct a review of the organizations current policies and procedures to update to ensure they are inclusive.
ADFM	All content (e.g. webinars) delivered on care delivery/transformation should have highlight on DEI; Developing a series of position papers focused on FM leadership at academic health centers that will have a DEI lens; Creating a "practice" profile with DEI metrics for departments to measure
AFMRD	
NAPCRG	
STFM	(tactic) Initiate and develop relationships with external organizations to drive actions leading to addressing racism in medicine, particularly the AAMC, AMA, and family medicine orgs.

Duration of Family Medicine Residency Training

Background materials

MEMORANDUM

TO: Family Medicine Leadership Council Attendees

FROM: Warren Newton, MD MPH
Karen Mitchell, MD

RE: Duration of Family Medicine Residency Education

DATE: August 3, 2021

We write to introduce the Saturday morning session on the duration of residency education in Family Medicine.

As all of you know, Family Medicine has been involved over the last 18 months in an extensive discussion about the future of Family Medicine Residency Education. All organizations and over 3,500 people have participated, culminating in the December national summit and 36 peer-reviewed papers published in the July issue of *Family Medicine*.

The spotlight has now shifted to the ACGME Family Medicine Writing Group, led by Stacy Potts, which will be drafting the residency standards. With support from ACGME administration, the writing group conducted a scenario-based future planning process in November and identified tentative major themes for the major revision in March, which were then open to public comment. That public comment was extensive—thank you to all of you!--and the writing group held a virtual national meeting on June 23 to brainstorm solutions for problematic issues.

Critical to discussion of what and how to teach is the issue of duration of Family Medicine Residency education. Since 1969, Family Medicine Residency education has been three years. There are good arguments for keeping this duration, nicely summarized by Dr. Woolever in the special edition (attached). At the same time, over the last 10 years, a trial of 4 vs 3 years of training has been conducted with extensive formal evaluation, and support is increasing for 4 years. Dr. Douglass' commentary (attached) makes the case for 4 years. Peer reviewed papers of the outcomes of 3 vs 4 years are beginning to appear—outcomes in terms of applications and finances already, with one on cognitive knowledge under review and ones on scope of practice and readiness for practice in process. But duration of residency education may not be limited to the number of years in formal residency

programs: one could alternatively envision a third phase of mentored apprenticeship just after residency before Board Certification, similar to what other specialties do. Examples are summarized in another commentary which is attached.

Duration of residency education is a salient and critical issue for us at this juncture of time. An increasing literature argues for "imprinting": what residents learn in residency, including quality and cost-effectiveness, lasts for at least 10-20 years. If we want to address the quadruple aim, therefore, residency education must be an important part of the strategy. At the same time our specialty is committed to advancing competency-based assessment, which will require substantial development and may ultimately influence the length of training, and will need to balance experience, assessment, and confidence in what we want in graduates. Dr. Fowler's commentary on the lessons from Canada is very valuable and is also attached. Finally, as the ABFM and the ACGME RC leaders raised the issue of duration of residency education with the leadership of ACGME, there has been a striking openness to extending the length of training. As Tom Nasca mentioned to Warren Newton on July 5th, the ACGME is very supportive of a four-year residency program, given our focus on competency assessment and on meeting the needs of society. If we want to do this, Dr. Nasca offered to go to CMS with us to advocate for funding for 4 years. This message was a surprise to all of us!

So where do we go now? Obviously, the discussion is moving rapidly, but we thought that it would be important to take advantage of the FMLC meeting to get some initial input from the leadership of the specialty. We want to stress that we are still at the beginning of the discussion, with many details to be worked out, and that the issue of dedicated time for education is still unresolved. On Saturday morning, we will assume you have read the background articles, and will only briefly present the case for 3 years and options for longer training. We will preserve more than 2/3rds of our time for discussion and input, and conduct pre and post zoom polling.

Thank you in advance for your engagement and wisdom.

COMMENTARY

The Case for the 4-Year Residency in Family Medicine

Alan B. Douglass, MD

(Fam Med. 2021;53(X):pp-pp.)
doi:
Published Online First May XX, 2021

Family medicine residency programs are tasked with training physicians capable of, as the Millis Commission put it in 1966, "highly competent provision of comprehensive and continuing medical services."[1] However, due to ever-increasing complexity of care and reductions in training time, the ability of programs to deliver on this task is increasingly stressed. The optimal length of training has been debated since the specialty's inception, with recognition of the need for curricular flexibility and that training could take up to 4 years to complete.[2]

In 2004 the Future of Family Medicine report called for residency innovation.[3] Beginning in 2006 the P4 Project facilitated 14 programs modeling diverse changes in curriculum design and training length.[4] Middlesex Health implemented the first required 4-year curriculum in 2007.[5] Several optional 4-year models were also developed. In 2012 the Accreditation Council on Graduate Medical Education (ACGME) Length of Training Pilot, a prospective case-control study of the 4-year residency, was initiated and is currently reporting findings.[6]

What Is a 4-Year Residency?

A 4-year residency is a substantially enhanced training experience.[7] It contains all the core components of a 3-year program with three significant additions. First is an enhanced core curriculum with 6 additional months of required experiences in areas of particular need such as care of children, practice and health system management, and population health. Second is an area of individual concentration (AOC) consisting of 6 months of immersion in a specific area of passion or anticipated practice need such as maternal-child health, academics, or behavioral health. Finally, residents receive enhanced continuity experience with up to 50% additional clinical encounters in all areas of family medicine (Table 1).This basic model can be implemented in a variety of approaches and settings based on program focus and community need.

The Case for 4 Years

There Is More to Teach

The fundamental structure of family medicine training has not changed since 1968. However, to meet escalating societal needs family physicians must now have substantially more expertise. Complexity of care is increasing, and diagnostic and therapeutic modalities are proliferating. Today's family physicians must be competent in many areas not envisioned 50 years ago, including health information management, population health, HIV care, point-of-care ultrasound, management of teams within complex health systems, telemedicine, genomics, medication-assisted treatment of addiction, leadership, and advocacy.

Training Time is Decreasing

The 2003 implementation of ACGME duty hours led to a substantial reduction in training time. While an important advance, the 2020 American Board of Family Medicine family leave guidelines remove up to an additional 8 weeks of training. Any serious future efforts to promote trainee wellness will reduce training even further.

From the Middlesex Health Family Medicine Residency Program, and the University of Connecticut and Quinnipiac University Schools of Medicine.

Table 1: Clinical Encounters in 3- and 4-Year Residency Programs

	ACGME Minimum*	3-Year Model Average**	4-Year Model Average***
Core curricular months	33	Data not available	42
Elective study months	3	Data not available	11
Continuity encounters	1,650	1,800	2,500
Continuity encounters <age 10 years	165	Data not available	270
Adult inpatient encounters	750	Data not available	1,500
Newborn encounters	40	Data not available	140
OB nontrack deliveries	None	42	80
OB track deliveries	None	Data not available	260

*ACGME Program Requirements in Family Medicine effective July 1, 2020.

**ACGME Web Accreditation Data System (WebADS) data

***Source: Personal communication, Wendy Barr MD MPH MSCE, Joe Skaria DO MPH MBA, Kelly Hill, MD, and Dan Casey, MD, MS.

Programs are increasingly struggling to fit even basic requirements into 3 years, with continuity visits declining. Both residents and program directors feel medical school graduates are not adequately prepared for residency,[8,9] a trend exacerbated by the COVID-19 pandemic. Residents are less confident in their preparation to enter practice, with 17% planning a fellowship and another 20% considering it.[10]

Some argue that wide implementation of competency-based education could deliver more efficient training and create needed curricular space within the existing 3-year model. However, there is no substitute for substantial experience in developing competence and confidence. Reducing it will only exacerbate current trends.

Scope of Practice Is Eroding

Broad scope is a defining characteristic of family medicine, and a key student attraction to the discipline. However, care of children, maternity care, and procedures are all declining as need is increasing, particularly in rural and other low-resource areas. Broader scope is associated with higher levels of medical knowledge,[11] lower levels of burnout,[12] higher levels of job satisfaction,[13] and lower costs of care.[14] If scope continues to narrow it will be increasingly difficult to distinguish ourselves, at least in the eyes of some, from the large numbers of physician assistants and nurse practitioners entering the primary care workforce.

Residents Want Choice

Additional individualized training to achieve broader scope is difficult to achieve in the increasingly constrained 3-year model. Robust AOCs are in effect structured longitudinal fellowships integrated in parallel with ongoing generalist training. They are educationally ideal for physicians planning generalist practice, and much more than an aggregation of a few months of electives. They can also provide advanced degrees. Completion of an AOC is associated with broader scope of practice,[15] while stand-alone fellowships are associated with more focused scope. Production of family physicians with additional expertise is particularly important in maternity care and academics, both critical to our discipline's future.

We Must Preserve the Ability to Innovate

If family medicine is to maintain its position as the lead primary care specialty we must preserve the ability to innovate in response to new challenges, and train future leaders in health care transformation. However, lack of available training time stifles any opportunity for widespread curricular innovation. Further, many residency offices have fallen behind industry best practices and are no longer aspirational innovative spaces.

Both Students and Programs Are Interested

Family medicine has the broadest scope yet the shortest duration of training of any US specialty, and other than Canada, the shortest in the developed world. Many students are skeptical they can acquire breadth and feel both competent and confident in less time than narrower specialties. Family medicine must appear

attractive if we are to match more than 8% of US medical graduates.

At least one-third of students view 4-year curricula positively.[16] Forty-eight percent of Family medicine residents expressed interest in a fourth year of training if it were available.[17] Applicant pool and match performance are unaffected by extended duration of training.[18] Required 4-year programs report dramatic growth in both volume and quality of applications, with a 62% increase in US applicants per offered position between 2014 and 2020 (Personal communication, Wendy Barr, MD, MPH, MSCE).

There is also substantial interest among programs. Twenty-five percent of faculty feel the optimal duration of required training should be 4 years[19]; 34% of current 3-year directors would consider converting their program to 4 years if financial barriers were removed, while 16% would convert regardless if permitted by the ACGME (CERA Survey data, personal communication, Wendy Barr, MD, MPH, MSCE).

Four Years Is Financially Feasible

From a program perspective, adding a fourth year requires resident salary support plus variable amounts of additional faculty and operational expenses. Additional revenue can come from a variety of sources. Fourth-year resident professional fees typically cover resident direct expenses. If under cap, a fourth year of training in family medicine receives only 50% of federal direct medical education funding, but more lucrative indirect medical education support remains intact. Teaching health center funding, health system partnerships, and institutional support are all available sources of additional revenue. All required 4-year programs have demonstrated sustainable funding in a variety of models, maintaining or improving their contribution margins to their sponsoring institutions.[20]

From a resident perspective there is an intrinsic economic trade-off between a fourth year of resident salary ($75,000) and an additional year of practice income ($215,000). Choosing a fourth year therefore appears to carry an opportunity cost of $140,000. However, once marginal tax brackets are accounted for, the increment shrinks to $93,000. Four-year graduates possess unique attributes that are highly valued by employers and provide the opportunity to quickly defray this increment. Additional clinical experience and broader scope facilitate higher levels of early practice productivity. Four-year graduates are also prepared to assume more highly compensated leadership roles earlier in their careers.

Conclusions

Family medicine is the specialty with the broadest scope but shortest training time. Training is currently being eroded from both ends with more to learn and less time to learn it. Scope of practice is diminishing and threatening our identity and differentiation from other primary care clinicians. These constraints are limiting our ability to be innovators and primary care leaders. Students want to graduate competent and confident, but are increasingly skeptical that they can acquire either in the current model. Four years of training is not a deterrent to entering family medicine, but 3 years may soon be. As we consider the future of training over the next decade, now is the time to bolster training, not reduce it.

The 4-year residency provides a flexible solution to all these challenges. It is both practically and financially feasible, and sought by increasing numbers of applicants and programs. It would be a serious mistake for our discipline to eliminate this option. To do so would commit family medicine to an increasingly confining curricular box and continued decline in scope of practice.

Recommendation

The family medicine community should advocate to the ACGME to preserve the opportunity for interested programs to continue in or transition to a 4-year model in response to their training goals and community needs. This would provide the discipline with needed flexibility to address current curricular constraints, maintain broad scope of practice, and innovate in response to future challenges.

CORRESPONDENCE: Address correspondence to Dr Alan B. Douglass, Director, Middlesex Health Family Medicine Residency Program, 90 South Main Street, Middletown, CT 06457. 860-358-6305. Alan.douglass@midhosp.org.

References

1. Millis Commission. The graduate education of physicians: the Report of the Citizens Commission on Graduate Medical Education. Chicago: American Medical Association; 1966.

2. Carek PJ, Anim T, Conry C, et al. Residency training in family medicine: a history of innovation and program support. Fam Med. 2017;49(4):275-281.
3. Bucholtz JR, Matheny SC, Pugno PA, David A, Bliss EB, Korin EC. Task Force Report 2. Report of the Task Force on Medical Education. Ann Fam Med. 2004;2(suppl 1):s51-s64. doi:10.1370/afm.135
4. Carney PA, Eiff MP, Waller E, Jones SM, Green LA. Redesigning residency training: summary findings from the Preparing the Personal Physician for Practice (P4) project. Fam Med. 2018;50(7):503-517. doi:10.22454/FamMed.2018.829131
5. Douglass AB, Rosener SE, Stehney MA. Implementation and preliminary outcomes of the nation's first comprehensive 4-year residency in family medicine. Fam Med. 2011;43(7):510-513.
6. Carek PJ. The length of training pilot: does anyone really know what time it takes? Fam Med. 2013;45(3):171-172.
7. Pugno PA. One giant leap for family medicine: preparing the 21st-century physician to practice patient-centered, high-performance family medicine. J Am Board Fam Med. 2010;23(suppl 1):S23-S27. doi:10.3122/jabfm.2010.S1.090291
8. Engelhardt KE, Bilimoria KY, Johnson JK, et al. A national mixed-methods evaluation of preparedness for general surgery residency and the association with resident burnout. JAMA Surg. 2020;155(9):851-859. doi:10.1001/jamasurg.2020.2420
9. Lyss-Lerman P, Teherani A, Aagaard E, Loeser H, Cooke M, Harper GM. What training is needed in the fourth year of medical school? Views of residency program directors. Acad Med. 2009;84(7):823-829. doi:10.1097/ACM.0b013e3181a82426
10. Sairenji T, Dai M, Eden AR, Peterson LE, Mainous AG III. Fellowship or further training for family medicine residents? Fam Med. 2017;49(8):618-621.
11. Peterson LE, Blackburn B, Peabody M, O'Neill TR. Family physicians' scope of practice and American Board of Family Medicine recertification examination performance. J Am Board Fam Med. 2015;28(2):265-270. doi:10.3122/jabfm.2015.02.140202
12. Weidner AKH, Phillips RL Jr, Fang B, Peterson LE. Burnout and scope of practice in new family physicians. Ann Fam Med. 2018;16(3):200-205. doi:10.1370/afm.2221
13. Rivet C, Ryan B, Stewart M. Hands on: is there an association between doing procedures and job satisfaction?. Can Fam Physician. 2007;53(1):92-93.
14. Bazemore A, Petterson S, Peterson LE, Phillips RL Jr. More comprehensive care among family physicians is associated with lower costs and fewer hospitalizations. Ann Fam Med. 2015;13(3):206-213. doi:10.1370/afm.1787
15. Eiff MP, Hollander-Rodriguez J, Skariah J, et al. Scope of practice among recent family medicine residency graduates. Fam Med. 2017;49(8):607-617.
16. Duane M, Dovey SM, Klein LS, Green LA. Follow-up on family practice residents' perspectives on length and content of training. J Am Board Fam Pract. 2004;17(5):377-383. doi:10.3122/jabfm.17.5.377
17. Carney PA, Eiff MP, Waller E, Peterson LE. Factors associated with interest in pursuing a fourth year of family medicine residency training. Fam Med. 2017;49(5):339-345.
18. Eiff MP, Ericson A, Uchison EW, et al. A comparison of residency applications and match performance in 3-year vs 4-year family medicine training programs. Fam Med. 2019;51(8):641-648. doi:10.22454/FamMed.2019.558529
19. Starfield Summit IV: Re-envisioning Family Medicine Residency Education. https://residency.starfieldsummit.com/community-dialogue. Accessed March 27, 2021.
20. Douglass AB, Barr WB, Skariah JM, et al. Financing the fourth year: experiences of required 4-year family medicine residency programs. Fam Med. 2021;53(3):195-199. doi:10.22454/FamMed.2021.249809

COMMENTARY

The Evolution of Residency Training in Family Medicine:

A Canadian Perspective

Nancy Fowler MD, CCFP; Francine Lemire, MD, CM, CCFP, CAE, ICD.D; Ivy Oandasan, MD, CCFP, MHSc; Roy Wyman, MD, CCFP

(Fam Med. 2021;53(X):pp-pp.)
doi:
Published Online First May XX, 2021

Both Canada and the United States are in the process of reviewing residency training in family medicine. This commentary examines the College of Family Physicians of Canada's experience with competency-based medical education and length of training decisions as both countries grapple with how best to ensure that training keeps pace with societal needs.

In Canada, we are nearing completion of the College of Family Physicians of Canada's (CFPC) Outcomes of Training Project, a national reflection on residency training that is leading us to pursue a longer training period.[1,2] This will be no small feat to accomplish. Most interesting perhaps is how we got here—our experience with competency-based medical education (CBME) and what we might learn from each other as the United States embarks on a similar process of residency review.

At 2 years in length, Canada has the shortest family medicine residency training in the developed world. We share a commitment with the United States to prepare graduates for a full scope of practice that includes hospital, emergency, and maternal-child (including intrapartum) care. Our family physicians serve a highly diverse population and vast geography where almost 20% of the population lives in a rural or remote environment, including indigenous peoples deeply impacted by colonization and systemic racism.[3,4] This is the broadest training mandate in the developed world, matched only by Australia's rural stream.

What Is Our Story?

In 2010 the CFPC introduced CBME via a reform called the "Triple-C Competency based Curriculum" (Triple C). This reform focused on **C**omprehensiveness, **C**ontinuity, and authentic family medicine learning environments (**C**entered in family medicine), together with transformed workplace-based competency assessment.[5,6] Competence in family medicine was defined by the Canadian Medical Education Directives for Specialists (CanMEDs)-Family Medicine competency framework adapted for family medicine and organized around seven physician roles: expert, communicator, collaborator, leader, professional, advocate, scholar.[7] Assessment benchmarks referred to as the Evaluation Objectives (now Assessment Objectives) were created to guide certification decisions.[8]

Social accountability was the main motivation for introducing Triple C. Originally defined by the World Health Organization in 1995 as "the obligation to direct education, research, and service activities towards addressing the priority health concerns of the community, region and/or nation they have a mandate to serve," social accountability is a value firmly entrenched in Canadian medical schools and

From the College of Family Physicians of Canada (Drs Fowler, Lemire, Oandasen, and Wyman); Department of Family Medicine, McMaster University (Dr Fowler); and Dept of Family & Community Medicine, University of Toronto (Drs Lemire, Oandasan, and Wyman).

codified in both undergraduate and postgraduate accreditation standards.[9,10]

The CFPC's assertion was that an enhanced commitment to competence would attract and ensure graduates who are fully able (and therefore willing) to take up the task of comprehensive care in our many and diverse environments. A logic model was established with a defined theory of change and anticipated set of outcomes.[5] This was supported by programmatic evaluation, and a national Family Medicine Longitudinal Resident Survey (FMLS) was established to follow learners' educational experiences, career intentions and actual choices at three intervals through training and into practice. This data allows a critical examination of Triple C implementation and its impact.

Where Are We 10 Years Later?

There have been many successes, and residency programs are collectively much stronger as a result. Improved workplace-based assessments focusing on direct observation with feedback and guided reflection has resulted in timelier, more learner-centered educational remediation.[11,12] Triple C transformed residency programs – empowering them to take charge of curricula and elevating the role of family practice teachers. This cultivated a sense of ownership, professional identity, purpose, and enthusiasm within the family medicine teaching community and spawned a generation of educational leaders.[13]

Despite these important accomplishments, CBME does not appear to have moved the needle on our social accountability goals. Rural, indigenous, and inner-city populations are still underserved, with a maldistribution of family physicians and the scopes of practice and practice intentions of our graduates continuing to narrow.[14] Program directors tell us that the "curriculum is full" and so capacity is limited to respond educationally to the many challenges and changes we face as a society.

Lessons Learned?

Based upon Triple C program evaluation, we learned that residency programs did not have a clear understanding of how comprehensive care was being defined and specifically what graduates were expected to be able to do across the broad scope of family medicine by the end of residency. This led to some inconsistencies across programs.[13] As our experience with CBME deepens, we observe that competence, while necessary, may be insufficient on its own to ensure preparedness and uptake of comprehensive practice. What else is required? Family physician colleagues have talked to us about the role that confidence and self-concept play in professional identity formation and career decision-making. We want to better define adaptability for family medicine and to deepen our understanding of the educational conditions that support adaptability and adaptive expertise in our learners.[15] Our rural colleagues have introduced us to the term "clinical courage" pushing us as generalists to think more about what is required to function beyond the comfortable limits of our certainty or competence.[16]

A Theory of Planned Behavior analysis of family medicine residents' career intentions suggests that perceived social norms of practice have a significant influence and so we recognize that the community of practice that surrounds each resident is as important as what we teach in the formal curriculum.[17] There are social and market forces far more powerful than the training experience itself in shaping residents career choices and this forces us to discern how and where we can have an impact. Where do we go from here?

Through the Outcomes of Training Project, we have yet-unpublished data showing that many graduates do not feel prepared for clinical activities outside the office-based primary care setting and this is reactivating our long-standing debate about the length of training. In a CBME paradigm time is considered a resource rather than a metric for learning, a weak proxy for experience.[18] How much resource we require will depend on our goals and this has forced us to reexamine our role(s) as family physicians, and to articulate our intended training outcomes with a clearer link between education and practice. This is the logic behind the CFPC's development of the *Family Medicine Professional Profile* (FMPP) released in 2018.[19] The FMPP is a job description of sorts, defining our collective commitment to a comprehensive scope of practice as well as our care philosophy and interdependent work arrangements such as the Patient Medical Home.[20] The FMPP has been elaborated for training purposes into a Residency Training Profile (RTP) detailing the expectations/scope of training through a set of Core Professional Activities (CPAs) that are brought to life in a series of Practice Narratives assembled from field research done with family physicians.

Both countries face dynamic health care trends with practice and training implications: new technologies and therapeutics, an aging population, complex care needs including an opioid crisis, dehospitalization and shorter stays intensifying community care demands, interprofessional care models, and now, of course a pandemic. These increased demands on education come at a time when, for all good reasons, resident duty hours are reduced. Just prior to the pandemic, the issue of physician burnout was on everybody's lips with various root cause analyses and a sense that narrowing our scope has deskilled us, shrinking our horizons and leading to demoralization and/or a feeling of dislocation.[21]

The CFPC is engaged in an ongoing and iterative attempt to "get to better," defining and using outcomes evaluation as an important tool in the process. Detailing the expected scope of training has made it much easier to identify that we are seriously underresourced. And so, our next educational chapter focuses on the length and scope of training in the larger pursuit of social accountability. Although some decision makers prefer to think of community needs as primary, secondary, or tertiary care, we prefer to position our contribution in terms of proximity care—we commit to a person and to meeting their needs wherever they are, using all means available to us, including collaboration and innovative technologies.[22] Ongoing medical education renewal is a necessary but insufficient ingredient to an improved delivery of community-based care. It must be accompanied by policies and remuneration models that support comprehensiveness and a broad scope of practice, rather than incentivized episodic care. This represents a big task, for which the time has come. The status quo is no longer an option for us.

FINANCIAL SUPPORT: The Outcomes of Training Project cited in this article is fully funded by the College of Family Physicians of Canada.

CONFLICT OF INTEREST STATEMENT: All four authors are paid employees of the College of Family Physicians of Canada. The authors have no other potential professional or personal conflicts of interest to declare.

CORRESPONDING AUTHOR: Address correspondence to Dr Nancy Fowler, College of Family Physicians of Canada, 2630 Skymark Avenue, Mississauga, ON, Canada L4W 5A4. 905-629-0900. nfowler@cfpc.ca.

References

1. Lemire F, Fowler N. Linking education and practice: The Outcomes of Training project. Can Fam Physician. 2018;64(11):866.
2. Sawchuk P. Outcomes of Training: preparing for the future. Can Fam Physician. 2019;65(4):301.
3. Advancing Rural Family Medicine: The Canadian Collaborative Taskforce. The Rural Road Map for Action – Directions. Mississauga, ON: Advancing Rural Family Medicine: The Canadian Collaborative Taskforce; 2017. https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/Directories/Committees_List/Rural%20Road%20Map%20Directions%20ENG.pdf. Accessed February 26, 2021.
4. Indigenous Health Working Group of the College of Family Physicians of Canada and Indigenous Physicians Association of Canada. Health and Health Care Implications of Systemic Racism on Indigenous Peoples in Canada. Mississauga, ON: College of Family Physicians of Canada; 2016. https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/Resources/_PDFs/SystemicRacism_ENG.pdf. Accessed February 26, 2021
5. Tannenbaum D, Kerr J, Konkin J, et al. Triple C Competency-based Curriculum. Report of the Working Group on Postgraduate Curriculum Review - Part 1. Mississauga, ON: College of Family Physicians of Canada; 2011, https://portal.cfpc.ca/resourcesdocs/uploadedFiles/Education/_PDFs/WGCR_TripleC_Report_English_Final_18Mar11.pdf. Accessed February 20, 2021.
6. Oandasan I, Saucier D, eds. Triple C Competency-based Curriculum Report—Part 2: advancing implementation. Mississauga, ON: College of Family Physicians of Canada; 2013. https://portal.cfpc.ca/resourcesdocs/uploadedFiles/Education/_PDFs/TripleC_Report_pt2.pdf. Accessed February 20, 2021.
7. Shaw E, Oandasan I, Fowler N, eds. CanMEDS-FM 2017: A competency framework for family physicians across the continuum. Mississauga, ON: The College of Family Physicians of Canada; 2017. https://portal.cfpc.ca/resourcesdocs/uploadedFiles/Resources/Resource_Items/Health_Professionals/CanMEDS-Family-Medicine-2017-ENG.pdf. Accessed February 20, 2021.
8. Crichton T, Schultz K, Lawrence K, et al. Assessment Objectives for Certification in Family Medicine. Mississauga, ON: College of FamilyPhysicians of Canada; 2020, https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/Education/Certification_in_Family_Medicine_Examination/Assessment-Objectives-for-Certification-in-FM-full-document.pdf. Accessed February 20, 2021.
9. Boelen C, Heck JE. Defining and Measuring the Social Accountability of Medical Schools. Geneva, Switzerland: World Health Organization; 2015, http://apps.who.int/iris/bitstream/10665/59441/1/WHO_HRH_95.7.pdf. Accessed February 20, 2021.
10. Rourke J. Social Accountability: A framework for medical schools to improve the health of the populations they serve. Acad Med. 2018;93(8):1120-1124. doi:10.1097/ACM.0000000000002239
11. Ross S, Binczyk NM, Hamza DM, et al. Association of a competency-based assessment system with identification of and support for medical residents in difficulty. JAMA Netw Open. 2018;1(7):e184581. doi:10.1001/jamanetworkopen.2018.4581
12. Lawrence K, Van der Goes T, Crichton T, et al. Continuous Reflective Assessment for Training (CRAFT): A national programmatic assessment model for family medicine. Mississauga, ON: College of Family Physicians of Canada; 2018, https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/About_Us/CRAFT_ENG_Final_Aug27.pdf. Accessed February 20, 2021.

13. Ellaway RH, Palacios Mackay M, Lee S, et al. The impact of a national competency-based medical education initiative in family medicine. Acad Med. 2018;93(12):1850-1857. doi:10.1097/ACM.0000000000002387

14. Weidner AKH, Chen FM. Changes in preparation and practice patterns among new family physicians. Ann Fam Med. 2019;17(1):46-48. doi:10.1370/afm.2337

15. Mylopoulos M, Kulasegaram K, Woods NN. Developing the experts we need: fostering adaptive expertise through education. J Eval Clin Pract. 2018;24(3):674-677. doi:10.1111/jep.12905. Accessed February 23, 2021.

16. College of Family Physicians of Canada. Priority Topics for the Assessment of Competence in Rural and Remote Family Medicine. Mississauga, ON: College of Family Physicians of Canada; 2018. https://portal.cfpc.ca/ResourcesDocs/uploadedfiles/Education/Rural-PT_KF_EN.pdf. Accessed March 24, 2021.

17. Grierson LE, Fowler N, Kwan MY. Family medicine residents' practice intentions: theory of planned behaviour evaluation. Can Fam Physician. 2015;61(11):e524-e531.

18. Holmboe ES, Sherbino J, Englander R, Snell L, Frank JR; ICBME Collaborators. A call to action: The controversy of and rationale for competency-based medical education. Med Teach. 2017 Jun;39(6):574-581. doi:10.1080/0142159X.2017.1315067.

19. College of Family Physicians of Canada. Family Medicine Professional Profile. Mississauga, ON: College of Family Physicians of Canada; 2018. https://portal.cfpc.ca/resourcesdocs/uploadedFiles/About_Us/FM-Professional-Profile.pdf. Acessed March 24, 2021.

20. Weidner AKH, Phillips RL Jr, Fang B, Peterson LE. Burnout and scope of practice in new family physicians. Ann Fam Med. 2018;16(3):200-205. doi:10.1370/afm.2221

21. College of Family Physicians of Canada. A new vision for Canada: Family Practice—The Patient's Medical Home 2019. Mississauga, ON: College of Family Physicians of Canada; 2019. https://patientsmedicalhome.ca/files/uploads/PMH_VISION2019_ENG_WEB_2.pdf. Accessed March 24, 2021.

22. Beaulieu MD. The perils and the promise of proximity: Dr Ian McWhinney Lecture, 2016. Can Fam Physician. 2016;62(12):964-968.

COMMENTARY

What Family Medicine Can Learn From Other Specialties

Warren Newton, MD, MPH; Michael Magill, MD

(Fam Med. 2021;53(X):pp-pp.)
doi:
Published Online First May XX, 2021

Family medicine is not the only specialty with passionate commitment to excellence in residency education and the formation of young physicians. The major revision of the program requirements for family medicine and the related American Board of Family Medicine (ABFM) policy on board eligibility can take inspiration from other specialties to individualize resident experience, enhance evaluation, and perhaps offer an innovative fourth-year experience to help residents master the increasingly complex reality of family practice.

A first option would be to adapt residents' experiences to meet individual learning needs and support career development. Pediatrics is leading development of formal individualized learning plans[1] during residencies. These are similar to our "areas of concentration,"[2] but with 6 months and typically more specificity and rigor. Developing such plans inevitably raises the question of the value of some of the rotations in our current requirements.

What we give up when we must change is important evidence of what we value. In the summer of 2020, the ABFM asked program directors what rotations they had eliminated in response to the pandemic. Programs most often cancelled subspecialty surgery, elective, and nursing home experiences. In parallel, and in preparation for the summit the Association of Family Medicine Residency Directors surveyed residency directors and the ABFM surveyed residents and residency faculty to ask what curriculum should be eliminated to make room in the curriculum for new requirements that might come with the new standards.[3,4] There was significant agreement that inpatient surgery, most subspecialty surgical rotations, electives, and inpatient pediatrics could be considered for removal, seemingly reflecting concern about the passive education in many subsurgical rotations and ineffective use of elective time. The surveys thus suggest that there is potential curricular space to individualize training in support of career development and help residents move beyond proficiency to mastery. We might think of offering "Areas of Concentration on Steroids," with more time, better focus, and accomplishment.

A second option is to conduct an in-person oral examination and assessment of clinical skills at the end of residency. The cultural, logistical, and financial challenges of adding this kind of intense individualized assessment would be daunting in family medicine. But many other specialties do this, including many surgical disciplines, physical medicine and rehabilitation, and emergency medicine. Our colleagues in these fields have learned how to conduct oral exams fairly, and they distinguish between the knowledge typically assessed in an examination with multiple choice questions and judgement and clinical decision-making uniquely assessable in oral examinations by trained examiners. One of the best examples is in the American Board of Urology, which combines an oral examination in combination with a practice log covering the first 16 months in practice, a description of the practice demographics, peer review from community urologists and explicit attention

From the American Board of Family Medicine, Lexington, KY (Drs Newton and Magill); Department of Family Medicine, University of North Carolina - Chapel Hill (Dr Newton): and Department of Family and Preventive Medicine, University of Utah, Salt Lake City, UT (Dr Magill).

to professionalism and the ethics of practice,[5] with particular emphasis on performance of unnecessary procedures. Surely judgement, clinical decision-making, and professionalism are critical for family physicians as we manage multimorbid patients with difficult family situations and challenging social contexts across the continuum of care!

Another example is in anesthesiology. To better assess clinical skills, the American Board of Anesthesiology has incorporated objective structured clinical examinations of communication and point-of-care ultrasound into the final component of board certification. For example, they ask candidates to demonstrate ability to deliver bad news.[6] Our anesthesia colleagues report that this kind of assessment has identified residents with excellent test scores but poor communications skills, and that these changes in certification have led to dramatic changes in anesthesia residencies. What about us? Family medicine has substantial experience and expertise with objective structured clinical examinations and in behavioral health and doctor-patient communication; do we think that assessment of communication—or, indeed, point-of-care ultrasound—is important enough to develop a national system to assure competence in all graduating residents?

A third option may be the most challenging: we could add a year of required clinical experience. As argued in this issue by Alan Douglass, MD, our current 3-year curriculum feels like an overstuffed potato to many in our community. Family medicine is complex, and is becoming more complex as family physicians lean into emerging clinical and health care problems such as opiate addiction, exploding multimorbidity, deeply disintegrated care, structural determinants of health and health equity. How might we implement a fourth year of experience in family medicine? We have several options. The Length of Training pilot program[7-9] has shown the potential value of a fourth year of residency and has helped grow support for adding a fourth year, but still only a minority of residency program directors, faculty, and residents support it.[10,11] Traditional Accreditation Council for Graduate Medical Education-accredited fellowships such as sports medicine, hospice and palliative medicine, or geriatrics might also count, as would any of the myriad of informal extra-year fellowships such as faculty development, maternity care, or hospitalist care that exist now or could be developed. Keeping in mind the intense education typical of the first year out in practice, a final option might be a mentored experience in the first year in practice, such as in a frontier, underserved, or other practice setting, prior to board certification. The rationale would be both practical and developmental. The focus would be on developing new skills and professionalism, and just enough structure to support learning.

CORRESPONDING AUTHOR: Address correspondence to Dr Warren Newton, American Board of Family Medicine, 1648 McGrathiana Pkwy, Suite 550, Lexington, KY 40511. 919-604-1241. WNewton@theabfm.org.

References

1. ACGME Program Requirements for Graduate Medical Education in Pediatrics. Chicago: Accreditation Council for Graduate Medical Education; 2020. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/320_Pediatrics_2020.pdf?ver=2020-06-29-162726-647. Accessed May 1, 2021.
2. AFMRD Guidelines for Individual Areas of Concentration. Leawood, KS: Association of Family Medicine Residency Directors. http://glfhc.org/residency/wp-content/assets/sites/7/2017/07/AFMRD-AOC_individual_guidelines.pdf. Accessed May 2, 2021.
3. AFMRD Survey on ACGME Program Requirement Revisions. 2020. https://static1.squarespace.com/static/5ef55bb3b8ab0958a88de0ac/t/5f613e96038ef679ebb3881f/1600208535779/AFMRD+Survey+on+ACGME+Program+Requirement+Revisions.pdf. Accessed May 1, 2021.
4. Starfield Summit IV: Re-Envisioning Family Medicine Residency Education Community Dialogue Survey Results. https://residency.starfieldsummit.com/community-dialogue. Accessed May 1, 2021.
5. Thrasher JB, Hamady CR, Franklin LW. Medical professionalism is like pornography: you know it when you see it. J Am Board Fam Med. 2020 Sep-Oct;33(Suppl):S62-S64. doi: 10.3122/jabfm.2020.S1.190408.
6. ABA Launches OSCE for Certification [press release]. Raleigh, NC: American Board of Anesthesiology; March 29, 2018. https://aba-thelatest.org/2018/03/aba-launches-osce-for-certification/. Accessed May 1, 2021.
7. Eiff MP, Ericson A, Uchison EW, et al. A comparison of residency applications and match performance in 3-year vs 4-year family medicine training programs. Fam Med. 2019;51(8):641-648. doi:10.22454/FamMed.2019.558529
8. Carney PA, Ericson A, Conry CM, et al. Financial considerations associated with a fourth year of residency training in family medicine: findings from the Length of Training Pilot Study. Fam Med. 2021;53(4):256-266. doi:10.22454/FamMed.2021.406778
9. Tepperberg S, Barnett KG, Fischer J, Johnson M, Coles S, Hines T. Training toward our future: questions about length of training in family medicine programs. Fam Med. 2019;51(8):636-637. doi:10.22454/FamMed.2019.711802
10. Re-envisioning Family Medicine Residency Education: Faculty. 2020. https://static1.squarespace.com/static/5ef55bb3b8ab0958a88de0ac/t/5fdb81a8dc9a6b6cb05a24b0/1608221096476/Faculty_All_201214_.pdf. Accessed May 3, 2021.
11. Re-Envisioning Family Medicine Residency Education: Q1 Year of Expected Graduation from Residency. 2020. https://static1.squarespace.com/static/5ef55bb3b8ab0958a88de0ac/t/5fdb81cb1b50515c6a61350f/1608221131118/Resident_All_201214_.pdf. Accessed May 3, 2021.

COMMENTARY

The Case for 3 Years of Family Medicine Residency Training

Donald Raj Woolever, MD

(Fam Med. 2021;53(X):pp-pp.)
doi:
Published Online First May XX, 2021

The duration of family medicine residency training in the United States has been 3 years since the inception of the discipline in 1969. Family medicine training around the world ranges from 2 to 5 years, with varying approaches to undergraduate and predoctoral education. Much has changed in US medicine since 1969, yet the core values of family medicine have remained consistent. While adjustments in curricula, structure, and sequence may be warranted, 3 years remains the appropriate length of training for family medicine residents. A longer duration of training poses significant challenges at the same time that learners need more choice and flexibility. Innovation in training requires creative thought, reforms, and adaptability, without increasing the length of training.

Continued Demand for 3 Years of Training

The 3-year family medicine residency experience allows for a graded exposure to key elements of training while also ensuring ready access to care for patients and communities. This is validated by sustained demand for the graduates of 3-year programs and the demand for additional training slots. In 2020, the physician recruiting firm of Merritt Hawkins identified family medicine as "the most in-demand specialty" by employers for 14 consecutive years.[1] The Medical Group Management Association has shown a 15% increase in family physician salaries to a median of $250,000 for outpatient practice in 2020.[2] At the same time, to meet the demand of trainees, the number of 3-year family medicine residencies has grown at approximately 3.5% per year, adding 99 new programs since 2018.[3]

Longer Duration of Training Poses Many Challenges

The current infrastructure is built with resources and funding to support 3 years of family medicine residency. Increasing the duration would result in a longer pipeline and a delay in graduating family physicians prepared to serve their communities. A 1-year increase in training would result in approximately 4,500 fewer family medicine graduates. Even if spread over several years, that would represent a significant loss of new graduates at a time when the United States is projected to have a shortage of 55,000 family physicians.[4]

For community-based family medicine residencies, the increase in unfunded requirements and staffing needs of additional training would prove to be a significant burden. At the national average of $150,000 per year per resident, even small programs could see a large increase in expenses.[5] Although some 4-year programs have reported financial stability, most depend on increased clinical volume or novel funding sources.[6]

Beyond the financial barriers, adequate clinical experiences and patient volumes, along with the concern for availability of clinical faculty, all pose significant hurdles. Accreditation Council for Graduate Medical Education data

From the Maine-Dartmouth Family Medicine Residency, Augusta, ME.

already shows declines in the number of continuity visits, pediatric visits, and continuity obstetrical deliveries managed by family medicine residents.[7] Additional teaching needs would further exacerbate the existing challenges of recruiting new faculty to community-based and rural programs.

Learner Choice and Flexibility

A change in length of training may also result in an overall decrease in the number of medical school seniors seeking family medicine residency positions. The existing structure maintains medical student interest and acknowledges the paradigm of educational debt. The Association of American Medical Colleges reported a median medical student debt burden of $200,000 in 2020.[8] An increase in residency length would mean a delay to full income potential. Although family medicine salaries have risen steadily, the discipline remains among the lowest paid, and a nearly $200,000 pay differential between resident and attending physician, balanced against an average $200,000 educational debt is significant. The path to becoming a physician, already a long and expensive journey, could lead some students to choose a 3-year training program in a different specialty.

Reform Without Increasing the Length of Training

The discipline should emphasize the quality of training rather than the quantity of time. A recent survey of family medicine faculty and residents showed a clear preference for maintaining 3 years of training with 74% of faculty and 77% of residents preferring 3 years or 3 years with an optional fourth year of training.[9] Longer length of training does not necessarily lead to increased knowledge. A recent study comparing emergency medicine residents in 3- or 4-year programs found no difference in board exam scores.[10]

There is a need for reexploration of the contents of the 3 years of family medicine training. While comprehensiveness remains a hallmark of family medicine, the current breakdown of training time is not reflective of the practice patterns for the majority of family physicians.[11] A strategic decrease in the time required in experiences such as inpatient pediatrics, and a refocus on high-functioning outpatient clinics would more closely reflect the future needs of graduates. Only 24.1% of respondents to a recent survey felt that it was still important to teach inpatient pediatrics to family medicine residents.[12] Use of "selective" or "area of concentration" opportunities could provide more cohesive learning experiences in important areas such as health equity and advocacy. This calls for a change in specific rotation requirements, different approaches to teaching and evaluation, and more flexibility in the overall curriculum, but it does not require an increase in length of training. Ultimately, flexibility should remain with the learner. There are ample fellowship and advanced degree opportunities for those who desire additional time for structured learning. The number of family medicine residents who choose to pursue fellowships is relatively small.[13]

Three years of family medicine residency is producing well-trained family physicians. Keeping the needs of patients, communities, and physicians at the forefront, learners should be able to determine for themselves the type and timing of any additional training. Ultimately, flexibility and autonomy will provide a consistent pipeline of well-trained, satisfied, and engaged family physicians to serve their patients and communities for generations to come.

ACKNOWLEDGEMENTS: The author acknowledges the assistance of Aaron George, DO, FAAFP, Meritus Health, Hagerstown, Maryland; and Deborah Taylor, PhD, North Ft Myers, Florida.

CORRESPONDENCE: Address correspondence to Dr Donald Raj Woolever, MD, Director, Maine-Dartmouth Family Medicine Residency, 15 East Chestnut Street, Augusta, ME 04330. 207-798-9756. raj.woolever@mainegeneral.org.

References

1. Merritt Hawkins Review of Physician and Advanced Practitioner Recruiting Incentives. Dallas, TX: Merritt Hawkins; 2020.
2. 2020 Physician Compensation Benchmarks. Englewood, CO: Medical Group Management Association; 2020.
3. Accreditation Council for Graduate Medical Education Family Medicine Review Committee, Chicago, IL. Accessed March 2021.
4. The Complexities of Physician Supply and Demand: Projections From 2018 to 2033. Washington, DC: Association of American Medical Colleges; 2020. https://www.aamc.org/data-reports/workforce/data/complexities-physician-supply-and-demand-projections-2018-2033. Accessed April 23, 2021.
5. Regenstein M, Nocella K, Jewers MM, Mullan F. The cost of residency training in teaching health centers. N Engl J Med. 2016;375(7):612-614. doi:10.1056/NEJMp1607866
6. Douglass AB, Barr WB, Skariah JM, et al. Financing the fourth year: experiences of required 4-year family medicine residency programs. Fam Med. 2021;53(3):195-199. doi:10.22454/FamMed.2021.249809

7. Hoekzema G. Trends in Family Medicine Residency Clinical Data from ACGME WebADS. Starfield Summit Position Paper. December 2020.
8. Youngclaus J, Fresne JA. Physician Education Debt and the Cost to Attend Medical School: 2020 Update. Washington, DC: Association of American Medical Colleges, 2020. https://store.aamc.org/downloadable/download/sample/sample_id/368/. Accessed April 23, 2021.
9. American Board of Family Medicine Survey of Residency Faculty and Diplomates: Preliminary Results, 2020. Lexington, KY: ABFM; 2020.
10. Hopson L, Regan L, Gisondi MA, Cranford JA, Branzetti J. Program director opinion on the ideal length of residency training in emergency medicine. Acad Emerg Med. 2016;23(7):823-827. doi:10.1111/acem.12968
11. Coutinho AJ, Phillips RL Jr, Peterson LE, Peterson LE. Intended vs reported scope of practice. JAMA. 2016;315(20):2234-2235. doi:10.1001/jama.2016.1727
12. Newton W, Mitchell K. Re-Envisioning Family Medicine Education. Residency Leadership Summit Pisacano Plenary. March 2021.
13. Sairenji T, Dai M, Eden AR, Peterson LE, Mainous AG III. Fellowship or further training for family medicine residents? Fam Med. 2017;49(8):618-621.

Organizational Reports

AAFP Organizational Update

August 2021

AAFP Operations

- The AAFP, like other organizations, continues to navigate the ongoing public health emergency associated with the COVID-19 pandemic. The AAFP continues to offer our programs and events in a virtual format and will continue to do so through the early fall of 2021.

- The AAFP's Family Medicine Experience and Congress of Delegates will be held September 26 – October 2, 2021.

- **Senior Leadership Update** – On July 1st, Margot Savoy, MD officially joined the AAFP staff as the Senior Vice President of Education.

NASEM Report on Implementing High Quality Primary Care

The AAFP joined with ACP, AAP, SGIM, ABFM, ABIM and ABP in sending a letter to Department of Health & Human Services Secretary Xavier Becerra signaling general support for the NASEM report and pledging to work with the Secretary and his team on implementing the key findings of the report.

The AAFP co-hosted a virtual national briefing on the NASEM report – Implementing High Quality Primary Care on Wednesday, May 26th. The briefing featured two members of the NASEM Committee, Carrie Colla, PhD (The Dartmouth Institute) and Tumaini Rucker Coker, MD, MBA (University of Washington & Seattle Children's).

Primary Care for America

In June, the AAFP and 13 other primary care organizations collaborated to launch Primary Care for America. Our official launch was proceeded by a public call to action authored by AAFP President Ada Stewart, MD and George M. Abraham, MD, MPH, President of the American College of Physicians. The editorial articulated the countries historical failure to prioritize and finance primary care and the consequences we are facing as a result.

Over the fall, the collaboration will focus on primary care innovations in Medicare, Medicaid and commercial insurance and the importance of growing the primary care workforce. The campaign is actively running Twitter and LinkedIn campaign promoting the value of primary care to individuals and communities and will feature large scale advertising in publications targeting key influencers

COVID-19

AAFP Update
The Academy continues our work to keep our members informed about developments related to the COVID-19 pandemic including clinical information, education, and practice management resources. A major focus is now on the COVID-19 vaccines, and AAFP has dedicated webpages (www.aafp.org/covidvaccine) which cover vaccine authorization, safety and efficacy information, and educational resources to address vaccine misinformation. The AAFP also is providing support to members and their practices as they work to help their patients and communities. Familydoctor.org is being updated with important information the public should know about the vaccines. In addition,

the AAFP is also partnering with numerous external organizations and campaigns to aid in encouraging COVID-19 vaccination efforts and addressing vaccine hesitancy and misinformation.

Continuing Professional Development Update
The AAFP recently secured a new educational grant around the topic of COVID-19 vaccine hesitancy and confidence. The funder for this grant is Johnson and Johnson (J&J). The grant will include multiple continuing medical education (CME) sessions that will be made available to our members as a free resource. In addition, FMX 2021 session will feature programming on the need to improve vaccine confidence. The AAFP also submitted a proposal to Pfizer for a comprehensive educational grant to equip members and their care team to effectively manage the short and potential long-term impact of COVID-19.

Vaccine Information and Education
AAFP resources have been created or made available to aid members in addressing patient questions and include:

- Updated COVID-19 Vaccine FAQs
- Tools to educate patients: Dr. Ada Stewart shares patient-friendly resources from the "We Can Do This" campaign aimed at fighting vaccine misinformation.
- Support conversations with the healthcare team: sample COVID-19 vaccine presentation.
- Links to CDC Interim Guidance and Resources

Familydoctor.org content related to COVID-19 continues to be updated as appropriate. There is a substantial amount of general vaccine information designed to address vaccine hesitancy. www.familydoctor.org/vaccines

Therapeutics and Post-COVID Syndrome

The AAFP has been working with the CDC on interim guidance for managing Post-COVID Syndrome (e.g. "long-haul Covid"). A panel session was held on July 21 with members to discuss the CDC guidance and provide practical information for identifying and managing patients with Post-COVID Syndrome as well as coordination of care between specialties. The panel included multiple perspectives from members practicing in urban, rural, and underserved communities as well as in the urgent care and residency settings. Additional resources are in the process of being developed to support members as these patients will be routinely managed in primary care.

Diversity, Equity, and Inclusion

Center for Diversity and Health Equity (CDHE)
The CDHE organized a Town Hall on April 14 in observance of Black Maternal Health Week (BMHW) in an effort to deepen the conversation about Black maternal health in the U.S.

During AAFP Annual Chapter Leader Forum, the CDHE facilitated a session with chapter executives and leaders titled “Navigating Change: A Chapter Leader’s Role in Advancing Racial Equity”. Staff were encouraged by the robust discussion among attendees.

The CDHE completed a collaborative project with the School Based Health Alliance (SBHA) involving two national learning collaboratives to increase the awareness of social determinants of health (SDOH) and social needs screenings in school-based health clinics.

The AAFP submitted comments to the Office of Management and Budget on areas to improve equity in programs across the government. The comments encompassed payment considerations, data collection and standardization, technological advancements, broadband, language accessibility, and financial assistance.

The AAFP and four other frontline physician organizations endorsed the Anti- Racism in Public Health Act and called for improved funding and research efforts on systemic racism.

The AAFP publicly recognized Black Maternal Health Week and commended HHS for taking actions to improve maternal health access.

Payment and Practice

CY 2022 Medicare Physician Fee Schedule (MPFS)
On July 13, 2021, the Centers for Medicare and Medicaid Services (CMS) released the CY 2022 Medicare Physician Fee Schedule (MPFS) proposed rule. This regulation also impacts the Quality Payment Program (QPP). CMS also released accompanying fact sheets on the MPFS and QPP. Comments on the proposed rule are due by September 13, 2021. The AAFP will thoroughly review the proposed rule and provide comments to CMS. The final rule will be released around November 1, 2021, and will take effect on January 1, 2022, except where specified otherwise in the final rule. The Academy's developed a summary of the proposed rule and plans to send detailed comments to CMS in August. The **AAFP** urged Congress in a letter to take action to prevent cuts to Medicare payment. Without new legislation, the 2022 Medicare conversion factor will decrease by 3.75 percent.

Primary Care First (PCF)
CMMI released a Request for Applications (RFA) for Cohort 2 of the PCF model on March 16, 2021. For Cohort 2, CMMI accepted applications from all practices, including CPC+ and non-CPC+ practices, that met the eligibility criteria in 26 regions. Cohort 2 will begin in January 2022 and run through 2026. Applications were due May 21, 2021 for practices and June 18, 2021 for payers. No payment methodology changes were announced in the RFA.

AAFP and ACP developed a practice sign-on letter encouraging CMMI to implement a bridge to ensure the progress and investments CPC/CPC+ practices made are not lost once the program sunsets. The letter had 167 signatories and was sent to CMMI on May 18. Practices noted their appreciation for the opportunity to communicate their concerns to CMMI. Additionally, the AAFP and ACP collaborated on a joint letter outlining recommended improvements to PCF.

Advocacy

The AAFP held a highly successful Family Medicine Advocacy Summit in a virtual setting. A total of 32 state chapters were represented in Congressional meetings. Attendees participated in 155+ congressional meetings (41 Senate meetings / 115 House meetings), and participants were highly engaged on social media.

The AAFP launched a new advocacy twitter account (@AAFP_advocacy) just before FMAS this year. The account will be used to highlight federal advocacy efforts and engage with policy makers.

AAFP Members, Dr. Kisha Davis and Dr. Warren Ferguson, were selected to serve on the HHS Medicaid Reentry Workgroup, which advises the Secretary on issues related to Medicaid coverage for previously incarcerated individuals.

Payment Reform and Practice Transformation
The AAFP continues to advocate with CMMI on development of alternative payment models. The AAFP signed on to a joint letter to CMS outlining potential improvements to CMMI's design and implementation of alternative payment models. The letter urges CMMI to partner closely with the physician community moving forward.

The COVID-19 pandemic forced the widespread and rapid adoption of telehealth by family physicians. Several legislative and regulatory flexibilities have been put in place to accommodate the increased need for telehealth. The AAFP and four other frontline physician organizations sent a letter to Congressional leadership calling for Medicaid payment parity.

The AAFP endorsed the Protecting Rural Telehealth Access Act (S.1988), which ensures rural and underserved community health care physicians can continue offering telehealth services, including the ability to offer audio-only telehealth appointments, after the current public health emergency ends. The bill would also permanently waive the geographic restriction allowing patients to be treated from their home. AAFP member Dr. Davis testified before the Senate Finance Committee on COVID-19 flexibilities and lessons learned, particularly as it relates to the telehealth.

Reducing Administrative Burden
The AAFP continues to work with the CMS on the Patients Over Paperwork initiative. The AAFP endorsed the Safe Step Act to implement transparency guidelines to prevent inappropriate use of step therapy in employer-sponsored

health plans and create a clear process for patients and physicians to seek reasonable exceptions to step therapy.

Student Choice of Family Medicine

Residency Leadership Summit

Residency Leadership Summit (previously known as PDW-RPS Symposium (Program Director Workshop-Residency Program Solutions) was held March 4 – 6, 2021 virtually. The 2020 event was cancelled due to the COVID-19 outbreak. Over 1000 attendees participated in numerous sessions, main stage presentations, poster sessions, and networking opportunities. The 2022 event is planned to be live in Kansas City, March 25-27.

National Conference of Family Medicine Residents and Medical Students

National Conference was held virtually July 29-31, 2021. This year's event featured two main stage presentations, pre-recorded and live workshops, wellness, and social activities. Additionally, facilitated networking sessions (on a variety of topics) gave attendees multiple opportunities to meet and connect with other attendees. The Expo Hall, always a highpoint of National Conference, utilized the platform's Artificial Intelligence functionality to assist attendees in finding exhibitors, attendees and speakers who share interests.

Public Relations

In 2019, the AAFP begin a campaign to elevate the profile of family physicians in the hearts and minds of health care consumers in the United States by using a team of media-trained family physicians (media ambassadors) to participate in interviews with various media outlets.

Here is recent summary of the consumer public relations efforts. Key areas of focus for 2021 are COVID-19, preventive health, immunizations, and mental health.

- Program impact for first two years (earned media):
  - 299 total news stories
  - 496 unique media outlets
  - Over 2.1 billion impressions
- Consumer immunization campaign
  - The campaign aimed to move patients from vaccine hesitancy to vaccine confidence by emphasizing that vaccines are a selfless act of prevention that protects individuals who are more vulnerable and builds a community of immunity.
  - The campaign featured an inspirational video and educational patient content across www.familydoctor.org/vaccines and social media. Family physicians across the country offered custom band-aids to drive awareness and facilitate meaningful conversations with patients. They spoke with the media about campaign messages to elevate the importance of vaccines to consumer audiences.
  - The general campaign ended in March 2021. The COVID-19 vaccine-specific campaign is currently underway.
  - Initial campaign results exceeded goals across most measurements.

AAFP Foundation Update
Family Medicine Leadership Consortium
August 2021

The following report provides updates on our three signature programs: Family Medicine Cares (FMC), Family Medicine Leads (FML), Family Medicine Discovers (FMD), and as well as AAFP Foundation's awards, recognitions, and nominations for 2021.

Family Medicine Cares – Humanitarian Signature Program

Family Medicine Cares USA (FMC USA): Provides grants for durable medical equipment and instruments to new and existing free clinics.

Last year, the Foundation received an $1M donation from The Humana Foundation to provide support to free clinics in areas of greatest need. This emergency relief grant opportunity was promoted through the FMC USA program for the purchase of durable, non-durable medical equipment and instruments, PPE, and to cover operational expenses. Because of partners like Volunteers in Medicine America, National Association of Free and Charitable Clinics, and the National Minority Quality Forum, we were able to expand our communication of this opportunity to eligible free clinics in need of support. In total FMC USA has given out 79 grants for a total of $1,130,349 as of November 2020 (66 of these clinics received Humana grant funding totaling $1M).

The FMC Work Group envisions this need will only continue to increase as our country struggles to provide care during and post the COVID19 pandemic. Therefore, this past May, the AAFP Foundation Board of Trustees increased the amount of FMC USA funds available each year from $75,000 to $150,000. This increase will allow more new and existing free clinics to continue serving patients in areas of the greatest need that otherwise would not have access to healthcare.

Following is feedback provided from one of the clinics that received additional FMC USA funds because of The Humana Foundation grant in 2020:

"Since COVID-19 hit our nation has taken note of the inequity in healthcare and we are starting to talk about how we might make things better. Thank you for being part of the change. Thank you for supporting Health For All, especially during this frightening time. We could not do it without you. Thank you for making it possible for more patients to access healthcare.

You helped patients like Angie. She is just one of the many patients we've heard from that were worried about being able to cover their medical care costs on top of all their other life expenses. Your grant made it possible for Angie to receive the necessary lab tests, medications and follow up care she needed. Patients like Angie can stay healthy and continue to support their families because of your generosity. Patients didn't have to make the tough decision between medical assistance, and other critical expenses like rent or food. You have been a lifeline for Angie and her family." *Health for All, Bryan, Texas*

FMC Resident Service Awards (RSA) - Creates an opportunity for FM residents to fulfill a desire to address health disparities by tackling the health needs of the underserved in their local communities.

The following FMC RSA Awards were approved and awarded in May 2021 totaling $33,000 for the following projects:

- **Drs. Arshely Fleuristal and Stefanny Santana Rivera** of **Community Health of South Florida**, Miami, Florida. Drs. Fleuristal and Rivera are both PGY-1(s) and the goal of their project, *"Community Health Weight Loss Initiative",* is to foster an environment that improves patient-provider engagement and communication around healthy lifestyles, minimizing barriers by offering practical and modifiable opportunities for healthy living. This project will also provide effective resources for overall wellness through exercise and healthy nutrition. The measurable outcomes include increase in time of weekly physical activity, adherence to the diet recommendations and modifications, decrease in weight, decrease in waist circumference, decrease in blood pressure, decrease in blood glucose, and decrease in LDL.

- **Dr. Rachelle Dulan** is a PGY-2 with **Grandview Family Medicine Residency** in Dayton, Ohio. Dr. Dulan's project, *"Food is My Medicine (Eating right to Fix What's Wrong)",* will be conducted at the Gem City Market in her hometown of Dayton, Ohio. Gem City Market is an up-and-coming community-owned grocery store established to address Dayton's longstanding issues of food insecurity. When Dr. Dulan discovered that there was only one major grocery store in her community for a population of over 68,000 underserved minority citizens, she went on a mission to encourage her patients to eat a healthy diet to combat their chronic disease. She states that, "While this project will run over the course of one year, the Gem City Market is in the community of Dayton to stay." It is the goal of the project to introduce the community to the concepts of healthy eating to foster an environment of improving health. In the short term, Dr. Dulan hopes to see weight loss, decrease in BMI, and a decrease in insulin use and fasting glucose. She also hopes to see an increase in food literacy, as well as acceptance and proficiency in disease management through diet.

After this funding cycle, FMC RSA has awarded a total of $247,500 to 25 first or second-year residents.

On July 29, the 2020-2021 FMC RSA awardees, Drs. Rebecca Rada and Mindy Guo, and Dr. L. Latéy Bradford, will present at the AAFP National Conference their community projects completed in June 2021 titled, *"Patient Centered Addiction Treatment: Leveraging Accessibility and Inclusion to Improve Medication for Addiction Treatment (MAT)"* and "*Queens Court: A Postpartum Education and Support Group Designed to Empower and Facilitate Wellness in Women of Color",* respectively.

A 2019-2020 awardee shared this about what she thought was the strength of the program:

"This project helped me identify my love for working out in the community, and personally was able to identify my passions for adolescent/ reproductive health. It allowed me to develop an academic medicine interest and to identify innovative interventions for increasing health access in communities of need. I applied for a Community Medicine Fellowship and just began the

fellowship one month ago. I always talk about the AAFP Foundation grant to all my co-fellows and encourage many residents to apply for the same. Thank you to the Foundation and our donors!"

Family Medicine Discovers (FMD) – Scientific Signature Program

FMD Rapid Cycle Scientific Discovery and Innovation (RapSDI):

Program Description: Family Medicine Discovers Rapid Cycle Scientific Discovery and Innovation (FMD RapSDI) launched in January 2019. FMD RapSDI is a collaboration between the AAFP Foundation and the AAFP National Research Network (AAFP NRN) that seeks to build research capacity for scientific discovery and innovation in family medicine by funding practicing family physicians to generate new evidence and innovative models for "what works" in real-world primary care settings.

This program seeks to attract and support practicing family physicians who are inexperienced researchers but interested in contributing to the knowledge base of family medicine. Unlike most research programs, this program does not require prior research experience and is not intended to be a stepping off point for those interested in a research career. The hope is that applicants who are not selected as FMD RapSDI Scholars also benefit from feedback and mentorship that could advance their ideas into fundable projects in the future.

The infrastructure allows AAFP members to submit ideas and questions that are relevant and responsive to AAFP and AAFP NRN members' current priorities and interests. Questions submitted during Round One should: address scientific & clinical questions that have a high potential to advance the knowledge base of the specialty and proposed projects should be feasible to accomplish within a 12-month timeline. Physicians selected as FMD RapSDI Scholars serve as Principal Investigators for their projects while receiving support and mentorship from experienced researchers to perform project activities, conduct data analysis and disseminate results.

Work Group:
AAFP NRN and AAFP Foundation staff work in conjunction with a Work Group comprised of five representatives from family medicine organizations and five AAFP Foundation Trustees to build the FMD RapSDI program. This group continues to guide the operationalized program objectives, including metrics, processes/procedures, timelines, and marketing strategy. Scholars are ultimately selected from a two-tiered application process. The initial low-burden application ("first round") yields four applicants ("finalists") who advance to a second round. Finalists complete an in-depth research project application with assistance from a mentorship team comprised of AAFP NRN leadership and external content or methods experts.

Key Highlights
The inaugural FMD RapSDI Scholars have been conducting their research projects since June 1, 2020. Both Scholars will conclude their projects in 2021.

2019-2020 ("Cycle 1") Selected Scholars

- **Scholar #1: Vijay Singh, MD, MPH, MS, FAAFP**
  - Project Title: "*Adapting Evidence-Based Male Intimate Partner Violence Perpetration Interventions for Use by Family Medicine Clinics and Patients*"

- **Scholar #2: Lauren Ciszak, MD**
    - Project Title: "*Medically Tailored Meal Kits as a Means of Decreasing ED Visits and Hospitalizations in Primary Care Patient with Chronic Disease*"

As of April 22, 2021, the second program cycle ("Cycle 2") has concluded. The Work Group has selected and nominated two FMD RapSDI Scholars. Their respective proposals were approved for funding bythe AAFP Foundation Boardof Trustees. The Scholar's projects began on 6/1/2021 and will conclude on 5/31/2022.

2020-2021 ("Cycle 2") Selected Scholars

- **Scholar #1: Sanjay Batish MD FAAFP**
  Study/Project Title: "*An Evaluation of the SaFETy Score as a Predictor of Gun Violence in Adolescent-Young Adult Patients in a Primary Care Setting*"

  Abstract: Firearm injury is the leading cause of death for individuals aged 12-24. About 7800 adolescents and young adults died of firearm-related causes in 2018, and another 40,000 suffered nonfatal firearm injuries. Despite the far-reaching impacts of gun violence, there is insufficient data available to inform prevention strategies. Screening adolescent patients and counseling those at high risk is one promising strategy that family physicians could implement in their clinics to prevent firearm exposure. However, few validated clinical tools are available to help physicians understand their patients' risk. One new tool is the SaFETy questionnaire, a 4-item scoring system designed and validated in the Flint Youth Injury studies in 2017. The SaFETy score was found to predict twenty-four-month gun violence exposure in drug-using adolescents presenting to an urban emergency room, but it has yet to be validated in primary care settings. This study aims to determine the predictive value of the SaFETy questionnaire in a more general primary care-based adolescent-young adult population. This will be a longitudinal quantitative study conducted over six months in easter North Carolina. We anticipate screening at least 150 patients derived randomly from six participating clinics.

- **Scholar #2: Iman Majd MD, MS, L.Ac**Study/Project Title: "*Feasibility of Implementing and Evaluating Group Auricular Acupuncture (AA) for Chronic Pain Management in a Primary Care Setting*"

  Abstract: Providing safe, effective, and satisfying care for chronic pain patients, is one of the greatest challenges for primary care physicians. In recent decades, use of opioids for chronic pain management has proliferated, resulting in many addictions and deaths and strained relationships between physicians and their patients. In response to this crisis, the AAFP issued a position paper emphasizing its commitment to participating in national efforts to improve chronic pain management and the Joint Commission recommended that non-pharmacological pain management options be offered to patients with chronic pain. Furthermore, the use of group visits is becoming a more popular strategy for increasing access to medical care. One non-pharmacological pain management modality, auricular acupuncture, can be easily learned and performed by physicians and has shown promising results for chronic pain management. This study will assess the feasibility of implementing and evaluating group auricular acupuncture visits in practice. Twelve patients referred by primary care providers for chronic pain management will receive auricular acupuncture (AA) during 8 weekly group sessions.

Acupuncture needles will be inserted in one ear for 30 minutes at each session and press needles will be inserted immediately afterward in the contralateral ear and retained for 5 days. Pain severity and impact on function and quality of life will be measured prior to the first treatment and just after the final treatment. Analyses of recruitment rates, numbers of treatment sessions attended, and rates of follow-up data collection will help determine the feasibility of conducting a larger trial.

Dissemination efforts: AAFP staff and Work Group members are currently finalizing a manuscript for publication about FMD RapSDI. The focus of this manuscript is a qualitative analysis of the Round 1 applications and research questions submitted to RapSDI for Cycle 1 and Cycle 2. In total 75 Round 1 applications were analyzed by the RapSDI program staff and the findings developed into a manuscript. We expect the manuscript to submitted to a scientific journal in early summer.

Additionally, one research poster that was presented at the 2020 North American Primary Care Research Group (NAPCRG) Annual Meeting, titled, "*What Are Family Physicians Curious About? A Qualitative Analysis of 45 Research Questions Posed for the FMD RapSDI Program"*, was awarded a 2020 NAPCRG Pearl by the NAPCRG committee. NAPCRG Pearls are chosen each year by the Community Clinician Advisory Group (CCAG) as the top research studies having the greatest impact on clinical practice as presented at the NAPCRG Annual Conference. Members of the CCAG present the Pearls at local, regional, and national venues. A special Pearl slide deck was created and provided to the committee for presenting. This poster served as the initial catalyst to the forthcoming manuscript.

Family Medicine Leads (FML) – Education Signature Program

FML Scholarships for National Conference:
The AAFP National Conference, July 29-31, 2021, is being held as a virtual conference due to the safety and health concerns of the global pandemic, COVID-19, for the second year in a row. Due to the travel-related expenses being cut, the AAFP Foundation was again able to increase the number of scholarships from 250 to 550 to help reach more students and residents, especially those who have never attended due to travel costs.

A total of 421 applications were received for the 550 scholarships available. Final attendance numbers, including scholarship recipients, will be available after the conference pending attendance verification, and evaluations from Medical Education; however, the number of students registered last year was reported at 2,293, which was a historical record for the conference.

Emerging Leader Institute (ELI):
ELI will welcome its seventh class of 30 Scholars in a virtual environment for the second consecutive time. Scholars will attend the AAFP National Conference and participate in ELI from July 29-August 1, 2021. The four-day schedule includes a panel of family physicians sharing personal leadership experiences, especially challenges faced over the last year on Thursday, workshops on Saturday, then concludes with a Project Management session on Sunday. Scholars develop and complete a project related to his or her leadership track and receive support from a family physician mentor.

The following nine resident and student scholars of the 2020 ELI cohort were selected as the Leadership Project Award recipients. They will share their leadership project work in the form of a poster viewable online at the virtual AAFP National Conference. All award recipients will participate in a video conference session to share project highlights and lessons learned.

The three Best Leadership Project Award recipients, one from each track, will attend a special AAFP opportunity related to his or her leadership track. At the virtual AAFP National Conference, the recipients will present their award-winning work in a video conference session that includes a live Q&A with participants.

Leadership projects were reviewed three times and scored using established criteria. The residents and students receiving the three highest average scores were selected from each track. The three leadership projects, using established criteria and receiving the highest average score, were selected for the “best” project award.

TRACK 1: POLICY & PUBLIC HEALTH LEADERSHIP

Resident(s):

Karen Scherr, MD, PhD (North Carolina)
Project: *“Increasing Utilization of the Diabetes Prevention Program (DPP) Through the Development of an Integrated Electronic Referral”*

Student(s):

Benjamin Kaplan* (North Carolina)
Project: “*I Know Me: Developing an Interactive Photovoice Gallery to Mitigate Bias against Complex Care Patients”*

Russyan Mabeza (California)
Project: “Learning and Unlearning Medicine: Creating an Antiracist Medical Curriculum”

TRACK 2: PERSONAL & PRACTICE LEADERSHIP

Resident(s):

Aisha Van Pratt Levin, MD, (California)
Project: *“Caring and Advocating for Pregnant Patients Under Customs and Border Patrol Custody in Our Labor and Delivery Units”*

Student(s):

Tiffany Tsay*, MPH, (Virginia)
Project: *"Implementing Medicare Annual Wellness Visits in Primary Care Practices”*

Amy Hoffman, (Pennsylvania)
Project: *“The UP-MAPS Collaborative: Creating Partnerships to Expand Representation in Healthcare”*

TRACK 3: PHILANTHROPIC & MISSION-DRIVEN LEADERSHIP

Residents:

Roshni Kakaiya*, DO (California)
Project: *"Addressing the Lack of Healthcare Services Utilized by Uninsured Immigrants in Palm Beach County, Florida"*

Olusunmisola Oyesiku, MD, MSc (Alabama)
Project: *"Selma Adolescent Healthcare Needs Survey"*

Ryan Walker, MD, MPH (Massachusetts)
Project: *"Developing a Multidisciplinary Weight Management Clinic at a Family Medicine Residency"*

*Best Leadership Project Award recipients

BACKGROUND: Family Medicine Leads focuses on the future of the Family Medicine specialty by supporting efforts to fill the workforce pipeline with the best and the brightest as well as developing more and better trained Family Medicine leaders through attendance at the AAFP National Conference of Family Medicine Residents and Medical Students and participation at the Emerging Leader Institute.

AAFP Foundation Awards, Recognitions and Nominations

The AAFP Foundation is pleased to announce the following awards and recognitions:

The 2021 Outstanding Program Award winner is the **California Academy of Family Physicians Foundation** to receive the 2021 Outstanding Program Award for the program titled, "Family Medicine Chief Residents Workshop."

Dr. Jason and Mrs. Kirsten Marker for 2021 Philanthropists of the Year.

Both the California Academy of Family Physicians Foundation and Dr. Jason and Mrs. Kirsten Marker will be recognized at the AAFP Foundation's Donor Recognition Virtual Event during the AAFP virtual FMX (Date/Time TBD). Stay tuned to the Foundation for a Save the Date in the next few weeks.

MEMORANDUM

TO: Family Medicine Leadership Council

FROM: Warren Newton, MD, MPH
President CEO of ABFM Board of Directors

RE: An Update from ABFM

DATE: July 18, 2021

Colleagues, greetings and I look forward to seeing you virtually in several weeks. What follows is a brief summary of the news since the last meeting of FMLC, except for our updates regarding Health Equity and large health systems which will be submitted separately.

1. The core work of ABFM is, of course, board certification and this spring's certification exams went without a significant hitch. Our total numbers will peak this fall over 100,000--a milestone--along with heading toward 15,000 residents! As you know, we extended due dates as a result of the pandemic. Many family physicians have taken advantage of the offer. We were very concerned about the impact of the pandemic on Family Medicine practices but the damage to practices, although still very significant, has been less than the forecast in April 2020. As the country comes back to life, we are in a situation similar to my NC roots – after the hurricane has passed, you go out of your house and see what's changed. We believe there will be substantial changes post pandemic across many sectors of life.

2. Evolution of Certification – As you know, one of the major strategic goals of ABFM is to evolve board certification. I am delighted to report that Family Medicine Certification Longitudinal Assessment (FMCLA) has been approved by ABMS as a permanent addition to the ABFM portfolio. About 70-75% of Diplomates each year so far have opted to do it. Feedback is extremely positive. The biggest lesson for us is that people describe it as supporting learning. We will, however, continue the point in time single day test – many of our Diplomates continue to want to do this.

   The ABFM National Journal Club will go live this August.. The National Journal Club Committee consists of 16 practicing family physicians with expertise in evidence-based medicine. They have extracted 44 articles from over 120 journals over the year 2020, prioritized them according to impact on practice, relevance to Family Medicine and methodologic rigor. The pilot will be released in the beginning of August. Any Diplomate and any resident who wants to participate will be able to do so. They will see/get a PDF of the actual article, and then answer four questions. If they get them all

right (they can retry after looking at the feedback), they will get credit for an ABFM requirement and CME credit from the AAFP.

Finally, the major revision of our Knowledge Self-Assessment (KSA) modules will be finished by the end of this year. Feedback on the new modules--with single best answer, heightened emphasis on current evidence--is excellent. While still quite challenging – the initial passing rate is about 8%--they are performing as they should – giving people a thorough assessment of how much they know in a particular area. More to follow.

3. ABFM is embarking on the development of a new blueprint. Thank you for your nominations. The blueprint is what we use to frame what clinical topics need to be addressed to assess the cognitive expertise necessary to be a board-certified family physician. For the last 20 years, the blueprint has been grounded in organ systems; the new blueprint will be grounded in clinical activities of family physician, supplemented by national and practitioner based surveys of what is done on the ground. The new blueprint will be designed to allow some customization to Diplomates' practice, to more easily include emerging and important knowledge like social drivers of health and COVID, and to support better targeted CME. Developing the blueprint will be a long process – probably three years. The Advisory panel will kick off in September.

4. As all of you know, a major activity over the last year has been a specialty wide project to re-envision the future .of Family Medicine residency training. The ABFM, along with the rest of the family, identified key questions (Newton W, Bazemore A, Magill M, Mitchell K, Peterson L, Phillips R. The Future of Family Medicine Residency Training Is Our Future: A Call for Dialogue Across Our Community. JABFM 2020;33:636–640). The specialty used these key questions to organize focus groups, surveys and background papers leading up to a national summit. The summit website includes all of the results: RE-ENVISIONING FAMILY MEDICINE RESIDENCY EDUCATION (starfieldsummit.com) The website is evergreen. The papers have been peer reviewed and revised and will be published by the time you get together - they are already up on the website of the journal *Family Medicine*. You'll find the commentaries provocative and passionate.

   With respect to residency redesign, the ball is now in the court of ACGME which just had a national summit on 6/23 to discuss the major themes of the major revision and now will focus on the specific standards. What emerges will determine the breadth and impact of Family Medicine in health care and the population of the United States.

   BREAKING NEWS: As we consider the duration of residency training, Dr. Nasca has endorsed a 4 Year residency for family medicine and potential tiering of requirements around Obstetrics—a major change in policy. We have put discussion of this issue on the agenda for our meeting.

   Of note, the issue of time for core faculty has not been resolved. After yet another special task force, the ACGME has allowed some room for specialties to define some rules for faculty time, within a flexible framework meant to cover all specialties. The framework keeps dedicated faculty time administration and education for family medicine at the same level as the July 2019 rule. The Family Medicine RC plans to appeal to get more faculty resources; signs are mixed for the prognosis of this appeal..

The appeal will be embedded into the proposal for the residency standards. As you know, ABFM believes dedicated time for teaching is critical for the specialty and that the June 2019 changes have had a substantial deleterious effect on our training programs. We await the results of the appeal process, and have argued that we need to know what resources we will get before we finalize the major revisions.

5. Match 2020 showed an increase in the number of students matching into Family Medicine residency but with declines in students from allopathic schools, even as the number of allopathic graduates is increasing rapidly. While overshadowed by COVID, this is a major strategic challenge for the specialty.

6. Health equity is a major focus of ABFM activities, as it is for all of you. More detail is available in the common table. Briefly, however, we laid out a plan in print in September 2020 and we have been working hard on various components of that. We have completed a substantial study of bias in multiple-choice questions used for board certification. Over 7 years, we have found some but not very many questions that are biased—a total of 10 in thousands. We will continue this annual screening process. Last summer, we established a new health equity PI program providing a lot of different opportunities for family physicians and are in the process of developing a knowledge activity (a "KSA") on various aspects of health equity with the AAFP. That one should be available by fall.

   This summer, we'll be adding a component of health equity to most of our PI modules. We are also beginning to talk with the USPTF and the CDC to define the highest impact health inequities and focus our work along those lines. Finally, our research both into workforce and into policy is focusing on issues related to health equity – both the distribution of underrepresented minorities in every aspect of work force but also the reimbursement necessary for service in underserved areas.

   Our research and policy team have pivoted to focusing on various aspects of equity and primary care, from workforce, team based care to supporting policy changes like payment adjustment for social deprivation of patients.

   Our Board has decided to fund a program to support leadership development for underrepresented minorities and other vulnerable populations. The ABFM Foundation will now take up the organization of this effort. More to follow.

7. An important event in early May was the publication of the National Academies Report on Rebuilding the Foundation of Primary Care. Bob Phillips, the Director of the ABFM Center for Professionalism and Value in Health Care co-led the report. This is the first report on primary care by NASEM since the mid 1990's--a big deal. This will be a major focus of our meeting together.

8. Our researchers continue to submit grants to support the development of our work. We recently won a new contract with the Office of the National Coordinator to use the PRIME registry to track the uses and value of EHRs across the US and with the CDC to determine the impact of COVID on primary care practices. In addition to initiatives supporting primary care, we are hopeful that PRIME will be come a tool for tracking social determinants of health—with the CDC and the Census

beginning to look at the data—as well as surveillance network for rural practices and emergent problems such as the next pandemic.

9. Leadership Development for Large Health Systems—the ABFM-Foundation funded ADFM to hold a national meeting in November 2019 to develop a strategy for a next generation of leadership development in our specialty. Modelling on programs to develop Hospital Nurse CEOs and the ELAM program, the goal is to develop future leaders of health systems and to scale up from the 6-8 ADFM fellows a year to about 50/year. The ramp up is going well. I suspect that ADFM will report on this to the group.

   The ABFM has committed to a significant new donation to the Pisacano Leadership Fund in order to double the number of Pisacano Scholars. ABFM believes that there is huge need for leadership in Family Medicine and this is something we can do to build and support the pipeline of potential leaders. The Pisacano Leadership Foundation Board will make the final decisions. ABFM is also thinking about how to better coordinate the various leadership programs we run—Pisacano, Puffer, short term research fellowships, and a potentially new fellowship for mid or late career leaders and innovators—along with those run by other organizations in the family. More to follow!

10. Working with other organizations—we look forward to FMLC and discussions about the priorities facing the discipline. We anticipate that ABFM will have an interest in supporting residencies with the changes that will come out of the major revision. We look forward to working with AFMRD and all of you on this. The new ABMS standards are in a phase of final input. We believe that most of the changes implied by the new standards have already been completed. The final decision will be made by the ABMS in the late fall.

Please follow up at our meeting or by email if you have any questions.

WN:cs

acofp AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS
advocacy • education • leadership

330 East Algonquin Road • Suite 1
Arlington Heights, IL 60005
Phone: 847.952.5100
Fax: 847.228.9755
www.acofp.org

ACOFP Activity Update | August 13-14, 2021

The ACOFP represents 18,000 osteopathic physicians, residents and students. Key initiatives include responding to recent mega-issues (COVID-19 and the growing focus on racial disparities and health), increased advocacy efforts, expanded member benefits and engagement opportunities, and updating and integrating new technologies to better meet the needs of the ACOFP membership.

ACOFP Leadership

ACOFP is the largest specialty in the osteopathic profession and is governed by a 16-member Board and its Congress of Delegates with proportional representation by state.

President Nicole H. Bixler, DO, MBA, FACOFP, Spring Hill, FL
nickbixdo@gmail.com

President-Elect Bruce R. Williams, DO, FACOFP, Blue Springs, MO
drwms87@gmail.com

Immediate Past President Robert C. DeLuca, DO, FACOFP *dist.*, Eastland, TX
docrockindo@yahoo.com

Executive Director Bob Moore, MA, CAE, Arlington Heights, IL
bobm@acofp.org

Congress of Delegates

In March 2021, our Congress of Delegates approved our Bylaws changes to allow MDs as members. The Membership Committee plans to host a podcast interviewing ACOFP's first allopathic member, Brian Bixler, MD. You may recognize the last name. ☺

ACOFP '21 Virtual

The 2021 Annual Convention was a tremendous success! We broke records for overall attendance and the overall event was rated at 4.26/5. New this year, we were able to implement a few recommendations from the Task Force on Convention Innovation report approved in October 2020:

- Different tracks: Attendees were able to choose from education that was labeled by track (General Care, Emergent Care, Outpatient Care, In-Patient Care and New Physician and Resident) and 77% of conference-goers found this helpful.
- Concurrent sessions: Multiple sessions were made available to attendees at the same time allowing them to choose the content of most interest live, while having the opportunity to stream other content on-demand. 94.7% of attendees liked having these options available.
- Opening keynote: This year we had a true opening keynote speaker, Sekou Andrews, who provided a wonderful breakdown of diversity and how it can be a positive force for change. That session rated in line with the event as a whole at 4.26/5.

DEI Task Force

We have partnered with The Exeter Group, a healthcare consulting firm based in Chicago, to complete Diversity, Equity, and Inclusion (DEI) Assessment to help us identify our strengths and areas of opportunity related to DEI. This assessment has allowed us to further enhance our commitment to creating a diverse, equitable, and inclusive environment for all. In addition to a DEI survey for members, Exeter conducted interviews with key stakeholders of our organization and provided DEI training to staff and the Board of Governors. Our discussions with Exeter and amongst ourselves will be more informed with the understanding of the perspective of the members that completed the survey. Although the survey is completed, the work is not nearly done. The Task Force on DEI sub-committees (Governance, Education and Community Outreach) are currently convening to review the findings and provide recommendations to the Board in October.

Additionally, a DEI Task Force Blog Content Development Team has been formed and has contributed multiple blog posts for acofp.net on first-person accounts, social determinants of health, PRIDE Month and DEI awareness, among other topics.

Faculty Development/Program Directors Workshop Update

This year's FDPDW set an attendance record as well. Much of the success is attributed to the content and marketing, but this year we also tried a promotion with OMTeaching where residency programs that purchased OMTeaching subscriptions received one free registration for FDPDW.

Other Updates and Initiatives

AAFP - Direct Primary Care Summit

ACOFP is cohosting the 2021 Direct Primary Care Summit (DPC Summit) with the AAFP, DPC Alliance and the Family Medicine Education Consortium on July 16-18, 2021 in a virtual/livestream event. ACOFP physician members and staff have represented ACOFP on planning committees that resulted in over thirty hours of CME educational programming consisting of a mix of allopathic and osteopathic physicians that work in the DPC setting. Medical students and residents interested in learning about DPC also have a dedicated track and scholarships available.

The Student Association of the ACOFP

The Student Association of the ACOFP currently has 50 Student Chapters at the 58 Colleges of Osteopathic Medicine and branch campuses. Members of the National Student Executive Board (NSEB) host quarterly regional Chapter President Roundtables to discuss chapter family medicine activities, national and local challenges they are facing and share ideas with each other.

The NSEB is developing proposals for leadership webinar series for the chapter officers which will be moderated by students and involving members of the ACOFP Board.

The NSEB moderated a panel of members from the Resident Council for a on demand webinar and two-part podcast called *Oh the Places You'll Go* which is about family medicine residency programs, selecting a program, discussing sub-internships, ranking programs, match process and work-life balance, among others. The NSEB is working with the Resident Council and the ACOFP Foundation on an upcoming webinar on the different pathways for board certification, the Early Entry Initial Certification pathway, and the Initial Certification Grant opportunities.

Students remain interested in leadership opportunities, both at the national level and within their chapter. The student association has four committees that are beginning to meet (Education, Membership Recruitment, Public Relations, and Resolutions).

Advocacy

In addition to the four comment letters ACOFP has developed on its own this year on the HIPAA Privacy Rule, H.R. 1025, the FY 2022 Hospital Inpatient Prospective Payment System Proposed Rule and healthcare infrastructure, we have been busy partnering with other organizations to advance legislation on a larger scale. In February, we signed on to elements of the Black Maternal Health "Momnibus" Act and letter to President Biden in response to the National Strategy for the COVID-19 Response and Pandemic Preparedness; in March, we partnered with STFM to sign-on to a request for legislators to support the Rural Physician Workforce Production Act; and in May, we signed on to a letter addressing Dr. Lorna Breen

Health Care Provider Protection Act (S. 4349) and the recently passed H.R. 1195, the Workplace Violence Prevention for Health Care and Social Service Workers Act, with AOA and other specialty and affiliate societies.

We also hosted an advocacy webinar on the first 100 days of the Biden Administration, which was converted into a podcast, and we developed several blog posts on key issues, like GME and E/M reimbursement, as well as the member-generated content, What About Advocacy? and All Hands on Deck: How a Forward-Thinking Profession Can Embrace Advocacy.

ADFM Report to the FMLC
August 2021

Below gives some updates on the efforts of ADFM since January 2021. How this work feeds into our efforts to be inclusive and anti-racist - and how we plan to work to move the recommendations of the new NASEM report on primary care forward - are highlighted in the other requested updates for this FMLC meeting.

2021 ADFM Conference (virtual)

We held a very successful first virtual conference in February. Our attendee numbers were higher than anticipated, close to what we have for our in-person conferences, and we had an emphasis on interactivity and engagement to keep things lively during the long hours of Zoom. The vast majority of attendees were satisfied with the conference but everyone is looking forward to being back in person in February 2022! More about the conference content can be found here: Preserving Priorities Amidst a Global Pandemic: ADFM'S Commitment to Health Equity

Updates on ADFM Strategic Areas

The main strategic efforts of ADFM are undertaken by our ADFM Strategic Committees. After the 2021 ADFM Annual Conference, all of the committees began the process of wrapping up, expanding or drafting new SMART goals as part of a new committee term. Below are more details about the strategic efforts underway.

Diversity, Inclusion, and Health Equity

The Diversity, Equity and Inclusion Committee (previously known as the Diversity, Inclusion & Health Equity Committee) finished up with its previous SMART goals. The first SMART goal led to developing a 3-pillar framework for DEI SMART goals modified from a definitional framework developed by the Department of Family Medicine and Community Health at University of Minnesota Medical School to fit ADFM's scope of work with pillars including: 1) care delivery & health 2) workforce recruitment & retention 3) learner recruitment & training. The subgroup responsible for this goal used this framework coupled with ADFM's anti-racism plan to deliver a successful session during the ADFM Annual Conference that focused on assisting members and their departments in strategizing for ways to become anti-racist organizations.
The second (completed) SMART goal created a process for frequently checking in with the other 5 strategic committees to ensure that they are keeping DEI work in their strategic aims. This effort involves each committee having a "DEI ambassador" responsible for attending the other strategic committees and providing a report out to the larger DEI group. The final SMART goal for this committee was to create some literature on best/promising practices around developing diversity plans at academic medical systems; the group working on this goal is in the process of revising a manuscript submitted to *Family Medicine*. They are also hoping to further this content by adding related questions to the 2021 ADFM Annual Survey.

The DEI committee intends to use the 3-pillar framework noted above to inform their next series of SMART goals, which will focus on developing profiles for each of the 3-pillars (practice, workforce, learning environment) that can be utilized by ADFM Departments to further their DEI aims.

Leader Development

Members of the Leader Development Committee helped facilitate a workshop during the 2021 ADFM Annual Conference on philanthropy, a topic pulled from the Competencies for Family Medicine Department Chairs that many chairs report feeling unskilled in.

With the leadership of new committee chair, Peter Catinella, the committee is looking at updating their SMART goals to include goals related to publications on best practices in leadership within Family Medicine, updating the chair competencies referenced above, and continuing to provide opportunities for leader development at various conferences, starting with plans to host a pre-con during 2021 STFM MSE Conference titled: "So You Want to Be a Family Medicine Senior Leader? Here Are the Tools That You Need!" and a workshop for new chairs during the 2022 ADFM Annual Conference. The committee is also curating a list of recommended executive coaches for members (based on member input) and maintaining a list of leadership resources that includes books, articles, films and podcasts.

Within our leader development efforts is our Leadership Education for Academic Development and Success (LEADS) fellowship. The program has been going incredibly well this year! The 20-21 Cohort wrapped up during the Annual Conference by providing "ignite talks" on their yearly projects. They also helped usher in the next cohort of 17 (!!) new fellows in the who are now meeting weekly for excellent discussions, journal clubs, project check-ins, and webinars.

Our application cycle for the 2022-2023 cohort is now open. Work for the expansion that will begin in 2022 is underway. A LEADS Oversight Committee that will include representatives from the ADFM Executive Committee, Leader Development Committee and ABFM-Foundation (who are helping support this expansion effort) has been formed to help oversee the expansion, which will include reviewing the applications and providing input on curriculum as needed.

Healthcare Delivery Transformation

In November, the ADFM Board approved the Healthcare Delivery Transformation Committee low-barrier and low-resource "opt-in" consultation model for departments around healthcare delivery topics to continue with a nominal fee (based upon the BRC consultation fee schedule). The service was launched during the ADFM Annual Conference and the hope is to start marketing it more heavily in late summer 2022. More info about ADFM consultation options can be found here: https://adfm.org/resources/consultation-and-coaching-services/

Through the new committee chair, Rich Lord's leadership, the committee has drafted two additional SMART goals. One focuses on creating a series of position papers that center on Family Medicine's role in academic health systems. The second additional goal is related to

continuing all-member hot topic discussions on urgent/timely care delivery topics. The committee has come up with a list of possible topics and is currently working on prioritizing them.

Our 2020 Annual Survey gathered data on the fluctuation of virtual visits (telephone and phone) before and during the pandemic and the team at the Graham Center has assisted greatly with analyzing these results. The group plans to submit a brief report on the analysis to *Family Medicine* in the near future.

Education Transformation

The Education Transformation Committee assisted with a session during the 2021 ADFM Annual Conference titled: "Moving the Needle on Racial Justice in Medical Education" which focused on the work that various members' institutions are doing in the realm of anti-racism and social justice. Like the other strategic committees, this committee is using this session to inform a new SMART goal on social justice/anti-racism in medical student education.

The committee had a series of discussions throughout the year on how family medicine departments found innovative ways to engage medical students during COVID. These discussions culminated in a commentary in the *Annals of Family Medicine* titled: "Family Medicine Educators as Exemplars of Master Adaptive Learning in Response to the COVID-19 Pandemic". The committee plans to have a new SMART goal that correlates with this topic in order to explore other ways family medicine has innovated in medical education during the pandemic. The committee is also in the process of gathering updates from programs featured in the "Best Practice Guide for Strategic Planning to Increase Student Choice of Family Medicine," as part of their ongoing SMART goal related to furthering the 25x2030 initiative.

Research Development

As a result of many conversations during 2020 on the committee's strategic aims and research across the discipline with various stakeholders, the Research Development Committee has come up with 10 key areas for enhancing and expanding research in family medicine. These areas have led to SMART goals related to: pushing forward advocacy efforts starting with developing a way to share funding opportunities among departments; developing a resource for new chairs negotiating chair packages; using the 2021 ADFM Annual Survey to help track key metrics in research capacity; and working with key partners to also push forward collective action on related research areas (such as pipeline, mentorship, infrastructure, etc.).

The committee helped support the Building Research Capacity workshop during the ADFM Annual Conference. Additionally, members helped plan and facilitate another research directors and chairs meeting in April 2021 that saw upwards of 50 participants and featured discussions around: multi-institutional collaborations; how are we resuming in-person activity within our research infrastructure; upcoming ACGME requirements changes; community engagement/health equity research; and engaging practices. In line with another SMART goal, the committee hopes to host these meetings on a quarterly basis in order to push for more connections and collaborations across institutions.

Advocacy

At the beginning of 2021, the newly formed Advocacy Committee finalized their SMART goals using a session during the Annual Conference to gauge member's advocacy-related priorities. Their goals will focus heavily on responding to legislative efforts; building a communication strategy and strengthening relationships with CAFM, AFMAC and AAMC; and sharing advocacy-related resources with members. Work is already underway in all of these areas. Letters to key partners inviting collaboration on advocacy efforts have been sent and a page has been added to the ADFM website to highlight the committee's efforts, including a form for members to share advocacy "case studies" that will be used to inform an advocacy-related workshop during the 2022 ADFM Annual Conference.

ORGANIZATIONAL UPDATE TO THE AMERICAN ACADEMY OF FAMILY PHYSICIANS COMMISSION ON EDUCATION AUGUST 2021

MISSION: The Association of Family Medicine Residency Directors inspires and empowers family medicine residency directors to achieve excellence in family medicine residency training.

VISION: The Association of Family Medicine Residency Directors envisions a vibrant community of residency directors engaged in excellence, mutual assistance, and innovation to meet the health care needs of the public.

The **2020-2023 Strategic Plan** is built around the following strategic objectives: Diversity, Equity and Inclusion; Member Engagement; and Impact in the Field of Family Medicine. The plan includes goals and objectives in five focus areas: Professional Development and Education; Residency Program Quality Improvement; Advocacy and Collaboration; Communications; and Infrastructure.

BOARD OF DIRECTORS:

Wendy Barr, MD, MPH, MSCE – President
Kim Stutzman, MD – President-Elect
Steven R. Brown, MD, FAAFP – Past President
W. Fred Miser, MD, FAAFP – Treasurer
Sarah Z. Cole, DO, FAAFP – Member-at-Large
Kristina Diaz, MD, FAAFP – Member-at-Large
Kevin E. Johnson, MD, FAAFP – Member-at-Large
Kelsie Kelly, MD, MPH – Member-at-Large
John B. Waits, MD, FAAFP – Member-at-Large
Karen Elisa Milian Olmos, MD, MPH – APD Rep.
Michael Flynn, MD – Resident Rep.

STAFF:

Deanne St. George – Executive Director
Kathleen Ingraham – Strategic Initiatives Coordinator
Sam Pener –Programming and Services Coordinator
Ashley Herman – Board Administrator
Hope Wittenberg – CAFM Director of Government Relations

SERVICES, PRODUCTS AND PROGRAMMING

National Institute for Program Director Development (NIPDD). After cancelling NIPDD in 2020 due to the pandemic, the NIPDD Academic Council is excited to be refreshing the curriculum and making plans for the 2021-22 fellowship, which will begin in October 2021.

Academic Council Members: Clark Denniston, MD, Chair, Alan B. Douglass, MD, FAAFP, Marjorie Guthrie, MD, Grant Hoekzema, MD, FAAFP, Melissa Nothnagle, MD, Shannon Pittman Moore, MD, Amy Stevens, MD, Karen Weaver, MD, Raj Woolever, MD, FAAFP.

SPECIAL PROJECTS

Program Director Tenure Study: In 2019 AFMRD contracted with the National Research Network on a two-part program director tenure study. Phase 1 focused on program directors departing their positions and the factors contributing to their departure. Phase 1 of the study is complete. The results of the study were published in Family Medicine in May 2021 *Why Family Medicine Program Directors Leave Their Position.* Phase 2 of this project focused on program directors serving in their positions for more than 15 years. Phase 2 is ready for publication. The AFMRD Board recently approved a third phase, which will explore factors related to program director departure and retention.

UCSF Center for Excellence in Primary Care (CEPC) Collaborative: The AFMRD is continuing collaborative efforts with the UCSF CEPC AFMRD offered a two-session webinar miniseries entitled *Continuity & Access – Applying the Clinic First Model in a Post-COVD World*. Sessions were open to all residency program staff and attendees and were well attended.

AAFP Health Equity Fellowship: AFMRD is sponsoring scholarships to support two fellows in the 2021 AAFP Health Equity Fellowship. Both recipients are associate program directors and are active members of AFMRD's Diversity and Health Equity Committee. The AFMRD Board recently approved continuing support for up to three fellows in 2022.

Diversity and Health Equity Committee: The Diversity and Health Equity Committee has developed Diversity, Equity, and Inclusion Milestones designed to help residency programs assess their DEI efforts. The Milestones were presented during the AAFP's Residency Leadership Summit in March 2021. The Milestones have been prepared for publication and further dissemination.

Mentorship: The AFMRD began offering monthly Mentor Monday sessions in February of 2021. Designed for new program directors, but open to all members, these sessions are facilitated by program directors and include a short presentation on 1-2 specific topics followed by an open Q& A session. Recordings of the sessions are available to members unable to attend. Attendance has been stable, and recordings are well utilized. Topics have included: scholarly activity, resident engagement, leadership development, diversity and health equity, incoming intern assessment and scholarship.

Accreditation Council for Graduate Medical Education (ACGME) Program Directors in Patient Safety & Quality Improvement (PDPQ) Educations Network: AFMRD recently participated in an ACGME pilot designed to develop specialty specific learning communities related to a national learning networked for program directors, associate program directors and faculty to rapidly advance their capacity to develop, model and evaluate resident and fellow engagement in patient safety and health care quality improvement.

Equity Matters: The AFMRD has named a team to participate in the joint Accreditation Council for Graduate Medical Education (ACGME), Council on Medical Specialty Societies (CMSS), and the Organization of Program Director Associations (OPDA) Equity Matters initiative. Equity Matters is an 18-month long learning collaborative focused on workforce diversity and creating safe, inclusive and equitable clinical learning and practice environments.

Respectfully submitted,

Wendy Barr, MD, MPH, MSCE
Association of Family Medicine Residency Directors - President

CAFM Report to the Family Medicine Leadership Consortium (FMLC)
August 2021

Recommendations for 2021-2022 Family Medicine Interview Process

CAFM and the AAFP Commission on Education (COE) released recommendations to improve equity in the family medicine application process and reduce challenges in the recruitment process, including costs, travel, and the pressure for students to apply to a large number of residency programs.

CAFM's next step is to better understand what research on the effects of virtual recruitment on family medicine is already being done and identify any gaps. CAFM believes that research on virtual recruitment is vital to better understand how to improve the overall recruitment process.

CAFM Leadership Demographics

The four CAFM organizations published an article in the March/April issue of *Annals of Family Medicine* describing the need for a more robust and diverse leadership pipeline for academic family medicine and publishing the current baseline demographics collected by the four organizations.

Membership data will be used to:

- Better understand the current diversity of key groups of leaders within academic family medicine
- Set appropriate future diversity goals
- Track progress towards increasing diversity
- Determine the impact of diversity-focused interventions

In the summer of 2021, CAFM discussed how to set appropriate metrics to track progress. The group plans to finalize these metrics later this summer and will then publish the metrics in a future *Annals of Family Medicine* article.

CAFM Education Research Alliance (CERA)

The response rate for resident surveys has been low. In 2019, the response rate was 5.66% and in 2021 (with an incentive for completing the survey) the response rate was 5.3%. CERA works with the AAFP to get these surveys distributed to residents and students.The CERA Steering Committee discussed possible ways to increase the response rate and will meet with the AAFP representative to discuss options.

Grace Shih, MD, MAS has been accepted as the first CERA fellow. The goals of the fellowship are to increase education in survey methodology as well as help the fellow increase scholarship, become a strong mentor to faculty re. CERA, and learn more about analysis and the writing process.

At the most recent CERA meeting, the committee discussed the need to keep demographic questions consistent between surveys. Edits will be made to ensure future surveys are more consistent.

CAFM Government Relations

A separate report will be provided by Hope Wittenberg to the Family Medicine Leadership Consortium.

Family Medicine Leadership Consortium
Organizational Update - NAPCRG
July 2021

Incoming Leaders

NAPCRG administered its Call for Nominations in the spring. The terms of incoming Board and committee members will not begin until November 23, 2021 and Diane Harper, MD, MPH, MS will serve as president.

NAPCRG's 49th Annual Meeting

The 49th Annual Meeting will be held virtually on November 19-23 this year. The meeting will feature greater opportunities for live discussions and interaction as well as in-depth dives into certain topics in the form of workshops and forums. There is still time for students, fellows and residents to submit proposals for poster presentations. The submission deadline is August 16, 2021.

Confirmed Plenaries (to date):

- Professor Sir Michael G. Marmot MBBS, MPH, PhD, FRCP, FFPHM, FMedSci, FBA; Director of the Institute of Health Equity (UCL Department of Epidemiology & Public Health). Professor of Epidemiology at University College London since 1985 and author of The Health Gap: the challenge of an unequal world (Bloomsbury: 2015), and Status Syndrome: how your place on the social gradient directly affects your health (Bloomsbury: 2004), among other accomplishments. Topic: "Taking action to reduce health inequalities is a matter of social justice.
- Edward Bujold, MD; Granite Falls Family Medical Care Center. Named "One of America's Best Family Doctors" by the Consumer Research Council of America, Dr. Bujold has been providing personalized, leading edge family medicine for more than 25 years. He has been a long-time contributor to PBRN Conferences and PaCE and is a member of NAPCRG's Community Clinicians Advisory Group (CCAG).

Awards & Recognition
We are accepting nominations for awards, including the prestigious Wood Award. Check the details for submission deadlines. Recipients will be recognized during the Annual Meeting.

- Distinguished Research Mentor Award
- Mid-Career Researcher Award
- Marjorie Bowman and Robert Choplin Junior Investigator Award
- Outstanding Research Coordinator Award
- Maurice Wood Award

New Publishing Benefit

We are pleased to announce a new publishing opportunity associated with NAPCRG's conference. Abstracts for completed research, including SRF poster abstracts for completed research, are eligible to be published in the *Annals of Family Medicine*. These conference proceedings will appear in digital form following the meeting. (The deadline to verify all authors for purposes of publication is September 15, 2021.) NAPCRG will fund this benefit and evaluate satisfaction over the next few years.

Strategic Plan

The Board is expected to approve a new strategic plan at its fall meeting in October. Priority areas include 1) diversity, equity and inclusion, 2) membership development, 3) research pipeline and workforce, 4) strengthening global connections among primary care researchers.

50th Anniversary Celebration

NAPCRG will celebrate its 50th anniversary next year. Plans for the celebration will be developed by an ad hoc committee. We are recruiting for interested volunteers to serve on a planning committee chaired by former president Judy Belle Brown, PhD. All are welcome to apply, and previous experience as a NAPCRG volunteer or NAPCRG leader is not required. We are looking for a diverse group of committee members so the celebration appeals to a broad audience and represents a mix of different perspectives.
Call for Volunteers

NAPCRG seeks to promote the participation of a diverse membership in its leadership, meetings and programs, research, employment, and all of its other endeavors. We strive to include all regardless of sex, gender, sexual orientation, age, race, religion, disability, ancestry or national origin.

Other Conferences

NAPCRG is host to two smaller meetings during the year, funded in part by the Agency for Healthcare Research and Quality.

1) The Practice Based Research Network Conference (June 24-25) provided opportunities for PBRN researchers -- community clinicians, practice facilitators/study coordinators and network leadership -- to share strategies, methods and results focused on diversity, equity, and inclusion. Over 150 attendees

2) International Conference on Practice Facilitation (Aug. 5-6) will examine practice improvement innovations in response to the pandemic, healthcare system changes and inequities. Plenary topics include:

- Adapting Facilitation: In Fall 2019, just prior to the COVID-19 outbreak, the Agency for Healthcare Research and Quality awarded six regionally based awards to help primary care practices increase efforts to address patients' unhealthy alcohol use. A panel will feature an exploration of lessons learned as awardees adapted programs amid the pandemic. New best practices will be highlighted to inform skills and strategies to retain in the "new normal" post-COVID era.
- Using Facilitation to Promote Health Equity: Preliminary Thoughts on an Explicit Shift, Eva Woodward, PhD (VA Center for Mental Healthcare and Outcomes Research Center for Health Services Research, University of Arkansas for Medical Sciences. This presentation will share three principles for facilitation focused on health equity, including detecting disparities, understanding why implementation disparities exist, and preliminary ideas on strategies facilitators can use to intervene to address disparities.

Training Opportunities

1) Building Research Capacity (BRC) – Developed in conjunction with ADFM, a new fellowship, designed to teach individuals how to build research capacity within their own programs and organizations, is open. Candidates need to have been asked to be a change agent for building their organization's capacity for producing scholarly activity. The fellow's organization should support development of that capability, including supporting the development of a strategic plan as a product of the BRC Fellowship. Fellows might be chairs, aspiring chairs, research directors, research change agents in a residency program, administrators or others charged with making change in the organization.

   Another focus this year is succession planning. ADFM and NAPCRG worked jointly to recruit a new chair and vice chair of BRC (Peter Seidenberg, MD and Navkiran Shokar, MD) with terms that began in June. We will continue to build out succession plans for committee members as another step in this program’s evolution and maturation.

2) Grant Generating Project (GGP) – a new fellowship year is open. The GGP is open to all faculty members who are interested in pursuing investigator-generated independent research on topics of interest to primary care. Applications are welcome from individuals with MD, PhD, ScD, EdD and other terminal degrees. Previous course work or applied experience in research methods is preferred for optimal participation.

STFM REPORT TO THE FAMILY MEDICINE LEADERSHIP CONSORTIUM
AUGUST 2021

What follows are the highlights of significant or new STFM activities since the January 2020 FMLC meeting.

NASEM Report on Implementing High-Quality Primary Care

The STFM Board has reviewed the report and started discussions on what STFM is doing and could do in the focus areas and how those actions advance the objectives in STFM's strategic plan.

Protected Faculty Time Guidelines

This task force wrapped up its work with publication of the Joint Guidelines for Protected Nonclinical Time for Faculty in Family Medicine Residency Programs.

Antiracism Action Plan

STFM formed a new task force that began meeting in March. To date, the task force has:

- Defined action items aligned with STFM's strategic objectives (see below).
- Submitted a grant proposal for an academic family medicine learning collaborative. The collaborative will include one Underrepresented in Medicine faculty member from up to 20 family medicine departments or residency programs and one ally (pairs) from the same program, institution, or health system. Selected pairs will attend two full-day in-person sessions and three virtual sessions within a 20-month timeframe. During the 20 months, participant pairs will refine and work on projects within their institutions.
- Developed and administered a survey to gather baseline data on STFM members' perceptions of racism in their academic environments. The survey was distributed on June 24 to nearly 5,000 members, including residents and students. As of July 15, more than 1,000 members had responded.

Strategic Plan Objective	Tactic/Action Item
Create institutional change: • Help members identify racist structures and behaviors within their institutions and work with leaders to implement change. • Provide family medicine faculty and learners the knowledge and skills to be effective advocates for antiracism policies and practices in their institutions and communities.	• Create a confidential online assessment that departments and programs can use to evaluate their current structures and policies. Link results to resources for improvement. This assessment may be based on the Association of Family Medicine Residency Directors' DEI Milestones. • Conduct a summit with Diversity Officers and Health System Senior leaders to Empower participants to work as teams to identify racist structures and behaviors within their academic institutions and become leaders for change. • Initiate and develop relationships with external organizations to drive actions leading to addressing racism in medicine. • Explore developing an Antiracism Performance Improvement Activity where family medicine faculty meet PI requirements for continuing certification by implementing projects to reduce the prevalence of racism in their institutions.
Promote allyship: • Enhance the knowledge and skills of family medicine faculty and learners in bestowed power and intercultural humility so they may more	• Implement an antiracism learning collaborative with one URM faculty member and one ally (pairs) from up to 20 family medicine departments or residency programs.

effectively serve as allies to BIPOC peers and trainees. • Help STFM members take action as upstanders	• Educate members on being effective allies. • Share examples of microaggressions and strategies for responding to microaggressions.
Model antiracism: • Integrate an antiracist analysis and identity into the work of all STFM resources and programming provided to members.	• Create and/or promote the use of tools to help authors of STFM resources incorporate antiracism, health equity and social justice themes into their materials.
Empower the next generation to impact change: • Provide support to STFM members in their efforts to transform family medicine educators, learners, and their institutions to be more antiracist.	• Create or link to antiracism curriculum for the Family Medicine Residency Curriculum Resource. • Develop and/or disseminate training and mentorship for residents and students on the history of racism, advocacy skills, combatting racism in medical schools and residency programs, and how to dismantle the institutional racism they will encounter in their careers. • Provide opportunities for students to teach about racism.

Health Systems Engagement Action Plan

One of the key areas of STFM's strategic plan is engaging with health systems leaders, from an organizational level as well as from an individual member standpoint.

Highlights of progress:

- A task force has been compiling and creating curriculum for faculty development. They are developing new modules on health systems data and health systems finance.
- STFM collaborated with the Graham Center to identify family physicians in positions of leadership and to author a paper for *FPM*: "The View From the Top: Conversations With Family Physician Executive Leaders".
- The initiative put out a call for case studies about family medicine leaders during COVID. These have been published on the STFM website.
- The initiative submitted a CERA proposal on "Attitudes about and current scope of clinical practice of academic family physicians."
- The initiative chair conducted a series of interviews with family medicine-friendly health systems leaders.

STFM Underrepresented in Medicine Activities

STFM staff and members continue their work to increase the number of URM medical students, residents, and new faculty going into academic family medicine.

Updates on major projects:

Focus Area	Key Elements	Timeline/Steps
Scholarship	• A series of webinars for students, residents, and early career faculty on building scholarly writing and research skills • A series of Twitter chats that promote skills to engage and produce research that leverages open science • Hands-on virtual workshops on specific topics to build research experience – 2 per year	2020-2021 • Webinar series launched in Oct. 2020, 6 planned through 2022. 2 held so far. • Quarterly Twitter Chats began in Aug. 2020. 3 held so far. • 2 workshops planned for 2021. 1 held in Mar. 2021.
Scholarship	• Building from contacts generated out of the webinar and Twitter chats, the group will build an online "Community of URM Scholars" forum to provide research support and mentorship for URM faculty	2021 • Fall 2021: "Community of URM Scholars" forum launches
Scholarship	• STFM Leadership through Scholarship Fellowship for URM faculty with focus on developing	2019 – 2021: • 2019-2021: Pilot of the fellowship

	scholarly writing skills for academic advancement and leadership • Fellows learn how to recognize, navigate, and overcome the minority tax in scholarship and leadership • Fellows receive practical guidance on navigating promotion and tenure opportunities at their institutions	• July 2021: STFM fellowship began with 14 fellows
Mentorship	• A longitudinal year-long mentorship program with ~25 mentors and mentee pairs • Mentor training webinars on mentee action plans, having conversations around experiences of racism and bias, and how to help mentees build professional success and connections	2020 – 2022: • Year 1 cohort: Aug. '20–Aug. '21 • Year 2 cohort: Aug. '21– Aug. '22
Mentorship	• Development and release of "Train-the-trainer" facilitator guides for URM mentorship • Record webinars and provide training materials for URM mentorship/mentee pairs	2021-2022 • July 2021: Release of resources 1.0 • Spring 2022: Updates based on feedback
URM Faculty Pipeline	• A podcast series that explores the academic track for family medicine residents, with a focus on the unique perspectives and experiences of URM learners and faculty. Topics include academic advancement and CV advice; contract negotiation; implicit bias in medicine; writing a good poster presentation; charting a leadership career path…	2021 - 2022 • First episodes released summer 2021
URM Faculty Pipeline	• Presentations, booths, and ads at relevant conferences to recruit to academic track	2021 – 2022 • Presentations begin summer/fall '21
Leadership	• Virtual and in-person presentations to academic medical leaders on countering structural racism in academic medicine and fostering URM leadership	2021: • Presentations at ADFM, STFM Conference on Medical Student Education, Residency Leadership Summit
Leadership	• Virtual and in-person panel presentations on "Becoming" to model paths to leadership for URM learners and faculty	2021: • Presentations at ADFM and the STFM Conference on Medical Student Education
Leadership	• Free online course on pathways to leadership in academic medicine, addressing minority tax and systemic racism, building networks and finding mentors, and defining leadership pathways	Fall 2021 • Course released

Much of this work is being funded by the ABFM Foundation.

Telemedicine Curriculum

The STFM telemedicine curriculum task force is nearly finished with the first stage of their work, developing telemedicine modules and guidance for teaching clinicians. The following modules for residents and students will launch in September 2021. They will be free to STFM members:

- **Module 1: Intro to Telehealth**
- **Module 2: The Telehealth Encounter**
- **Module 3: Requirements for Telehealth**
- **Module 4: Access and Equity in Telehealth**
- **Module 5: Future of Telehealth**

The task force will be conducting a pilot project, beginning in September 2021, to evaluate the effectiveness of the new curriculum. A call for applications went out to residency programs and departments. Seventy-five applied, and the task force selected 15 residency programs and 15 medical school departments to participate.

Selected departments/programs are expected to:

- Complete a pre-pilot survey (completed as part of the application process).
- Participate in a pre-pilot kick-off virtual meeting and a post-pilot wrap-up virtual meeting.
- Require students and/or residents to complete all modules in the curriculum. The department/program can determine how/when the modules are assigned and completed between September and December of 2021.
- Complete a post-pilot survey about effectiveness of the curriculum and how it was used.

STFM Conferences

Virtual conferences continued in 2021, with each offering simulive, on-demand, and poster sessions.

- The 2021 Conference on Medical Student Education was February 1-4, with 430 attendees. This attendance figure is about 72% of the regular in-person attendance.
- The 2021 Annual Spring Conference was May 3-7, with 1,400 attendees experiencing more than 500 sessions. This attendance figure is about 87% of the regular in-person attendance.
- The 2021 Conference on Practice & Quality Improvement is scheduled for September 13-15.

Resident Leadership Training

The Faculty for Tomorrow workshop for Residents was held in 2021 as a 4-hour virtual session attended by more than 50 residents. It included presentations on Career Tracks in Academic Medicine, Finding Your Place as a Teacher in Family Medicine, and Physician Leadership. Scholarships were provided to 20 Faculty for Tomorrow Resident Scholars, including 11 URM recipients.

For the 2021 Annual Spring Conference, STFM's Graduate Medical Education Committee put out a call for submissions for sessions on leadership development for residents and junior faculty. Accepted presentations for the virtual conference were curated into an online track with approximately 15 sessions on topics such as effective leadership, teamwork, conflict management, and mentorship.

Expanded Special Issue of *Family Medicine*: "Reenvisioning Family Medicine Education"

The July/August issue of *Family Medicine* included 37 articles and commentaries to inform new residency standards that will impact family medicine teachers, learners, and patients for the next decade and beyond. The papers came out of a process implemented over the past year to gather input from practicing clinicians, educators, researchers, administrators, and learners.

The 180-page issue is divided into the following sections:

- Foundations of Residency Redesign
- What Should We Teach?
- The Practice Is the Curriculum
- How Do We Teach?
- Building a Better System of Residency Education
- Increasing the Social Accountability of Residencies
- Shaping the Future of the Specialty

The articles were published online ahead of print beginning in early June.

The special issue was funded by the ABFM Foundation, and Warren Newton, MD, served as guest editor.

Virtual Coaching Program

STFM's Virtual Coaching Program began as a pilot in September of 2020 and rolled out to all STFM Members in February 2021. The program, funded by the ABFM, offers brief, interactive coaching experiences that can help participants:

- Solve a challenging problem
- Receive feedback on a process or project
- Identify and achieve their professional and personal goals

To date, 46 coaches and 36 learners have signed up. There are currently 10 active and 11 completed coaching relationships. Recruitment of coaches and learners is ongoing through advertising, email, and social media.

Preceptor Expansion Initiative

In January of 2021 STFM began a new phase of the Preceptor Expansion Initiative, focusing on refining the resources that have been developed over the past five years and disseminating them more broadly. A key piece of this is engaging with and through AAFP chapers. To date, STFM has:

- Presented at AAFP's Chapter Leadership Forum: "New Ideas for Tackling the Preceptor Shortage in Your State."
- Convened (virtually) chapter executives from states that have tax incentives for preceptors to see if the incentives are making an impact. This dialogue took place in webinar format as a facilitated panel presentation.
- Offered precepting presentations for chapters for their virtual and in-person annual meetings (up to 8). One is complete; 7 are scheduled. STFM will also exhibit at these meetings if there is an opportunity to do so.
- Created a series of one-page tips for chapters to share with preceptors in their publications and/or on their websites.
- Created print and social media ads for chapter publications.