NORTH AMERICAN PRIMARY CARE RESEARCH GROUP POSITION STATEMENT ON THE DEFINITION OF BEHAVIORAL AND SOCIAL SCIENCES RESEARCH

Efforts to Define

Within the National Institutes of Health, the Office of Behavioral and Social Sciences Research (OBSSR) coordinates behavioral and social sciences research (BSSR) efforts across institutes. As part of its authorizing legislation, Congress asked OBSSR to “develop a standard definition of the field to assess and monitor funding in this area.”1 The current standard was developed in 1996 and revised in 2019 after an open request for input from the public.1 In order to ensure that the revised definition was aligned with the tenets of primary care research, the Research Advocacy Committee of NAPCRG submitted comments in February 2019.

The OBSSR definition of BSSR spans a variety of fields, and links BSSR to biological and ecological contributors to disease. However, the previous definition left out fundamental unifying principles, as well as several, primary care–relevant fields which we believe exist firmly within BSSR. Our response reflected these views.2

Unifying Principles

Whether utilizing mathematical models, qualitative exploration, or mixed methods, a unifying feature of BSSR is its recognition of research that is difficult or impossible to control via experimental settings. Statistical models rely on answers that are possibly true, assessed through calculations of probability. In any statistical model that is non-definitional, the error term contains everything that could not be measured, or properly operationalized. Likewise, studies that rely on qualitative techniques intrinsically accept a non-positivist, non-reductionist view, and embrace complexity in searching for answers to research questions. Similar to primary care research, BSSR embraces probability, error, and approximation in the process of answering complex questions about both social structures, and the inner lives and expressed behaviors of the individual in the context of those social structures.

Domains to Include in the Definition

While the previous definition of BSSR was wide-ranging, there were notable exclusions.1,2 One notable area we believe falls within the BSSR umbrella is public health, and all of its embedded subfields, such as environmental health, organizational administration, and health policy research. Similarly, the socioecological model and epidemiology should be mentioned by name,3 and we believe it is worth considering that whether one is studying economics, psychometrics, sociological demography, quantitative policy research, biostatistics, or epidemiology, all are utilizing similar methods derived from the General Linear Model of statistics. All use the same fundamental quantitative procedures and use qualitative research to inform what quantitative exploration cannot.

Additionally, education research, the field of study examining learning processes and the human attributes, interactions, organizations, and institutions that shape educational outcomes, as well as quality improvement and program evaluation are core fields that utilize social and behavioral science principles and methods. Educational and program evaluation designs belong within the broader family of BSSR studies, and many primary care researchers are actively engaged in research on educational and training methods, as well as the related area of health workforce composition.

Finally, we believe primary care research needs to be included in the definition of BSSR. As primary care researchers, working in departments of family medicine and in other specialties, we engage in all of these research designs, and employ theories and methods from every field mentioned in the current definition. Primary care research is a unique context for the application of BSSR. More than the translation of laboratory findings or the execution of clinical trials, a major domain of primary care research is the study of the longitudinal expression of wellness and disease, and the interaction between the individual and their own behaviors, their families, and their communities.4,5 Primary care research also studies how it ensures an adequate distribution of medical expertise throughout the health workforce, via medical education and workforce policy studies.6 Primary care research evaluates primary care systems via quality improvement and health services research, the interplay between social determinants of health and the individual, as well as the factors that create and perpetuate health disparities.7 In short, as a frequent con-
Residents who have children during residency continue to face barriers to receiving adequate time away to care for themselves and their newborns. New parents often still face negative cultural biases related to the perceived impact on their education, clinical work, and sharing of workload among colleagues. While family leave in residency training was historically utilized for birth mothers, it has in recent years begun to be considered for fathers and other non-birth parents. Graduate Medical Education (GME) programs nationwide will see an increase in the number of residents requesting Parental and Family Leave, especially with women now comprising more than 50% of medical school graduates, and with shifting cultural norms toward diversity of parenting roles and family structures.

Allowable time away from training is affected by multiple issues, some of which may not be coordinated or consistent with each other. These include human resource policies of different institutions in which residency programs reside, varying definitions of Family Leave types, American Council on Graduate Medical Education (ACGME) training requirements, and medical specialty boards’ requirements for board eligibility. The ACGME has had no specific leave policy on parental leave, rather, allowable time away from training has largely been determined by the medical specialty boards. Leave policies of sponsoring institutions add another dimension to the equation that residents and their program directors must consider in planning for time away for residents welcoming a child into their family.

Numerous articles have been published on this topic in recent years, largely focused on the variability of approaches to leave-of-absence decisions that result in inequity both across and within residency programs. Specialty boards contribute to this inequity with wide variation in the time required to become board eligible at the end of training. Currently, American Board of Family Medicine (ABFM) policy does not distinguish parental or family leave from a ‘general leave’ policy. Family Medicine residents are limited to 1 month of leave per academic year; for any reason. This is among the least amount of time allowed across boards and has been called out by Family Medicine residents as being ‘least family friendly’ of the specialty boards. Both anecdotal and survey findings across specialties have reported 2 major drivers of resident choice to return to training sooner than required after childbirth: (1) a strong desire to not have to extend their training to become board eligible, and (2) a pervasive culture within medical training that is less supportive of new parents than it is of those residents whose leave results from a serious personal medical condition or illness and/or death of an immediate family member.

Female resident to fellow classmates: “I wanted to let you know that I am pregnant… and I am sorry.”

Restrictive residency training program policies and culture regarding Parental and Family Leave are common and have not changed significantly over time. text and site for BSSR studies, and as a home to many BSSR researchers, we believe primary care research belongs in the definition of BSSR.

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From the American Board of Family Medicine

AFMRD From the Association of Family Medicine Residents Directors

Ann Fam Med 2020;18:280-282. https://doi.org/10.1370/afm.2551.

FAMILY LEAVE FOR FAMILY MEDICINE RESIDENTS: TIME FOR A NEW WAY FORWARD

Female resident to fellow classmates: “I wanted to let you know that I am pregnant… and I am sorry.”

Restrictive residency training program policies and culture regarding Parental and Family Leave are common and have not changed significantly over time.
A study published in *Family Medicine* in October 2019 demonstrated wide variation among Parental and Family Leave policies and practices across family medicine residency programs. Nearly 30% of programs offered no paid maternity leave. Of those that did, most offered 6 weeks or less and only 2 offered 12 weeks or more leave time. For new fathers, nearly 40% offered no paid paternity leave option and 10 offered no paternity leave at all. Notably, this study also demonstrated that family medicine residents, on average, utilize less Family Leave time than is offered by their training programs by one-half to 1.5 weeks.10 ABFM data for 2019 show 355 leave of absence records in which a reason was cited; these were related to maternity (240; 67%), paternity (20; 5%), personal medical (78; 22%), or family medical (17; 5%) reasons. The preponderance of both maternity and paternity leave was taken in the PGY-2 or PGY-3 years, while personal medical leave was equally balanced across training years. Female residents were more likely to take personal medical leave (59% vs 41% for male residents) and significantly more likely to be represented in numbers of residents utilizing family medical leave (82% and 15%). Very few residents needed more than 1 leave of absence during their training. For those whose residency was extended based on needed leave, the average time for extension was 54.5 days with a range of 4 to 233 days. Approximately one-half (48%) utilized vacation time toward their leave of absence, with an average of 13 days used (range 1-30).

Reconsideration of the current approach across our specialty is necessary to support resident well-being and to optimize early childhood development for the children of resident trainees. Fathers and other non-birth parents need to be supported as well, so that they may participate in early bonding and contribute to early child care responsibilities. Finally, sponsoring institutions should support residents through other impactful events, including significant personal illness and care of a critically ill or dying member of the resident’s immediate family.

The ACGME and the member boards of the American Board of Medical Specialties (ABMS) have been working together to address concerns regarding Family and Parental Leave policies in GME, with the belief that existing approaches are insufficient to support resident well-being, optimize the early childhood development of trainees’ children, and promote equality of gender participation in parenting and household activities. The 2 organizations held a summit on this topic in February 2020. A diverse group of participants assembled—residents/fellows, program directors, chairs, designated institutional officials (DIOs), health system leaders, ACGME and ABMS leadership, including those from respective member boards—to review the current evidence and imagine a new way forward that all could endorse. Dr Tom Nasca, President and CEO of ACGME, led the conference with a story of his personal experience, decades earlier, as a father who went back to work immediately after the birth of his children. He followed this with a reminder of the clear evidence supporting the importance of the early newborn period on future cognitive development of children, challenging us to consider changes in both policy and culture that would support the investment in this important period. Additional speakers shared data on the attrition of female residents from training because of issues related to narrowly defined leave policies, little support for childrearing demands, and required extensions of training.11,12 Additive to this is a culture they encounter that often left them feeling inadequate and burned out. As it currently stands, The House of Medicine makes it difficult for us to practice what we preach.

After robust and rich conversations over a day and a half, consensus around the direction of change was clear. Common themes included:

- New policies should be inclusive of any and all personal and family leave needs: childbirth, personal leave for medical conditions, and care of immediate family members during serious illness or death/bereavement.
- Family and Parental leave should be normalized with no differences between a resident giving birth, a resident with a hematologic condition requiring bone marrow transplant, or a resident parent with an older child who has a serious physical or mental health issue requiring close support and care. The consistency needed extends not only to policies, but also to the culture of how we treat our trainees and they treat each other.
- ACGME and ABMS should develop a “time away from training” policy that supports a family friendly culture and gender equity. This policy should establish a floor of 6 weeks allowable leave per year of training and should include a requirement that a minimum of 1 week of vacation time be preserved for use each year beyond the leave. Banking of leave for time off should be allowed, but not to the extent that a resident is permitted to exhaust all vacation time before a leave of absence. Time away for the Family and Parental leave is not a “break.” These residents also need vacation options for personal wellness just as other residents who do not require time away.
- Policies must be clear and accessible to everyone, including students who are selecting residency programs. Proactive planning for coverage requirements needs to be established, and program directors and sponsoring institutions would benefit from any com-
mon guidance that can be provided by ACGME and ABMS Boards.

The ABFM Board of Directors and executive leadership are committed to a change in policy related to training standards for board certification that will provide for a more supportive approach to changes in the lives of residents and their family members. We hope to share this with the community before the 2020-2021 academic year. Our approach will be inclusive and permissive, while at the same time remaining consistent with our duty to the public to assure that a board-eligible or board-certified physician completing residency training is worthy of entrusting their care. We will work to support residency programs in understanding and implementing these new guidelines, cognizant of some of the challenges this will present to managing both educational and coverage needs. The ACGME will play a corresponding role in policy development and resources. It is the right time and the right thing to do. We look forward to the transition ahead and working together to promote healthy residents and healthy families.

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AAFP TAPS VETERAN FAMILY MEDICINE ADVOCATE AS NEXT CEO/EVP

When longtime AAFP CEO and EVP Douglas Henley, MD, announced last year that he planned to retire this summer, the Academy launched an exhaustive national search for his successor. That intensive 11-month process came to a close on March 11, 2020, when veteran family medicine advocate Shawn Martin was formally named the next CEO/EVP.

Martin, the Academy’s senior vice president for advocacy, practice advancement, and policy, is already familiar to many AAFP staff members and family physicians, having served in that role since 2012. Before joining the Academy, Martin served more than a decade as director of government relations for the American Osteopathic Association.

The announcement capped a busy few weeks for Martin, who—in addition to accepting this promotion—recently turned 50 and completed his master’s degree in health care delivery science from Dartmouth College in Hanover, New Hampshire. Now he’ll move from the Academy’s Washington, DC, government relations office to its Leawood, Kansas, headquarters.

He will continue serving in his senior vice president’s role until June 1, 2020 and then will work alongside Henley as CEO designee during a transition period until Henley’s retirement on August 1, 2020.

AAFP News sat down with Martin to discuss his new role, his vision for the Academy, and the challenges ahead.

Q: You grew up in rural Oklahoma as the son of a family physician. How did your father’s medical career shape your understanding of primary care and your interest in health policy?

A: I saw at a young age the impact that a single physician, or a group of physicians, can have on individual patients and on a community. The burden on primary care was real even in the 1970s and ‘80s. We were
isolated, far from the big health care centers in Oklahoma City or Tulsa. People relied on my father and the other primary care physicians in our county for the majority of their health care. I saw the capability that existed in family medicine to be comprehensive and deliver care in the traditional cradle-to-grave sense. I also learned the importance of access to health care in ensuring a thriving and sustainable community. Beyond that, as thousands of our members tell us, it is not easy to go into an underserved rural community and practice family medicine. Seeing my father dedicating his life to that every day for years made a lasting impression on me.

Q: You've been focused primarily on governmental advocacy for more than 20 years in leadership roles with both the AOA and the AAFP. What motivated you to take on this broader role?
A: I've spent all my adult professional career working in and around health care policy at the convergence of policy and politics. But I've always had other responsibilities in both of the organizations I've worked for. I've described it as being kind of a public brand ambassador for the organizations because I've played a role in communicating or collaborating with other people in the health care sector—employer groups, insurance companies, etc. I've come to those responsibilities through a government relations or health policy position, but I've had the opportunity to engage in a broader set of activities around the organization and its mission inside and outside of the political arena. The mission of the AAFP and working with our members are 2 things that really motivated me over the past 8 years and will continue to motivate me in the future. There is an incredible amount of opportunity that exists for family medicine. Our future—as a discipline—can be whatever we want it to be.

Q: What are your short- and long-term priorities in your new role?
A: There are 3 things I spend a lot of time thinking about: being strategically focused, organizationally disciplined, and structurally aligned with the first 2 issues. We have a good strategic plan. We have good strategic objectives. That will allow us to create value for members, create a health care system that is foundational in family medicine and primary care, and allow patients to gain access to the benefit of comprehensive, continuous, coordinated family medicine and primary care. We're developing an operational plan that will help us be disciplined and align our human and financial resources to that strategic plan. That's an important endeavor we have started in the past year. It will be a point of emphasis moving forward.

Q: The Academy has advocated for increasing the percentage of health care dollars invested in primary care. How can your experience in Washington help family medicine move the needle in that direction?
A: My experiences in Washington are part of me. My view of the world is shaped by the reality I've existed in for the past 20 years. I understand that audacious goals meet political reality and financial reality pretty quickly—sometimes in a really rude introduction. That doesn't mean there's not work we should do or there's not work that's worthy of pursuing. When we think about payment and investment in primary care, one of the things people are going to hear from me a lot is that our product is family medicine, and we need to be talking about the value of family medicine more aggressively. Part of that is paying family medicine more, and part of that is putting family medicine in a better position to be successful. We need to remove barriers from family physicians and allow them to do what they're best at, which is providing care to patients. We also need to make sure purchasers and payers are prioritizing family medicine and that government agencies understand the value of family medicine. We need to talk about the value of family medicine more and in different ways. My Washington experience will help us do that.

Q: Administrative burden is another area members are asking for help with. What are your plans to keep fighting against prior authorization and other barriers that are encroaching on the time family physicians spend with their patients?
A: Members identify administrative burden as their top frustration and their top priority for the Academy. We've initiated a lot of efforts aimed at reducing and eliminating administrative burden in its various forms. I've been pretty vocal in my blog and elsewhere that there was a failure in health care policy with respect to electronic health records and the HITECH (Health Information Technology for Economic and Clinical Health) Act. It's one of the few places in any industry where tech hasn't created efficiency. It's actually decreased efficiency in health care in many respects. It's a tragedy of policy-making that needs to be corrected. I don't think it means we get rid of electronic health records. I believe the digital collection, aggregation, and distribution of medical information is an essential tenet of a 21st-century health care system. But we have to find a way to do this in a manner that doesn't detract from physicians' core function. We've all seen and heard stories that physicians are distracted and doing a lot of things besides actually listening and providing care to the patients in their exam room. Again, it's a real failure of health care policy that we are where we are today.
I also believe that rapidly transitioning away from fee-for-service and into new alternative payment models is important. Our healthcare delivery system is built around episodes, and those episodes each have complicated documentation and auditing requirements. Alternative payment models (APMs) offer an escape from these legacy approaches to delivery and payment. The AAFP has been a national leader in the development, implementation, and advancement of APMs, ranging from the Primary Care First and accountable care organizations programs to direct primary care. Each of these, while different from each other, is built on a new approach to delivery and payment that moves away from fee-for-service as the foundation. We have a lot of work to do in this area, but the AAFP leadership in this area is well established.

Q: Other thoughts?
A: I really look forward to working collaboratively with our staff in DC, Leawood, and around the country to ensure they have the direction needed and they feel empowered to do the good work we, as an organization, do every day. I'm also excited to work with our state chapter executives, who are dynamic leaders and partners, and the 7 other family medicine organizations. It's a team sport.

David Mitchell
AAFP News

Ann Fam Med 2020;18:284-285. https://doi.org/10.1370/afm.2547.

CLOSING THE GAP: OUR CHALLENGE, OUR OPPORTUNITY
A Review of ADFM’s Annual Conference, February 12–15, 2020

2020 was a year of firsts for ADFM’s Annual Conference in New Orleans. The first with a new name ("Annual Conference" replacing the legacy name "Winter Meeting"), the first with Amanda Weidner, MPH, as Executive Director, the first with over 250 attendees, and the first with a keynote “Heritage Fund Speaker,” Professor Sir Michael Marmot, Director of the UCL Institute of Health Equity.

Professor Marmot’s eminent career of over 40 years researching health inequalities and inequities directed the title and theme of this year’s conference, with his book, The Health Gap: The Challenge of an Unequal World, selected as the One Book, One ADFM title. His presentation started with the baseline question, “Why treat people and send them back to the conditions that made them sick?” followed by data on life expectancy trends for men and women, the steady decline of children earning more than their parents, and the impact changes in well-being had on inequalities. Professor Marmot also shared data and details related to the 6 objectives of his Fair Society, Healthy Lives policy, evidence-based strategies to address fairness and social justice which also reduce health disparities: (1) Give every child the best start in life; (2) Enable all children, young people, and adults to maximize their capabilities and have control over their lives; (3) Create fair employment and good work for all; (4) Ensure healthy standard of living for all; (5) Create and develop healthy and sustainable places and communities; (6) Strengthen the role and impact of ill health prevention.

The theme of "closing the gap" in health inequalities was also covered in a variety of other sessions:
• ADFM President Allen Perkins, MD, MPH, shared his personal experience, as a physician and Chair of the Department of Family Medicine at South Alabama University, of slowly moving the health equity needle forward when in a “red state.”
• ADFM’s Diversity, Inclusion, and Health Equity committee organized 6 action-oriented breakout discussion sessions on: (1) recruitment of faculty staff, (2) retention and recruitment strategies for students and leadership development, (3) coming together in action for inclusion, equity, and diversity, (4) inclusion of those with disabilities, (5) diversity and inclusion training (including implicit bias and others), and (6) intentional management throughout the system.
• Topic tables during breakfast sessions on Thursday and Saturday mornings included content on ways to address social determinants of health and recruiting medical students to family medicine.
• ADFM’s 5 strategic committees (Diversity, Inclusion, & Health Equity, Education Transformation, Healthcare Delivery Transformation, Leader Development, and Research Development) met over lunch on Thursday (open to all attendees). New in the 2-year strategic plan are diversity, health equity, and inclusion goals unique to each committee’s focus.

Steven Waldren, MD, Vice-President and Chief Medical Informatics Officer of AAFP, was also a keynote speaker, with a plenary that explored the emerging “4th Industrial Revolution” of artificial intelligence and its potential impact on family medicine. Understanding the differences between artificial intelligence and machine learning, identifying opportunities and challenges in AI/ML, and noting key issues that will
need to be addressed by academic departments of family medicine led to a lengthy and active question/answer period that concluded the session!

ADFM has many collaborative partnerships and priority initiatives that generated other plenaries. The Best Practice Guide for Strategic Planning to Increase Student Choice of Family Medicine made its soft launch debut at the 2020 Annual Conference. It was developed by ADFM’s Education Transformation Committee with feedback and support from several FM associations and the 25x2030 Student Choice Collaborative. Building Research Capacity (BRC) is a joint initiative between ADFM and NAPCRG in cooperation with STFM and AFMRD. BRC held their very first preconference workshop, The Leader’s Guide to Decision-Making When Building Research and Scholarship Capacity and also facilitated the ABFM Updates and Opportunities for Research Partnership—Working Together presentation by ABFM President & CEO, Warren Newton, MD, MPH. Development of leadership skills and the theme of having critical conversations was addressed by the Leader Development Committee’s Conflict Management 301 preconference workshop; How Departments Can Engage in Respectful Dialogue in an Era of Diverse Values, session moderated by Christine Arenson, MD, with a panel of Kevin Grumbach, MD, Julie Moretz, and Thomas Peterson, MD; and the Leadership & Management Dilemmas Dinner moderated by Jeff Borkan, MD, PhD, Thomas Peterson, MD, and Steven Rothschild, MD.

The business of running a department is always covered in numerous ways at the ADFM conference. This year, it was addressed by The Changing Landscape of Reimbursement: Challenges and Opportunities moderated by Kim Roe, MBA, with a panel of Norman Ward, MD, David Serlin, MD, Jeff Borkan, MD, PhD, The ‘Unproductive Provider’: A Systematic Method for Evaluation and Improvement of Under-Producing Physicians and Advance Practice Nurses presented by C. Kimi Suh, MD, MPH, FAAFP, Karen Tate, MPH, Aaron J. Michelfelder, MD, FAAFP, FAAMA, and Communication in a Complex Family Medicine Department presented by James Pacala, MD, MS.

Overall, something of interest for all attendees with some fun thrown in—a party to celebrate Emeritus Executive Director Ardis Davis on Thursday night and yoga led by our own Reid Blackwelder, MD, on Friday morning. Not to mention pre-Mardi Gras parades around the hotel that added a beat and spectacle each night. Now, on to Atlanta (Buckhead) for the 2021 Annual Conference!

Susan Latta

STFM FORMS TASK FORCE TO DEVELOP A NATIONAL TELEMEDICINE CURRICULUM

Telemedicine or telehealth—defined as the long-distance delivery of medical care using technology—has grown exponentially in the United States in the past 20 years, and contemporary trends in the health care environment are serving to fuel this growth into the future. More than one-half of all US health care institutions provide some form of telemedicine, and more are employing increasingly sophisticated tools. Undoubtedly, the COVID-19 pandemic has quickly escalated this need in the first half of 2020.

“When all is said and done, the COVID-19 pandemic will likely be seen as a tipping point for telemedicine in the United States. Telemedicine has been indispensable in delivering care to patients sheltered at home, while minimizing risks to providers. Prior to COVID-19, only 28% of US physicians were using telemedicine; today it is the preferred, if not dominant, method of delivering care in a time of crisis. Yet, there remains no widely recognized gold standard for telemedicine training for medical students and residents. What we need now is a national telemedicine curriculum to be developed and taught in medical schools and residencies across the country,” said STFM Telemedicine Task Force Chair Steven Lin, MD.

Telemedicine is associated with better patient access (especially in underserved and rural areas), decreased health care costs, high patient and provider satisfaction, and equal or better patient outcomes for selected conditions compared with in-person care. One of the biggest barriers to telemedicine adoption is lack of provider training. A 2017 survey of nearly 5,000 family physicians found that, despite considerable interest, only 15% of respondents were using telemedicine; 55% cited lack of training as their reason for not using it. The AMA and AAMC have called for telemedicine to become a core competency of medical students and residents. According to AAMC and LCME, approximately 80 medical schools (about 50%-60%) currently include telemedicine as a topic in required or elective courses. There is a lack of data on how many residency programs provide telemedicine training. There is no widely recognized gold standard for telemedicine training for undergraduate or graduate medical education. A handful of institutions have described courses or parts of courses/clerkships that

Ann Fam Med 2020;18:285-286. https://doi.org/10.1370/afm.2549.
provide telemedicine training. These experiences offer insight into emerging best practices for a potential national curriculum.

At its December 2019 meeting, the STFM Board of Directors discussed the current state of telemedicine training in US medical schools, residency programs, and teaching hospitals, and approved the formation of a Telemedicine Curriculum Task Force to develop a national telemedicine curriculum for students, residents, and faculty that will include an organized repository of resources representing foundational topics and best practices in telemedicine, including but not limited to the following: modules, videos, case-based presentations, facilitators’ guides, quizzes, OSCEs, etc.

The curriculum will be designed to help faculty integrate telemedicine topics into courses, clerkships, and residency curricula. The same content can also help students, residents, and faculty at institutions without such resources to obtain the skills needed to deliver telemedicine care in their practices. Because technology changes rapidly, the curriculum will be easily modifiable and not focus on specific technologies. The curriculum will:

• Provide strategies for integrating telemedicine into the clinical workflow
• Specifically address needs in rural and other underserved areas
• Include a guideline for integrating telemedicine into clinical practice. The guideline will be free and open access

“The task force is made up of telemedicine pioneers, change leaders, content experts, and key stakeholders from a diverse group of organizations, including the AAFP, VA, large health delivery systems, and academic medical centers that are driving the nation’s telemedicine education innovations,” said Dr Lin.

The STFM Telemedicine Curriculum Task Force members include:

• Steven Lin, MD, Stanford University
• Rika Bajra, MD, Stanford University
• Tom Banning, Texas Academy of Family Physicians
• Lance Fuchs, MD, Kaiser Permanente San Diego Family Medicine Residency
• Kevin Galpin, MD, Veterans Health Administration
• Bonnie Jortberg, PhD, RD, CDE, University of Colorado
• Mahesh Patel, MD, University of Illinois, Chicago
• Kerry Palakanis, DNP, APRN, Connect Care Operations, Murray, UT
• David Rakel, MD, University of New Mexico
• Scott Shipman, MD, Association of American Medical Colleges
• Steven Waldren, MD, American Academy of Family Physicians
• Mary Theobald, MBA, Society of Teachers of Family Medicine, Leawood, KS

The STFM Telemedicine Curriculum Task Force will complete its work in 2020-2021 with a curriculum launch scheduled for Fall of 2021. STFM will promote the curriculum and guideline through papers, peer-reviewed journals, and presentations at the STFM Annual Spring Conference, the STFM Conference on Practice and Quality Improvement, the STFM Conference on Medical Student Educations, the AAFP Program Directors’ Workshop, and the AAFP National Conference.

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