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# Table of Contents

**Sept/Oct 2018, Vol. 16, Iss. 5**

ADFM .........................................................................................................................................................................3
“The GME Initiative” and GME in States

AFMRD ........................................................................................................................................................................4
Opioid Prescribing: A Generational Perspective

NAPCRG .......................................................................................................................................................................5
2018 PBRN Conference Highlights: Addressing Health Disparities in PBRN Research

STFM ..........................................................................................................................................................................7
Residency Faculty Fundamentals Certificate Program Wraps Up Successful First Year

**Nov/Dec 2018, Vol. 16, Iss. 6**

STFM ...........................................................................................................................................................................10
STFM Begins Update of Its Strategic Plan

ADFM ...........................................................................................................................................................................10
Alternative Payment Models in Departments of Family Medicine: Our Journey Towards the Quadruple Aim

AFMRD .......................................................................................................................................................................12
Advocacy in Family Medicine: Family Medicine Advocacy Summit

NAPCRG .......................................................................................................................................................................13
NAPCRG Annual Meeting Distinguished Papers
“THE GME INITIATIVE” AND GME IN STATES

Family medicine struggles to fund graduate medical education (GME) due to antiquated Medicare rules that fund hospitals for GME. Medicare GME funding inadequately covers family medicine residencies, is inequitable with variation across the United States, and does not fill gaps in the cost of training. Program leaders need to identify funding streams which include state initiatives, and learn to advocate for options to create sustainable residency infrastructures to produce needed workforce in their states. Having answers to key questions about state GME funding and collaborative partnership opportunities, and sharing best practices to advance these efforts will support advocates at state levels to optimize opportunities for meeting state and regional workforce needs.

The GME Initiative (GMEI) (http://www.gmeinitiative.org) is a grassroots, volunteer group of roughly 150 members representing approximately 35 states and is comprised of health care learners, educators, advocates, and leaders who are passionate about reforming GME through payment reform, partnerships, state initiatives, legislation, advocacy, and education at the state, regional, and national level. Beginning with a policy brief calling for GME Reform, a GME Summit was held in 2015 (http://www.gmeinitiative.org/november-2015-summit/x0i4v). A key recommendation from this summit was to create a workgroup focused on state-based GME reform initiatives. The goal of the GMEI’s State Initiatives Workgroup is to track state initiatives, educate others about state GME activities, look at the finance, accountability, and governance of GME reform, and to host conference(s) on behalf of the GMEI. The first GMEI summit focusing on States was held January 2017 in Albuquerque New Mexico (http://www.gmeinitiative.org/2017summitmaterials). Thirty-three states were represented at the Summit; since then more states have joined the GME Initiative and work of the States’ Workgroup.

In general, states that do support GME do it through Medicaid, through state general funds, taxes, special fees, or some combination of these. To better understand specific sources and availability of funds to support GME at the state level, the GMEI States’ Workgroup has developed a template for gathering key information across states. Key areas addressed in this template are: (1) state-specific goals for GME; (2) total annual amount of non-CMS federal dollars; (3) sources of funding—where does the money come from?; (4) strategies (legislative, financial) to expand GME within a state; (5) governance and accountability structures to ensure oversight over finances; and (6) barriers and challenges.

With pilot information from 9 states, the GMEI is beginning to learn about common strategies and common barriers/challenges. A key strategy for any GME activity is to engage stakeholders and legislators to educate them about what GME is and how targeted GME efforts support state workforce needs over time. A number of states are engaged in specific efforts targeting rural areas and often involve a coalition of multiple stakeholders (state Academy of Family Physicians, state medical association, state hospital association, medical school, and others). Barriers and challenges we are learning about include too many disparate stakeholders, administrative burdens related to oversight of funds, continual need to educate and reeducate legislators about what GME is and how long it takes to produce a physician workforce, and Medicare GME cap limits which prevent residency program expansion, especially in underserved areas.

Whatever the strategy or policy in play within a given state, what the GME States’ Workgroup strives to do is to “connect the dots” between the intent of a particular policy or strategy and the reality on the ground. An overriding inherent challenge in any state-supported GME effort is the time-limited nature of state funding. This is diametrically opposed to the hard-wired funding through Medicare from CMS which continues to flow with no accountability tied to those funds. State GME efforts require constant attention to data to demonstrate accountability while at the same time constant attention to ensuring that stakeholders continue to see the value.

There is much more to learn about GME at the state level. In a recent survey of Association of Departments of Family Medicine, more than one-half (54%) of the Departments are reportedly involved in formal regional or statewide efforts to address family physician workforce needs and workforce planning. What we have found through the GME Initiative is...
that there is much to be gained by learning from each other. For more information about the GME Initiative, and how one can join, contact Mannat Singh at mannat.singh@gmail.com.

Ardis Davis, Chair, GMEI States’ Workgroup, Washington State
Mannat Singh, Director, GMEI Initiative, Colorado State

References


FAMILY MEDICINE UPDATES

Resident Physician

She has a deep vein thrombosis (DVT). It is the first textbook DVT I have seen in my short career, but she won’t go to the hospital. She is here today for her 50 MME of codeine and morphine. I have never met her before. She is angry at me because I don’t want to prescribe her monthly prescription unless she goes to the hospital; I worry her narcotics are concealing her life-threatening pain. I feel helpless, I feel like a drug dealer. I do not feel that I am helping her and I don’t know how to help her. The surge of frustration rises, I want to quit. I alternate rapidly between disgust and pity and confusion. The laws are mounting and the insurance coverage is tightening against my choices, but I have not started ANY of my patients on regular controlled substances. I am drowning in evidence against chronic opiates for these diagnoses but cannot follow any of the recommendations without losing these patients or putting them through withdrawal and suffering. I have walked into a trap of addiction and these patients will desperately and persistently strategize ways to maintain access to my prescribing habits. When I start my clinic day, I look up all new patients on the state controlled substance database. I scan for other acute pain complaints to make sure I am prepared for the demands of my opioid-seeking patients. I avoid starting new patients on these high-risk medications unless there is a very clear clinical need. I seek alternative therapies, though most patients cannot afford acupuncture, talk therapy, or topical analgesics. I set appropriate expectations for pain management, but this is not helpful for the patients I inherited. What I am lacking is the ability to safely treat opioid dependence. I don’t know how to help them, so I sustain them.

Two stories, two generations, one emotion: frustration. As resident education moves forward, family medicine must be a part of the solution to this epidemic. Resident physicians are an untapped resource to dispense or withhold them based on my own judgment of someone else’s suffering, and first experiencing the anger and fear this can generate in patients. It is much clearer today than it was then, that a policy of unlimited dose escalation for chronic non-cancer pain is a recipe for dependence, addiction, overdose, potential diversion, and little to no benefit. The drawing of rigid lines, however, can disregard the situations where these powerful medications can provide significant improvements in function and quality of life. I see doctors coming out of training today, immersed in the crisis of opioid addiction, and fearful of offering even very small prescriptions of opioids or of taking on the challenge of connecting with patients who have been dependent on them for decades. The laws and regulations that now limit my prescribing are based on better science, and I try not to resent them as I fill out prior authorization paperwork to allow my patients access to pain medication when I believe they do need it. We are all constantly looking for that balance between compassion and caution, between guidelines and individualized medicine.

Faculty Physician

Fresh out of residency in 2004, trained in the era of ‘pain is the fifth vital sign’ and the upswell of OxyContin prescribing that began in the mid to late 90s, I felt overwhelmed by the number of my patients suffering from chronic pain and unprepared to help them. A woman with bipolar disorder had compartment syndrome in her right arm after a suicidal ingestion that left her unconscious in her car for 18 hours. The muscle atrophy and scars from fasciotomy were impressive, resulting in a combination of severe neuropathy and hyperalgesia that were impossible to heal, and it was with consultation that I prescribed her fentanyl patches and later methadone for pain. The guidelines at the time purported that patients receiving opioids for pain relief did not become addicted and that doses should be titrated to pain relief without a ceiling. Medicine has no pain-relieving options more immediately effective than opioids, and I remember the discomfort of first realizing I have the power to prescribe or withhold them based on my own judgment of someone else’s suffering, and first experiencing the anger and fear this can generate in patients. It is much clearer today than it was then, that a policy of unlimited dose escalation for chronic non-cancer pain is a recipe for dependence, addiction, overdose, potential diversion, and little to no benefit. The drawing of rigid lines, however, can disregard the situations where these powerful medications can provide significant improvements in function and quality of life. I see doctors coming out of training today, immersed in the crisis of opioid addiction, and fearful of offering even very small prescriptions of opioids or of taking on the challenge of connecting with patients who have been dependent on them for decades. The laws and regulations that now limit my prescribing are based on better science, and I try not to resent them as I fill out prior authorization paperwork to allow my patients access to pain medication when I believe they do need it. We are all constantly looking for that balance between compassion and caution, between guidelines and individualized medicine.

OPIOID PRESCRIBING: A GENERATIONAL PERSPECTIVE

As our nation grapples with an epidemic that fractures families and wreaks havoc in communities, an aspect of the opioid crisis often goes unspoken. How has this complex patient care dilemma affected family medicine education? Can there be a teachable moment in our past to improve our future? The AFMRD leadership shares 2 stories, one from a faculty physician teaching for over a decade and one from a resident physician in the middle of training.

in the opioid epidemic. They are desperate to get their patients off these substances and are driven to set boundaries with the patients they inherit, but they need the training. More family medicine residency programs are offering training in pain management and care of those addicted to opioids. More family physicians trained in buprenorphine prescribing, better access to behavioral health specialists, and an education of our population about reasonable pain management are needed. There are encouraging efforts by family physicians to promote legislation supporting these goals. In the meantime, we need to listen to our shared experiences and learn from them.

James W. Jarvis, MD, FAAFP, Katie Harlt, MD, Jessica Bloom-Foster, MD, FAAFP

from the North American Primary Care Research Group


2018 PBRN CONFERENCE HIGHLIGHTS: ADDRESSING HEALTH DISPARITIES IN PBRN RESEARCH

The 2018 NAPCRG Practice-Based Research Network (PBRN) Conference brought together the energy of 160 participants from the United States, Canada, Haiti, and Australia in Bethesda, Maryland on June 25-26, 2018. The theme for this year’s conference was “Addressing Health Disparities in PBRN Research.” Conference co-chairs, Donald Nease, Jr and Denise Campbell-Scherer provided the welcome and orientation for this Agency for Healthcare Research & Quality (AHRQ)-sponsored conference.

Robert McNellis, MPH, PA, Senior Advisor for Primary Care at the AHRQ, highlighted AHRQ’s Primary Care areas of interest and achievements of which several were produced by PBRNs.

Dayna Bowen Matthew, F. Palmer Weber Research Professor of Civil Liberties and Human Rights at the University of Virginia School of Law and author of Just Medicine: A Cure for Racial Inequality in American Health Care, delivered the first plenary on “Who and What We Study Affects Who and How We Heal,” highlighting how filling the gaps in research participation and design could contribute to narrowing health disparities. Ms Matthew noted that research questions that impact the populations most burdened by disease and injury are not being asked. Although social determinants have been shown to have great impact on health outcome, researchers have not equipped primary care clinicians with the knowledge to confidently screen, much less prescribe treatment for the inequitable housing, educational attainment, food security, exposure to violence, and other social determinants that must be addressed to close health disparity gaps that persistently plague our nation.

The second plenary was delivered by Donna Manca, MD, MCISC, FCFP, Program Lead of The BETTER Program, entitled “A BETTER Way of Addressing Disparities in Primary Care Research.” Dr Manca’s presentation discussed how the BETTER program has developed an effective approach that bridges the “second valley of death” and positively impacts patient-level outcomes. Additionally, participants learned about the effective BETTER intervention to chronic disease prevention and screening, including how the intervention has been adapted to address chronic disease prevention and screening in various settings, including for those living in rural and in low-income neighborhoods.

The third plenary was given by Dedra Buchwald, MD, Director of the Initiative for Research and Education to Advance Community Health (IREACH), as well as the Founding Director of the Partnership for Native Health and the Washington State Twin Registry. Dr Buchwald offered an overview of 3 unique programs at Washington State University: (1) the new community-based medical school at Washington State University in Spokane; (2) the institutionally supported Initiative for Research and Education to Advance Community Health (IREACH), and (3) the Native Investigator Development Program. Dr Buchwald discussed how the medical school uses a geographically dispersed model of training and focuses on training physicians that will practice in rural and underserved areas of Washington State.

The 11-member PBRN Planning Committee reviewed 106 abstracts leading to 51 poster presentations, 9 workshops, and 40 oral presentations. Each submitter was asked to include a statement of why their research is relevant to clinical practice and patients. The 10 oral presentation tracks included PBRN Infrastructure, Network Operations, Practice Facilitation, Quality Improvement, Health Disparities, Chronic Care Management, Dissemination and Implementation, Behavioral Health, Community Engaged Research, and other clinical topics.

The planning committee allowed for substantial time to accommodate 9 workshops. The workshop topics covered a variety of topics, including: innovation, building a national primary care research infrastructure, measuring quality in primary care, and using community infrastructure to reduce health disparities, just to name a few.
The 3 poster sessions were well attended with ample opportunity for extended conversations and networking. Themed poster walks, in which attendees were led by a facilitator while presenters shared their research questions, methods, results, and key implications, were held this year. Poster walks offered the opportunity for attendees to learn more about a particular subject matter and research methodologies.

The career of L.J. Fagnan, founding Director of the Oregon Rural Practice-based Research Network and the Meta Learning And Research Consortium (Meta-LARC), was celebrated with a lifetime achievement award.

Conference participants were asked to vote for their choice of the best posters for the 2018 David Lanier Poster Awards. Winning posters can be found on the NAPCRG website (http://www.napcrg.org/Conferences/PastMeetingArchives/2018PBRNConferenceMeetingMaterials).

The enthusiasm and engagement at the 2018 PBRN Conference was high from start to finish. Videos of the 2018 plenary presentations and conference resource materials are available on the NAPCRG website (http://www.napcrg.org/Conferences/PastMeetingArchives/2018PBRNConferenceMeetingMaterials).

The 2019 PBRN Conference will take place June 24-25, 2019 in Bethesda with the theme of, "How do we keep prevention on the table in face of disease management incentives?"

Hope to see you there next year!

Donald E. Nease, Jr, MD,
Denise Campbell-Scherer, MD, PhD, Jill Haught
Funding for this conference was made possible [in part] by 1R13HS024893-02 from the Agency for Healthcare Research and Quality (AHRQ). The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does mention of trade names, commercial practices, or organizations imply endorsement by the US Government.

One particular brand of e-cigarette, known as JUUL, has been drawing a lot of heat. Extremely popular among adolescents and young adults, the product is the focus of an FDA crackdown and multiple lawsuits.

To ensure that AAFP members stay up-to-date on the concerns swirling around this relative newcomer to the electronic nicotine delivery system (ENDS) market, the Academy has created resources to help educate family physicians (https://www.aafp.org/patient-care/public-health/tobacco-nicotine/e-cigs.html) and their patients (https://www.aafp.org/dam/AAFP/documents/patient_care/tobacco/juuling-fact-sheet-patient.pdf) about the product.

What Is JUUL?

According to former assistant surgeon general and family physician Douglas Kamerow, MD, MPH, of Washington, DC, JUUL’s popularity among younger users has driven the product’s massive sales, with the device now accounting for almost 70% of convenience store e-cigarette business.

“It’s shaped like a small, sleek USB drive—easy to use and easy to conceal,” Kamerow told AAFP News. “High-school and even middle-school students love its shape and ease of use and enjoy flavors such as mango, fruit medley, and cool cucumber.”

Each JUUL starter pack contains 4 pods of flavored e-juice that are formulated with nicotine salts from natural tobacco leaves instead of the free-base nicotine commonly used by other e-juice manufacturers, says the Public Health Law Center at Mitchell Hamline School of Law.

“Kids like the flavors and trade them back and forth, as the e-juice pods are removable," said Kamerow. “JUUL has higher nicotine concentrate than other e-cigarettes, so it may be more addictive than other e-cigarette products. There are many anecdotes about kids starting JUUL to be cool but ending up needing to use it every day.”

The concentration of nicotine in each JUUL pod is about twice that of many other e-juice nicotine concentrations, listed at 5% nicotine by weight vs the more common 2.4% or less in other e-juices.

To combat the perception that JUUL’s higher nico-
NEW CENTER FOR PROFESSIONALISM AND VALUE IN HEALTH CARE OPEN IN WASHINGTON, DC

The American Board of Family Medicine (ABFM) and the ABFM Foundation are pleased to announce the establishment of the Center for Professionalism and Value in Health Care based in Washington, DC. The Center will be led by Robert Phillips, MD, MSPH, who has been named as its founding Executive Director.

“Health care in the United States is in the midst of transformational change; professional self-regulation and the public trust are at risk. To meet this challenge, the ABFM Foundation has decided to make a strategic investment in the creation of the Center with the ultimate goal of dramatically improving health and health care,” said ABFM President and CEO-Elect Warren P. Newton, MD, MPH.

The new Center aims to create space in which patients, health professionals, payers, and policy makers can work to renegotiate the social contract. “The social contract between health care professionals and the public gives clinicians the privilege of self-regulation in exchange for responsibility to act in the best interest of patients. This contract is fraying as increased employment of clinicians creates pressures to serve business interests over those of patients. The erosion of autonomy, strain of regulation, and exploding reporting burden is producing unprecedented levels of burnout,” says Dr Phillips. “It has gotten so bad,” continues Phillips, “that physicians are unwittingly asking many state legislatures to remove long-standing mechanisms of self-regulation and public accountability. We cannot afford to have the public question health professionals’ willingness to be accountable, and patients cannot afford our surrender of that role to payers and policy makers.”

The Center will seek to define value across the health care spectrum, reaching beyond medicine to engage the broader health care community as well as patients and families to consider what they believe professionalism and value mean, how to measure it, how to improve it, and how to engage and develop leaders. The Center welcomes collaboration with all others interested in professionalism and value in health care, including other specialty boards, other professions, and other organizations interested in working together on this common ground.

“The selection of Bob Phillips to lead the Center is an outstanding choice,” says James C. Puffer, MD, President and CEO of the ABFM. “In his role as ABFM Vice President of Research and Policy, he helped the ABFM Research Department grow to become an influential source of information about the value of primary care. He also led the launch of the national PRIME Registry, which now helps primary care practices in 49 states liberate data from their electronic health records, thus enabling easier monitoring and improvement of quality measure reporting, and completion of certification requirements. He was instrumental in the creation and successful launch of the ABFM PHATE tool, which helps practices understand how their patients are affected by social determinants of health and how to meet their needs, as well as to support enhanced reimbursement.”

Dr Phillips graduated from the University of Florida College of Medicine and completed residency training and a health services research fellowship at the University of Missouri. Prior to coming to the ABFM, he directed the Robert Graham Center for Policy Studies in Primary Care. Dr Phillips is an elected member of the National Academy of Medicine and was a Fulbright Specialist to the Netherlands and New Zealand. He currently serves on the National Committee on Vital and Health Statistics, is a Professor at Georgetown University and Virginia Commonwealth University, and maintains a continuity family medicine practice in Virginia.

Robert Cattoi, ABFM

RESIDENCY FACULTY FUNDAMENTALS CERTIFICATE PROGRAM WRAPS UP SUCCESSFUL FIRST YEAR

Background

In June 2017, STFM launched the Residency Faculty Fundamentals Certificate Program to provide foundational training for residency faculty. The program covers: the structure and requirements of residency education; how to be an effective and efficient faculty member; the nuts and bolts of...
curriculum development and teaching; and strategies for assessment, feedback, and remediation of residents.

Courses include readings, videos, interactive modules, quizzes, and assignments. Topics include:

- ACGME program requirements
- Competencies, milestones, and EPAs
- Structure and funding of residency programs
- Billing and documentation requirements
- Recruiting and interviewing residents
- ABFM rules and requirements
- Scholarly activity for residency faculty
- Writing for academic publication
- Curriculum development
- Didactic teaching skills
- Clinical teaching skills
- Assessment and evaluation
- Feedback
- Residents in difficulty: academic and behavioral problems

Assignments require participants to gather information about their programs and to put into practice what they learn in the courses. Six of the courses contain assignments that must be reviewed and approved by the instructor, Karyn Kolman, MD. Dr Kolman is the Interim Vice Chair for Education for the University of Arizona Department of Family & Community Medicine, and the Associate Program Director for the University of Arizona South Campus Family Medicine Residency.

To graduate from the program, participants must complete all courses and assignments and pass a final exam within a 1-year timeframe. Those who graduate receive the certificate, 30 hours of CME credit, a letter of congratulations noting the accomplishment, a letter to the graduate’s program director, and a press release to distribute locally.

The Residency Faculty Fundamentals Certificate Program was developed by the STFM Graduate Medical Education (GME) Committee, STFM staff, and subject matter experts.

Year 1 Results
As of the writing of this article, 183 learners from 37 states had enrolled. While the program was designed for new residency faculty, and most self-identified as “residency faculty,” learners include program directors, residents, department chairs, fellows, and medical student education directors.

Thirty-one programs have more than 1 learner enrolled.

Graduate Data
Twenty learners have completed the coursework and graduated. A list of graduates is available at http://www.stfm.org/RFFGraduates. The average number of days between starting and completing the program was 237; the fastest completion was 21 days.

The average pre-test score was 55.87%; the average post-test score was 96.37%.

Of the 20 graduates, 9 have been faculty for less than 1 year. When asked on the program evaluation “which course did you learn the most from?,” the courses selected most often (4 times each) were Curriculum Development and The Structure and Funding of Residency Programs. Comments on these courses included: “I had never really looked into how the residency program was funded. It was information that I had never thought I could obtain from my institution” and “I learned a lot about the steps to developing a solid curriculum through the modules and in practicing on the assignment.”

When asked “which course did you learn the least from?,” the course selected most often (4 times) was The Structure and Funding of Residency Programs. Comments included: “Not really learned the least, just learned the least I need to know to function as faculty on a day-to-day basis” and “I did learn a lot, but probably not as much new information as in the other topics because I was more familiar with this topic.”

One-half the graduates indicated they were extremely satisfied with the program, 35% were satisfied, 15% were somewhat satisfied. None said they were not at all satisfied.

Eighteen of 20 graduates felt the content was at the right level for them. Two, who indicated they’d been in faculty positions for 4 to 5 years, felt it was too basic.

Lessons Learned
Over the course of the year, staff and the GME Committee gathered feedback from learners through email, the graduate evaluation, a Facebook group, a get-together at the STFM Annual Spring Conference, and during presentations at STFM and AAFP conferences.

The sheer number of participants demonstrates that there is a great need for this type of program. Graduate comments such as “I like the use of multiple instructional tools,” “I liked the variety of teaching modalities used,” and “I very much appreciated the varied format of information ... It kept my attention focused” confirmed that the program’s combination of short interactive modules, videos, quizzes, and assignments is keeping learners engaged.

Almost unanimously, graduates have been satisfied with the course content: “I think this course gives a good foundation for the role and responsibilities of being a faculty member. It touched on all the areas of my job that I had questions and struggles with during my first year in my program. It was easy to do a module each week and feel like I accomplished learning.”
There has been mixed feedback about the assignments. Some graduates felt they were “time consuming” or “tedious” or “busy work.” Many graduates and current participants have commented that assignments took much more time than they’d expected when they enrolled. Some felt like the instructions were unclear. One graduate said he/she didn’t like “bugging people to help me with my assignments,” although another remarked that the assignments provide an “excuse” to have conversations with “more senior people to ask questions about how things work” and helps new faculty begin “to be known in their organizations.” Program directors at presentations have noted that they want their new faculty to come to them and ask questions.

Learners also asked for more information about and a direct link to the instructor.

In response, staff and the instructor clarified the instructions for the scholarly activity assignment, reduced the requirements for another assignment, increased the CME credits from 25 to 30, and created a syllabus so learners know going in what all the assignments are and which might take longer than others. Staff also posted email links to the instructor and added a short video introduction from her.

**Next Steps**

Staff and the GME Committee will continue to monitor comments from learners and will make tweaks, as needed. The assignments will be discussed at the fall 2018 GME Committee meeting to determine whether any changes need to be made. A second instructor will be brought on board to help with the increasing workload. A few of the courses will be reviewed, and perhaps modified, based on the pending updates to the ACGME Program Requirements. The GME Committee is assessing the need for a Residency Faculty Intermediate Certificate Program.

A Medical School Faculty Fundamentals Certificate Program is in development, supported by the STFM Medical Student Education Committee and a variety of subject matter experts. It will launch in spring 2019.

*Mary Theobald, MBA, Vice President of Communications and Programs, Society of Teachers of Family Medicine*
STFM BEGINS UPDATE OF ITS STRATEGIC PLAN

The Society of Teachers of Family Medicine (STFM) has embarked on an update of its Strategic Plan for 2020–2025. STFM uses its strategic plan to guide the organization and its activities.

“The Board takes strategic planning very seriously. The strategic plan guides every major decision and for that reason it is so important that we regularly monitor and revise the plan, using input from our members and environmental scans,” said STFM President Beat Steiner, MD, MPH.

The Strategic Planning Committee (SPC) members include:
• Freddy Chen, MD, MSPH, University of Washington
• Renee Crichlow, MD, University of Minnesota
• Joe Gravel, MD, Greater Lawrence Family Health Center, Lawrence, MA
• Cristy Page, MD, University of North Carolina
• Heather Paladine, MD, NY Presbyterian Hospital FMR, New York, NY
• Andrea Pfeifle, EdD, Indiana University
• Randall Reitz, PhD, St Mary’s Hospital, Grand Junction, CO
• Beat Steiner, MD, MPH, University of North Carolina, SPC Chair
• Stephen Wilson, MD, MPH, University of Pittsburgh Medical Center
• Stacy Brungardt, CAE, STFM
• Stan Kozakowski, MD, SPC facilitator
• Mary Theobald, MBA, STFM

“STFM exists to serve its members. A strategic plan must attend to both the current environment as well as demonstrate value to its members in a rapidly changing workplace environment now and over the next several years,” said Dr Kozakowski, MD, who will serve as strategic plan committee (SPC) facilitator.

As part of the strategic plan update process, the SPC will be assessing the previous goals and strategies and the achievements of the organization in relation to the current plan. The committee will also review results of extensive data collected from the STFM member needs survey, interviews with current and past members, a staff survey, and SWOT (strengths, weaknesses, opportunities, and threats) analyses performed by each STFM Standing Committee. At its December 2018 meeting, the STFM Board will synthesize the ideas from the committee SWOT responses and prioritize the key issues to share with the SPC.

“This plan becomes more critical than ever as our members wrestle with an unsustainable health care system due to runaway costs, health care disparities, competing demands for clinical production and academic activities, and personal health and well-being,” added Dr Kozakowski.

The SPC will hold its first meeting in January 2019 and will continue its work through June 2019 with plans to have a preliminary draft of the 2020–2025 Strategic Plan for review by the STFM Board of Directors at its July 2019 Board meeting. Based on feedback from the Board, the SPC will refine the plan for final Board approval in September 2019.

Traci Nolte
Society of Teachers of Family Medicine

ALTERNATIVE PAYMENT MODELS IN DEPARTMENTS OF FAMILY MEDICINE: OUR JOURNEY TOWARD THE QUADRUPLE AIM

A combination of escalating costs of health care and an aging population with increased longevity and complexity is changing the environment of the patient office visit and how physicians are reimbursed for their services.

In 2008, Berwick et al presented the Triple Aim—improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations. Since that time, the Affordable Care Act was passed and new models of health care delivery have evolved to redesign the delivery of health care to meet these goals.

Various alternative payment models include payment rewards to providers for delivering high-quality
and cost-efficient care. A payment model founded on value-based care, the Accountable Care Organization (ACO), targets total population spending and was designed to provide incentives for physician groups or delivery systems to reduce per-capita spending and improve quality with the savings generally shared with the organization that employs the primary care physician. Medicare created the Medicare Shared Savings Program and the Advanced APMs, a subset, to allow practices to earn more rewards in exchange for taking on risk related to patient outcomes. Many practices have adopted the patient-centered medical home (PCMH) model with levels of recognition by NCQA and other review organizations. The PCMH model strives to establish long-term relations between patients and their primary care team from a population health standpoint. These models developed shared plans of care, coordination of care to include subspecialists and hospitals; and offer innovative access to services through improved scheduling and integration with community resources.

Recently, the Association of Departments of Family Medicine (ADFM) surveyed its membership to determine how academic family medicine departments are navigating through the changing environment. A large majority (87.6% of respondents) reported that their departments are involved in an alternative payment model. Among those with any alternative payment model involvement, Medicaid or Medicare ACOs are very common, with 67.4% and 56.5% respondents involved, respectively; though a significant number of departments (66.3%) are using the PCMH model with enhanced payment for either monthly care coordination or population-based payments in addition to fee-for-service payment received.

The survey results reported a shift within a majority of the family medicine departments from a fee-for-service or capitated arrangement to a value-based plan with only 2.2% of our surveyed members participating in a direct primary care model that consisted of fully capitated/per-member, per-month payment paid directly to the primary care practice by patients or their sponsors.

Utilizing a population health management approach is an imperative focus in order to decrease the overall cost of care while improving the quality of care delivered. A potential association of the additional work required to achieve the Triple Aim goals has been the increase in frequency of reported physician and staff burnout. Bodenheimer and Sinsky identified a fourth aim, The Quadruple Aim, to address this concern. The Quadruple Aim focuses on areas to adjust the work life of the clinician and their staff and accentuates its importance in order to succeed in improving population health in any model. Since 2015, ADFM has provided continuous programming to assist its members to identify, address, and manage burnout in their departments and rekindle the joy of practice with their faculty and staff.

Other identified challenges encountered in implementing and sustaining these new practice models have included: (1) the ongoing investment in time, staff, providers, and multiple other personnel required to implement further change; (2) the increasing financial risk in order to be eligible for or to attain an incentive that is not guaranteed; (3) the variations between payer contracts around attribution, metric definition, and various logistics (data capture and integration of other supplemental data); (4) the continued rise in general operational expenses such as the costs for supplies, labor market, pharmaceuticals, information technology, etc, while working within a defined budget; and (5) the increasing out-of-pocket expenses for our patients to meet the recommended follow-up and quality gap metrics the model is required to fulfill.

As part of the strategic plan over the next 2 years, the membership of ADFM has expressed interest in opportunities to share best practices in health care delivery that advance the Quadruple Aim and to identify ways to implement population health strategies in patient care, research, and education that benefit their departments. ADFM has an ongoing webinar series to address some of these content areas (more at: http://www.adfm.org/MembersArea/WebinarsResources).

We invite all in the “family of family medicine” to join our upcoming webinar on Alternative Payment Models, featuring a panel of those who have been involved in the various models. This webinar will take place on December 13, 2018 at 12:00 PM Eastern. Please register here: https://goo.gl/forms/DCKyxbbmmnAxN4Sce2.

George D. Harris, MD, MS, Michael Jeremiah, MD, FAAFP, Ardis Davis, MSW, Grant Greenberg, MD, MHSA, MA, Amanda K.H. Weidner, MPH

References

**Advocacy in Family Medicine: Family Medicine Advocacy Summit**

Many factors that influence residency education cannot be controlled on a program level. Advocating for our programs, our patients, our communities, and our learners on a regional, state, and national level should be an essential part of the life of a family physician and educator. The feeling that we often can’t do enough to address social determinants of health for our patients is an important cause of decreased physician well-being. Organization and advocacy is an essential activity to fight burnout: “When we recognize ourselves not as individual actors each isolated in an exam room, but as a collective joined in common cause, we start to feel less alone.”

The strategic plan of the Association of Family Medicine Residency Directors (AFMRD) includes “advocacy and collaboration.” The AFMRD works with other groups in the “family of family medicine” by way of the Academic Family Medicine Advocacy Council (AFMAC) to advance an agenda important to our programs and our communities. In addition, for many years, AFMRD has funded 10 competitive resident scholarships to attend the annual Family Medicine Advocacy Summit (FMAS) in Washington, DC. In 2018, AFMRD also funded 3 scholarships for our member program directors or association program directors. We hope these scholarships support advocacy leadership and inspire programs to engage locally, regionally, and nationally. Two scholarship awardees, a resident (T.K.R.), and program director (W.B.B.) share their FMAS experience here.

**Reflections From the 2018 Family Medicine Advocacy Summit**

Advocacy comes in many shapes and forms. Our advocacy work did not end with our meetings on Capitol Hill during FMAS; it continued as a residency-wide effort to promote our residents’ role as advocates. Family physicians see the entire range of ages and stages of our population. As community members and de facto public health champions, we witness the very real daily issues that our patients face. A privilege of our specialty is the ability to amplify and give weight to the voices of marginalized communities.

As a residency embedded in a community health center, we see the myriad issues our patients face daily. Unfortunately, it is easy to feel lost about what actions to take to improve the lives of our patients and communities. While at FMAS, we had the opportunity to aggregate stories and experiences into powerful messages to share with our senators and representatives. The most compelling aspect of our experience was understanding the weight of our voices. Elected representatives and their staff inherently understand the representation a physician can bring to the table. Bringing the collective voices of our patients to decision makers is powerful.

While advocacy may bring to mind images of lobbyists on Capitol Hill and the politics seen on the television shows *The West Wing* or *House of Cards*, other forms of advocacy are myriad and effective. As a program, we incorporate the exploration of all forms of advocacy into our health systems management and community medicine curricula. We encourage residents to reflect on patient experiences and share patient stories by authoring op-eds in local newspapers, creating blog posts for online forums, speaking at local city council meetings, and writing letters to local utility companies to advocate for patient needs. Residents are urged to further amplify their voice by joining organized advocacy efforts with the American Academy of Family Physicians (AAFP), our state AAFP chapter, our state medical society, or the Health Center Advocacy Network. These resources are well organized and allow family physicians to do what we can do best—tell the stories of our patients and communities.

Advocacy days through our state AAFP chapter afford an opportunity for residents and faculty to share our on-the-ground experiences, often untold at state and national levels. Similar to our experiences at the national level, state representatives are acutely interested and reach out for our perspectives on community issues. We can harness a strength of family medicine—the building of long term relationships. In advocacy, we build long term relationships with our elected leaders and their staff members.

Advocacy uses natural strengths of family medicine, telling community stories and nurturing long-term relationships. We are uniquely poised as a specialty to build a culture of advocacy in all forms. We should all move forward to bring this culture to residencies across the nation.

Steven R. Brown, MD, FAAFP; Tuhin K. Roy, MD, MPH, Wendy B. Barr, MD, MPH, MSCE

**References**

NAPCRG ANNUAL MEETING DISTINGUISHED PAPERS

NAPCRG’s Annual Meeting is a forum for primary care researchers from across the globe to gather and present their work, collaborate for new research, and foster growth for up-and-coming researchers. The 2018 Annual Meeting was held in Chicago, Illinois, November 9-13, 2018, and was attended by more than 1,000 researchers, clinicians, patients, and other stakeholder members from around the world.

Three papers from the 2018 NAPCRG Annual Meeting were selected and given the special designation of “distinguished paper” for excellence in research based on the following factors: overall excellence, quality of research methods, quality of the writing, relevance to primary care clinical research, and the overall impact of the research on primary care and/or clinical practice.

Below are brief summaries of this year’s distinguished papers; complete abstracts are available on the NAPCRG website.

United States Pharmacopeia Patient-Centered Prescription Bottle Label Standards and Medication Adherence

Paul Smith, MD; Kenneth Schellhase, MD, MPH; Henry Young; David Mott; Farah Pathan; Steve Sparks, MS

Patients frequently misunderstand prescription medication label instructions. The United States Pharmacopeia (USP) recommended evidence-based, patient-centered prescription medication label standards to improve understandability in 2013. The objective of the study was to pilot test the implementation process of revising prescription medication labels at 61 sites in 3 pharmacy organizations and assess medication adherence for patients served by 1 pharmacy organization. The results concluded that there is an association between a change to more patient-centered prescription medication labels and increased medication adherence based on medication possession ratio (MPR). Adherence improved most in patients with low and medium MPR values before the label change.

Full abstract: http://www.napcrg.org/Conferences/AnnualMeeting/SearchResearchPresentations?m=6&s=22773

The Australian Contraceptive ChOice pRoject (ACCORd): Results of a Cluster Randomised Controlled Trial Aimed at Increasing Long Acting Reversible Contraceptive (LARC) Uptake

Danielle Mazza, MBBS, MD; Cathy Watson; Kirsten Black; Angela Taft; Jayne Lucke; Kevin McGeechan; Marion Haas; Kathleen Macnamee; Jeffrey Peipert

Long Acting Reversible Contraceptives (LARC) reduce unintended pregnancy and abortion rates but Australian uptake is low. Therefore, the Australian Contraceptive ChOice pRoject (ACCORd), adapted from successful US Contraceptive CHOICE study, evaluated whether a complex intervention in primary care resulted in increased LARC uptake. The results concluded that ACCORd intervention resulted in significantly more LARC uptake at 4 weeks and 6 months and has the potential to reduce rates of unintended pregnancies in Australia.

Full abstract: http://www.napcrg.org/Conferences/AnnualMeeting/SearchResearchPresentations?m=6&s=22780

Exploring Practice Variation in Antibiotic Prescribing for Respiratory Tract Infection: Cohort Study Data Analysis Accounting for Illness Severity

Michael Moore, FRCGP; Beth Stuart; Sue Broomfield, Hanna Brotherwood, Paul Little, MD, MBBS, MCRP, MRCP; David Mant, Sue Smith, Ann Van den Brul, MD, PhD; Alastair Brown, Catherine van’t Hoff

Addressing antibiotic overuse is an international priority and prescribing for a sore throat and lower respiratory tract infection (LRTI) remains high. The objective of this study aims to describe antibiotic prescribing for a sore throat and LRTI in UK general practice in relation to illness severity and to explore the extent of potentially inappropriate prescribing and whether this varies by GP practice. The method included describing variations in prescribing rates accounting for individual patient baseline presentation, sociodemographic characteristics, and practice-level deprivation. Upon conclusion, it was found that higher prescribing practices do see more unwell patients. However, this does not fully explain the differences that we observed in prescribing rates. The odds were substantially higher of an identical patient receiving an immediate prescription in some practices than in others.

Full abstract: http://www.napcrg.org/Conferences/AnnualMeeting/SearchResearchPresentations?m=6&s=22895

Jill Haught, NAPCRG