Family Medicine Updates

AAFP From the American Academy of Family Physicians

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AAFP, ACP RELEASE NEW ACUTE PAIN CLINICAL GUIDELINE

The AAFP and the American College of Physicians (ACP) released a new clinical guideline on the management of acute pain in adults, titled "Non-Pharmacological and Pharmacological Management of Acute Pain from Non-Low Back, Musculoskeletal Injuries in Adults," online August 18, 2020 in *Annals of Internal Medicine*.

The guideline is based on findings from 2 systematic evidence reviews. Overall, it recommends topical NSAIDs as first-line therapy for patients experiencing pain from these types of injuries. The guideline also recommends that clinicians not prescribe opioids except in cases of severe injury or if patients cannot tolerate first-line therapeutic options.

"This guideline is not intended to provide a one-size-fits-all approach to managing non-low back pain," then-AAFP President Gary LeRoy, MD, of Dayton, Ohio, said in a press release. "Our main objective was to provide a sound and transparent framework to guide family physicians in shared decision-making with patients."

Guideline Development Process

The guideline was developed by the ACP's Clinical Guidelines Committee and several representatives from the Academy in accordance with the ACP's guideline development process.

In creating the guideline, the AAFP and the ACP used the results from a network meta-analysis on the comparative safety and efficacy of pharmacological and nonpharmacological treatments for acute musculoskeletal injuries in adults in the outpatient setting and a systematic review on the predictors of prolonged opioid use. Low back pain was excluded from the review because it was covered in a previous ACP guideline that the AAFP endorsed.

The meta-analysis included 207 trials encompassing nearly 33,000 patients who experienced a variety of musculoskeletal injuries. The systematic review included 13 observational studies with a total of more than 13 million participants.

Clinical outcomes were evaluated using the Grading of Recommendations Assessment, Development, and Evaluation framework. Outcomes measured were pain, physical function, symptom relief, treatment satisfaction, and adverse events.

When evaluating the evidence on benefits and harms, the clinical guidelines committee reviewed the results from both direct evidence and the network meta-analysis using the highest certainty of the available evidence.

Recommendations

Based on their analysis, the AAFP and the ACP issued the following recommendations for patients with acute pain from non-low back musculoskeletal injuries. In these patients, the organizations:

- Recommend using topical nonsteroidal anti-inflammatory drugs (NSAIDs) with or without menthol gel as first-line therapy to reduce or relieve symptoms (including pain), improve physical function and improve treatment satisfaction (a strong recommendation based on moderate-certainty evidence)
- Suggest using oral NSAIDs to reduce or relieve symptoms (including pain) and improve physical function, or oral acetaminophen to reduce pain (a conditional recommendation with moderate-certainty evidence)
- Suggest using specific acupressure to reduce pain and improve physical function, or transcutaneous electrical nerve stimulation (TENS) to reduce pain (a conditional recommendation with low-certainty evidence)
- Suggest *not* using opioids, including tramadol (a conditional recommendation with low-certainty evidence)

The organizations stated that topical NSAIDs were the only intervention that improved all outcomes in patients with acute pain from non-low back musculoskeletal pain.

Topical NSAIDs also were among the most effective options for treatment satisfaction, pain reduction, physical function and symptom relief, and were not associated with a statistically significant increased risk of adverse effects.

Oral NSAIDs were shown to be effective in reducing pain within 2 hours and 1 to 7 days after treatment and were associated with greater likelihood of symptom relief. However, oral NSAIDs also were associated with an increased risk of gastrointestinal adverse events. Clinicians were advised to assess a patient's risk factors and treatment preferences when choosing between oral NSAIDs and acetaminophen.

Specific acupressure improved pain at 1 to 7 days post-treatment and improved physical function, but there was only low-certainty evidence that it improved pain within 2 hours of treatment. Similarly, there was low-certainty evidence that TENS improved pain within 2 hours or at 1 to 7 days following treatment.

Regarding opioids, the evidence reviews found high-certainty evidence that acetaminophen plus opioids reduced pain at 1 to 7 days and also improved symptom relief. However, none of the other interventions reviewed (transbuccal fentanyl, tramadol, acetaminophen plus ibuprofen plus codeine or oxycodone) were associated with improvements in more than 1 clinical outcome.

Additional evidence showed increased risks of neurologic and gastrointestinal adverse effects associated with opioid interventions, and combination therapies with opioids were more expensive than similar interventions without opioids. Based on these and other substantial potential harms, the guideline recommends that clinicians should avoid prescribing opioids except in cases of severe injury or patient intolerance of first-line therapeutic options.

Family Physician Panelist Perspective

Kenneth Lin, MD, MPH, a professor in the Department of Family Medicine at Georgetown University Medical Center in Washington, DC, represented the AAFP as a panelist in the guideline's creation. He told *AAFP News* that the guideline should raise awareness among family physicians that for most patients with acute pain from non-low back musculoskeletal injuries, topical or oral NSAIDs are as effective, if not more effective, than opioids while producing fewer adverse effects.

In particular, Lin said that the strong recommendation for topical NSAIDs will likely change the way many family physicians currently treat patients with acute pain from these types of injuries.

"I think that most FPs have tended not to think of topical NSAIDs as effective relief for acute musculoskeletal injury pain," Lin said. "Although topicals are currently more expensive than oral NSAIDs, hopefully the topical NSAID diclofenac becoming available over the counter will drive down prices for these therapies."

The FDA approved a topical gel containing diclofenac for OTC use in February.

Lin added that the Academy has numerous resources available to help FPs combat the opioid crisis, including a collection of content curated by *American Family Physician* and additional resources in the AAFP Patient Care section of the AAFP website.

Finally, in patients with severe musculoskeletal injury pain who do require opioid treatment, Lin recommended that family physicians prescribe shorter courses (eg, 3 days instead of 7 to 10) to reduce the likelihood of persistent opioid use.

AAFP News

From the American Board of Family Medicine

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EVOLVING CERTIFICATION TO MEET TODAY'S NEEDS: THE ABFM'S KSA REVISION INITIATIVE

Why Knowledge Self-Assessment?

The American Board of Medical Specialties (ABMS) implemented the Maintenance of Certification Program as a way to provide a comprehensive approach to lifelong learning, self-assessment, and quality improvement for physicians in all specialties.[1] As demonstrated in a systematic review of 62 studies, physician knowledge, skills, and adherence to evidence-based medicine tend to decline as a function of time from initial training.[2] In addition, there is robust evidence that physicians, like other experts, are inaccurate in their own self-assessment—we simply do not always realize what we don't know.[3] Thus, a key role of Board Certification is to provide a guided, objective, independent, self-assessment program that goes beyond traditional, self-selected continuing medical education (CME). Ongoing self-assessment also supports acquisition of new knowledge and skills as changes in medical knowledge necessitate changes in practice, and it reinforces a broad knowledge base when physicians' scope of practice narrows over time. Participation in continuous certification empowers physicians to develop their own learning strategies supported by tools that can help direct their lifelong learning, while at the same time helping to assure the public they have demonstrated that they have the tools to provide high-quality care.

In 2004, the American Board of Family Medicine (ABFM) introduced self-assessment modules (SAMs), which consisted of a 60-item knowledge assessment followed by a corresponding computerized clinical simulation. Each SAM was divided into specific competencies and diplomates had to correctly answer 80% of the items in each competency to successfully complete the requirement. Diplomates were also presented with rationales and references for questions they

missed and were allowed multiple attempts to complete the activity successfully. SAMs were purposefully created to present an in-depth and challenging exposure to the content area in order to assist in the identification of knowledge gaps, not to simply reinforce what one already knew.[4] By 2012, SAMs covering 16 different topic areas had been created, drawn from the 20 priority areas identified by the Institute of Medicine.[5]

In 2016, the ABFM announced several changes in the continuous certification process, resulting from feedback provided by diplomates and the commitment to ensure that its programs were aligned with best practices in assessment, measurement, and quality improvement. Feedback on the knowledge assessment portion of the SAMs was very favorable; however, diplomates were less favorable about the clinical simulation.[6,7] Therefore, the knowledge assessment portion of the SAMS was uncoupled from the clinical simulation and the simulations were made optional. The knowledge assessments were renamed Knowledge Self-Assessments (KSAs) and the simulations were discontinued in 2019.

In the current continuous certification program, physicians are required to earn 50 certification points and acquire 150 CME credits during each 3-year stage. Self-Assessment and Lifelong Learning requirements now offer 2 options: (1) completing at least 1 ABFM-developed 60-question, topic-specific KSA activity, or (2) completing 4 quarters of Continuous Knowledge Self-Assessment (CKSA), consisting of 25 questions each quarter across a broad range of topics.

Improving KSAs

As part of ABFM's commitment to continual improvement of our certification activities, in 2019 we began evaluating and substantially revising the KSAs. A review of diplomate feedback over time has suggested the need for a more robust and transparent updating process and revealed frustration with the multiple true-false question format. At the same time, our Board of Directors were eager to add topics that would be more relevant, supportive of a broader scope of care, and reflective of changes in health care. We have made a number of changes to the KSAs activities, including transitioning all questions to a single best answer multiple-choice format and completing a thorough review of all questions including updates of the critiques and references. Some KSAs were combined into a single activity (eg, Well Child Care and Childhood Illness became a single KSA on Care of Children). Other topics such as Hypertension and Diabetes are in the process of a content overhaul to ensure that it is up to date and relevant. This internal evaluation also identified opportunities to cover important areas that could become new modules, such as palliative care, addiction medicine, and high-value care. Many of these topics were suggested by diplomates in surveys and focus group conversations at state chapter and other meetings.

The new process maintains the annual review of topics for evidence updates and a substantial review of each KSA every 3 years that includes revision or replacement of up to 20 items. Comments made by participants are regularly reviewed and considered at each step in the revision process. Additionally, we have instituted an internal peer-review process and enhanced our medical librarian support to ensure effective search capabilities across topics. In some cases, we have partnered with external experts for peer review and/or development of new KSAs. For example, the new Palliative Care KSA released earlier this year was accomplished by a knowledge development team through the Interstate Postgraduate Medical Association (IPMA). The American Academy of Family Physicians' (AAFP) Advanced Life Support in Obstetrics course will be added as a KSA-qualifying option in early 2021. A reliable mechanism for more frequent review of diplomate comments on KSA questions, and, when indicated, real time revision or replacement of questions was also established. We believe that this creates an ideal model of partnering with diplomates to help ensure up-to-date content. A schedule of the KSA revision initiative is shown in Table 1.

Lastly, the revision process also includes improvements in the KSA platform, providing participants with the ability to review critiques to any question they have already answered, not just the ones they answered incorrectly. Additional platform updates were designed to enhance the ease of navigation and improve the user experience for diplomates. The standard for successful completion was also changed from 80% correct in each competency area to 80% overall (48 out 60), in as many attempts as necessary.

What Are We Learning So Far?

In April of this year, the new Care of Children KSA was made available as the first newly revised KSA, combining content from the Well Child Care KSA and Childhood Illness KSA. As with all KSAs, completion of the Care of Children KSA fulfills the self-assessment requirement and earns the diplomate 10 certification points and 8 CME credits. It has been completed by 955 diplomates and 601 residents to date, with more than 400 currently in progress. Thus far this new activity is receiving higher ratings from participants with respect to relevance to practice (89%), usefulness (94%), currency of information provided (93%), and overall favorability (92%). Moving to a single best answer multiple-choice format for all

Table 1. ABFM KSA Revision Timeline

Current KSA Topic Title	New KSA Topic Title	Anticipated Deployment Date
(new)	Palliative Care	Released May 8. 2020
Childhood Illness Well Child Care	Care of Children	Released April 23. 2020
Hypertension	Hypertension	Released September 11, 2020
Coronary Heart Disease Heart Failure	Heart Disease	Released August 6, 2020
Diabetes	Diabetes	End of March 2021
Preventive medicine Health Behaviors	Health Counseling and Preventive Care	End of March 2021
Asthma	Asthma	End of March 2021
Depression Mental Health	Mental Health Care	End of March 2021
Vulnerable Elderly	Care of Older Adults	End of June 2021
Maternity Care Women's Health	Care of Women	End of June 2021
Hospital Management	Care of Hospitalized Patients	End of June 2021
Pain Management	Care of Patients With Pain and Addiction	End of June 2021

60 items, eliminating multiple true-false questions, and the new standard for successful completion have helped to increase the successful completion rate on the first attempt by 3.15 percentage points compared to the average rates on the 2 former KSAs (9.63%, compared to 5.55% and 5.15% for Well Child Care and Childhood Illness, respectively). The commitment to keeping the KSA challenging, with a goal of identifying knowledge gaps, was preserved in this revision process, but seems to have eliminated the frustration of the multiple true-false format, which previously comprised 70% of KSA questions.

The new Palliative Care KSA has been completed by 612 diplomates and 163 residents, with a 12.5% successful completion rate on the first attempt. Nearly 25% of all participants are physicians with a certificate of added qualifications (CAQ) in Hospice and Palliative Care. Feedback about currency of content (94%), relevance to practice (84%), usefulness (85%), and overall favorability of the activity (92%) has been very positive. Similarly, the new Heart Disease KSA, a combination of the former Heart Failure and Coronary Artery Disease KSAs, has been completed by 301 diplomates and 62 residents, with similarly higher ratings from early participants.

Next Steps

All KSAs will be updated by mid-2021, after which they will be scheduled into the new, ongoing revision process. We are already analyzing diplomate practice data and feedback to inform the choice of new KSA topics that could be added in the coming years. In partnership with the AAFP, we expect to add an alternative self-assessment activity on Health Equity in 2021. We will more explicitly link KSAs to a corresponding performance improvement activity in order to facilitate the translation of new knowledge into practice and increase the relevance of both activities. Finally, a journal article activity will be piloted in 2021, where diplomates will be able to read and answer questions about selected evidence-based, practice-changing articles as a self-assessment activity. In all of this, we will continue to engage diplomates and key partners to continually improve the suite of self-assessment options available to diplomates in Family Medicine Continuing Certification.

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STFM SOCIETY OF TEACHERS OF FAMILY MEDICINE **From the Society of Teachers of Family Medicine**

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PEER-REVIEWED REPORTS IN MEDICAL EDUCATION RESEARCH (PRIMER) ACCEPTED FOR INCLUSION IN PUBMED CENTRAL

STFM's online journal provides a dissemination opportunity for new researchers and small studies

Peer-reviewed Reports in Medical Education Research (PRiMER), was accepted for full participation in PubMed Central (PMC), an archive of biomedical and life sciences journal literature at the US National Institutes of Health's National Library of Medicine.

"We are excited about passing this scientific and scholarly milestone. Indexing in PMC will greatly increase the visibility of *PRiMER* content, increase citations of our journal articles, and attract new authors," said Christopher Morley, PhD, *PRiMER* editor-in-chief.

PRiMER publishes small, rigorously designed original research briefs in medical education and health workforce policy, as well as medical student and resident research.

"*PRiMER* was developed to both introduce newer scholars to academic publishing in primary care medical education, as well as to provide an outlet for smaller studies by experienced researchers and educational scholars," said Dr Morley. "Having articles from *PRiMER* included in PubMed Central will expose the journal's content to wider audiences and increase its connection to other related PubMed content benefitting the authors, the journal, and the primary care research community as a whole."

In order to be accepted for full participation, *PRiMER* had to meet all scientific, editorial, and technical quality specifications that together establish the journal's adherence to the highest standards for peer review and scientific publishing. Participation guarantees a perpetual home for the full text of every *PRiMER* article, beyond the journal itself. It also provides indexing for *PRiMER* articles in PubMed, the world's top literature citation database for life science and medical research.

"We are thankful for Dr Morley's vision during the journal's creation and grateful to STFM leadership for their strong support. We also appreciate all the hard work of the *PRiMER* editorial team, editorial board, reviewers, and authors," said Traci Brazelton, CAE, STFM director of publications, who served as *PRiMER* managing publisher since its inception.

In July 2020, Sam Grammer took over the role of managing publisher for *PRiMER*. Mr Grammer brings more than 15 years of experience in academic publishing to the position, 9 of which were spent serving as a content specialist for the National Library of Medicine's Bookshelf project.

For more information about *PRiMER*, visit journals.stfm.org/PRiMER and follow the journal via Twitter at https://twitter.com/PRiMER_Journal

By Traci Brazelton, CAE
STFM Director of Publications

NAPCRG **From NAPCRG**

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2020 PBRN CONFERENCE HIGHLIGHTS

Living Laboratories for Innovation and Dissemination/Implementation in Our Communities

Most of the care for most of the patients most of the time is provided in community-based primary care practices. Generating new knowledge by conducting research in these practices and communities, and implementing research findings, is widely recognized as necessary to achieve better health for populations. It is *the* way to meet patients where they are to derive the insights that shape practice beyond textbooks. Practices and communities are like living laboratories.

This Living Laboratory theme served as the backdrop for the 2020 NAPCRG Practice-Based Research Network Conference, which brought together the energy of nearly 130 participants from the United States, Canada, and Japan and Australia in a first-ever virtual environment on August 13-14, 2020. Sponsored by AHRQ, the conference featured an array of on-demand presentations and an online poster hall, all of which have remained available to registered attendees for continued access. The ability to go back to presentations has enhanced continued learning.

Plenary speakers focused on fundamentals like implementation sustainability and implementation science:

- Implementation Sustainability, Dr Sharon Straus

• Advancing Implementation Science: An NCI Perspective, David Chambers, DPhil
• NIH Panel - Interact with NIH leaders and learn how the organization can promote PBRN research: Dr Nicole Redmond, from NHLBI; Dr Eliseo Perez-Stable, from NIMHD; and Dr Wilson Compton, from NIDA

Not surprisingly, this year's pandemic compelled presentations on Covid-19 such as:
• *Clinical Trials Recruitment in the COVID-19 Pandemic: Challenges, Opportunities, and a Forum for Sharing Experiences* (Braden O'Neill, MD, DPhil, CCFP, & Aashka Bhatt, BSc).
• *The State Networks of Colorado Ambulatory Practices & Partners (SNOCAP) COVID-19 Crisis Response: One PBRN's Journey to Practice Outreach, Partnership, and Quick Response to the COVID-19 Crisis* (Mary Fisher, MPH & Donald Nease, MD).
• COVID-19 Panel - *An Interactive Discussion With Time for Q&A Around the Latest Developments and Response to the Pandemic* (Jack Westfall, MD, MPH, & Rebecca Etz, PhD).

The 10-member PBRN Planning Committee reviewed over 60 abstracts that covered 15 different themes: behavioral health, chronic care management, clinical practice, community engaged research, dissemination/implementation, health disparities, infrastructure/network operations, practice facilitation/quality improvement, prevention, proposal development/study design/methods, shared decision making/collaborative deliberation, stakeholder engagement, technology, training, Covid-19 responses. The schedule allowed for live, on-demand and interactive sessions, including informal networking over coffee chats and a virtual poster hall. To enhance the experience, some posters were featured in moderated discussions so that attendees could dive deeper into the subject matter and research methodologies.

Presentations remain available for viewing by registered participants on the meeting platform until November 10, 2020 and the American Academy of Family Physicians awarded the conference 8.00 continuing medical education credits.

Stay tuned to NAPCRG's website for information about the 2021 PBRN Conference, which is scheduled to be held in June in Bethesda, Maryland.

Donald Nease, Jr, MD
Michelle Greiver, MD, MSc

Funding for this conference is made possible [in part] by grant 1R13HS027067-01 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.

From the Association of Departments of Family Medicine

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THE COVID-19 PANDEMIC AND SILVER LININGS FOR PATIENT-CENTERED CARE

Before the COVID-19 pandemic hit in 2020, the Association of Departments of Family Medicine concluded work in partnership with the Family Medicine for America's Health (FMAHealth) initiative regarding the addition of a public member to its Board of Directors.[1,2] Through this work, ADFM engaged public and patient members of family medicine organizations' Boards of Directors[2] to reflect on the intent of these roles in organized family medicine. Underpinning all of the efforts to engage the public and patients in the work of organized family medicine is a conviction to ensure we are putting the patient and welfare of the public and our communities at the center of what we do. An irony reported in 2019 by Stollenwerk et al is that realizing the promise of patient-centered care is easier to articulate than to implement.[3] This irony has become a new reality as Alexander and Perkins reported in July 2020 with the pandemic providing a stark wake-up call to change care delivery and to change how we train and prepare doctors for the future.[4] They note that "in response to COVID-19, we and others were able to transform the health care system in a matter of weeks." Meanwhile, Krist, DeVoe and colleagues also reported in July 2020 that primary care had to reinvent itself to protect clinicians and staff and while remaining connected to patients.[5]

The patient and public members of family medicine organizations' Boards engaged in conversations about how these recent realities arising with the advent and progression of COVID-19 are "silver linings" which allow the true patient-centeredness of care to shine through. The COVID-19 pandemic has highlighted how the promise of patient-centered care is not just aspirational. The ways the practice of family medicine has maintained the connection to patients during the chaos of COVID-19, and has highlighted the visibility of the value of this level of patient-centeredness, are noteworthy. Here we share the silver linings that emerged from these conversations as important issues to continue to watch unfold as we all make our way through and out to the other side of this pandemic.

• *People are listening.* People are listening to primary care in new ways now—we have the opportunity to talk

about primary care and the importance of keeping our health care workforce intact and safe like never before.

• *Receptivity to change.* New and familiar partners are being brought to the table to consider changes in health plans and optimal care of populations and communities, not just individual patients. COVID-19 has pinpointed the criticality, and shortcomings, of care of vulnerable populations.

• *Exposure of a broken system.* Related to the above point regarding receptivity to change is the way the pandemic has raised the stark, ugly reality of how broken our health care system is. At the root of the problem is how poorly aligned the US business model for health care is with the needs of our populations and communities. In addition to being part of the solution for change, physicians need to fully understand our hospital and procedure-centric business model for health care and why this has failed amidst COVID-19. Physicians need to receive training at all levels about the business of medicine in our country and to use their enhanced knowledge to work toward a more efficient and equitable model. COVID-19 has exposed this potentially critical gap in training and continuing medical education for all physicians.

• *Teamwork.* A hallmark of primary care, teamwork, has always been an aspirational goal. With COVID-19, teamwork is happening in organic and seamless ways as the altered universe of "normal" has dictated a new level of health professionals working together to care for patients and communities.

• *Family as care team member.* Through COVID-19, there is a newfound appreciation for the role of the family in the care of patients. With the need for strict policies keeping people away from inpatients during the COVID-19 pandemic, family members/support persons normally critical to care of patients in hospitals are not available to assist with care. This has led some physicians to write orders for a support person to be present in the care of patients.

• *Enhanced communication.* Communication has been enhanced on multiple levels as all of us respond to the reality of COVID-19. There is the patient-centered level of communication related to translating patient care materials for diverse populations; there is enhanced communication at the organizational level through active use of already existing list-serves and other communication platforms as leaders learn from one another about on-the-ground challenges and solutions; there is the enhanced ability for collaboration among professionals in organizational conversations through the onset of virtual meetings, with unprecedented frequency and utility.

A final and concluding point is that these conversations with public and private members took place before there was subsequent heightened awareness of racial injustice in our country. Many of the "silver linings" touched on here are part and parcel with health equity. As Alexander and Perkins note, in this time of forced change, "why not create something better than normal?"[4] The true realization of these "silver linings" will be the lasting change brought about by institutionalizing the ones which truly lead to a more just and equitable system of care and a safer world for all.

Ardis Davis, Amanda Weidner, Julie Moretz, Ned Holland, with acknowledgement of contributions from conversations with other family medicine public and patient members Beth Bortz and Arturo Martinez-Guijosa

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Ann Fam Med 2020;18:571-572. https://doi.org/10.1370/afm.2621.

REFLECTIONS OF THREE HEALTH EQUITY FELLOWS

The Association of Family Medicine Residency Directors (AFMRD) is committed to delivering Health Equity education to residency directors and faculty. Over the past year, the AFMRD sponsored 3 individuals for the 2019-2020 AAFP Health Equity Fellowship. This yearlong fellowship develops family physicians into leaders with expertise in the social, institutional, and cultural influences that impact health. Fellows also complete a capstone project to demonstrate their achievement of the program's learning objectives.

The 3 fellows shared a brief summary of their experience in the fellowship.

Debra A. Rothenberg, MD

I came to medicine via the Peace Corps in Niger and then studying anthropology and have spent most of

my family medicine academic career teaching about and trying to address inequalities in the social determinants of health.

The goal of my capstone project was to design and implement an evidence-based, continuous evaluation plan for the community engagement-medical education project known as the Maine Medical Center-Preble Street Learning Collaborative (PSLC). The PSLC began in 2017 as a community-based site for low barrier access to both medical services and a coordination of complex care for people experiencing, or at risk of experiencing, homelessness. This evaluation plan included electronic health record data as well as narrative reports to regularly document whether or not we meet the goals to: (1) improve the care of homeless and at-risk clients, while learning about their health needs and how best to deliver their care; (2) demonstrate and evaluate the effectiveness of a population-focused approach to health care and medical education; and (3) design a culturally sensitive educational curriculum based on an understanding of health disparities, population health, and care of underserved and at-risk individuals.

The fellowship gave me permission to commit time and energy to both thinking about important issues and working on a project that will hopefully contribute to mitigating some of the disparities in my community.

Kristina G. Johnson, MD

Over the past few years, I have been developing a longitudinal health equity curriculum for our residency program. The impetus for the curriculum came from a combination of the Unite the Right Rally in Charlottesville, Virginia in August 11-12, 2017, and an inspirational panel of residents calling on graduate medical educators to explicitly include racism in curricula at the STFM Annual Spring Conference in 2019. Through working on this curriculum, I have become even more convinced that family medicine physicians can and should impact the health of patients and communities beyond the exam room.

My project focuses on expanding the advocacy portion of the University of Virginia Family Medicine Residency Program health equity curriculum. The health equity curriculum that I've developed lays a strong foundation for residents to be aware of present-day health disparities and the social forces that created and continue to perpetuate those disparities (with racism being chief among them). However, the curriculum falls short of empowering residents to translate this knowledge into action in advocating for their patients. My hope was that this addition to the curriculum would not only improve the lives of our residents' patients and communities as they go out into practice, but also provide some protection for residents against burnout—as feeling powerless in the face of health disparities is certainly a driver of burnout.

Kate Kearns, MD

A passion for health equity was really the driver for me to choose medicine as a career and to choose family medicine as a specialty in the 90's before the concept of social determinants of health was popular. Family physicians, compared with other specialties, arguably have the closest vantage point and perspective on social justice. As a program director, I saw this as an opportunity to bring my residency culture up to date in this aspect, and to influence future cohorts of residents to approach their patient care through a health equity lens.

My project related to launching a new Friday afternoon specialized clinic within our family medicine center that serves LGBTQ+ patients in our community. I had previously learned how transgender patients from our local community had to travel 90-100 miles away to larger cities to receive care, and that they frequently faced discrimination when trying to seek care from local physicians who did not have the proper training. Previous research showed poorer physical and mental health outcomes for this patient group. So, I was very excited for our residency program to begin filling the gap of unmet need for this vulnerable and marginalized patient population. My project involved doing a needs assessment survey, training residents, faculty, and staff, and collaborating with community organizations to support a strong launch for the clinic.

Debra A. Rothenberg, MD
Kristina G. Johnson, MD
Kate Kearns, MD