From the Society of Teachers of Family Medicine

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## BRIDGING THE GAP: TRANSFORMING PRIMARY CARE THROUGH THE ARTIFICIAL INTELLIGENCE AND MACHINE LEARNING FOR PRIMARY CARE (AIM-PC) CURRICULUM

Artificial intelligence and machine learning (AI/ML) are transforming primary care, and learners want to participate in the revolution. Despite beliefs that AI/ML should be a part of their training, many medical students report that this content is missing.[1-3] In the absence of curricula, learners at all levels of training may be neither prepared to use AI/ML tools nor contribute to their development. They may be unfamiliar with the benefits and strengths of AI/ML, as well as its limitations, impact on health equity, and potential harm to patients. Learners may not have the skills and confidence to adopt safe and effective tools and communicate with patients about the role of AI/ML in their care. They may be unable to advocate for the financial resources needed to purchase the equipment and develop the technical expertise required to select, install, and monitor these tools. The consequences of this gap are already apparent, with only 38% of physicians using AI/ML in practice.[4] In primary care specifically, research on AI/ML lags behind other specialties, and the percentage of AI/ML devices intended for use in primary care and approved by the US Food and Drug Administration is in the single digits.[5,6] Reversing these trends requires the creation of a primary care workforce with the knowledge and skills needed to advance AI/ML in the specialty. While curricula to train the health care workforce exist, none focus specifically on primary care learners in the United States.[7,8]

To address this need, we developed the Artificial Intelligence and Machine Learning for Primary Care (AiM-PC) curriculum for medical students, primary care residents, and practicing primary care clinicians. In conjunction with the Society of Teachers of Family Medicine and American Board of Family Medicine, funded by the Gordon and Betty Moore Foundation, and supported by an advisory committee, our team consists of educators with expertise in primary care, computer science, instructional design, and ethics. By harnessing these diverse perspectives, AiM-PC will equip learners with the skills needed to be engaged stakeholders, use AI/ML in their practice, and ensure responsible and ethical use of AI/ML.[9,10] The curriculum consists of 5 modules (AI/ML Essentials; Social and Ethical Implications of AI/ML; Evidence-Based Evaluation of AI/ML-Based Tools; AI/ML-Enhanced Clinical Encounters; and Integrating AI/ML into the Clinic) and is designed for learners with minimal experience with AI/ML. Alongside the curriculum, we are launching a video series called *Interview with an Innovator.* The interviewees include health care AI/ML thought leaders, all of whom provide real-world examples and context to supplement the material in the modules.

To achieve our goals, we need engagement from primary care educators and practicing clinicians. AiM-PC will be launched in a staged fashion beginning late 2024 through Spring 2025, and we are recruiting sites interested in piloting the curriculum. If interested, please contact the authors. While this training overlaps with evidence-based medicine and health informatics, we want to learn from educators and potential end-users about how this content can be integrated in educational and clinical settings. Implementation of the curriculum will be key to bridging the existing training gap and ensuring that primary care learners use AI/ML to enhance effectiveness, efficiency, and equity.

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**From the Association of Departments of Family Medicine**

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## LESSONS ON LEADERSHIP FROM LEADS: LEADERSHIP EDUCATION FOR ACADEMIC DEVELOPMENT AND SUCCESS

Leadership is well studied in the business world and is the subject of multiple books and articles.[1] Although leadership skills can be taught, there is still the perception that there are "natural leaders." There are currently multiple leadership training programs for physicians in academic medicine, with many centering on specific identities (minoritized identity, women, etc), individual specialties, or unique skill sets.[2-8] Regarding family medicine, the Association of Departments of Family Medicine (ADFM) and Society of Teachers of Family Medicine (STFM) have produced manuscripts on leadership pathways and negotiation for chair positions.[7,9]

However, leadership in family medicine remains a challenge, as evidenced by the many open chair positions. Family physicians want to see patients, and leadership positions require reduced patient care time. This, among other reasons, can make recruiting family physicians for leadership positions difficult.

The ADFM created the Leadership Education for Academic Development and Success (LEADS) fellowship to increase the quantity and diversity of qualified candidates for chair positions and to prepare mid- to senior-career family medicine faculty for leadership in academic medicine.[10] During the 2022-2023 fellowship year, the LEADS fellows heard and discussed multiple axioms regarding leadership and career guidance; we compiled those that we heard during our LEADS meetings and queried our cohort on which were most important and which career stage the axiom most pertained to.

Most of the cohort participated in this ranking (7/12, 58%), and they identified 15 leadership axioms that could be helpful for early-career faculty, mid-career faculty, and senior faculty, as illustrated in **Table 1**.

The early career axioms suggest to new faculty that it is impossible to know certain things about a position before you take it; that although physicians learn to do everything ourselves, physician writers should work on teams; actions have more substantial consequences than words; you should carefully choose what assignments you accept; and that no one ever wishes they spent more time at work, but they do regret not spending enough time with those they love.

The mid-career axioms suggest to those in this stage that moving is a real possibility and may be required to advance; constantly evaluate new opportunities; doing things once and well is better than doing it often but not as well; we need to be present on decision-making bodies to meet our department, specialty, and individual needs; standing with others is vital to get things done and to be happy in our careers; and that listening is more important than talking.

Senior career axioms suggest to those in this stage that having a bad team member can ruin the work environment; developing those behind you to take your place or surpass you is now your job; you need to choose which problems to

**Table 1. Leadership Axioms, Frequency, and Career Stage Designation**

| Early career | Frequency rank | Mid-Career | Frequency rank | Senior career | Frequency rank |
|---|---|---|---|---|---|
| You don't know what you don't know | 1 | Always think about your "to" | 1 | It is better to have a hole on the team than an a**hole on the team | 1 |
| No one writes alone | 2 | Efficiency is not possible without effectiveness | 2 | Sponsorship is the responsibility of the senior faculty | 2 |
| You can't talk yourself out of something you behaved yourself into | 3 | If you're not at the table, you're on the menu | 2 | Just because it's the right problem to address, it does not mean you are the right person to address it | 3 |
| If you can't write about it, don't do it | 3 | Allyship is a superpower that requires great humility and yields great joy | 3 | Sometimes, you have to be the sponsor, mentor, or coach you did not have | 3 |
| Don't negotiate for money—negotiate for time | 4 | You have two ears and one mouth for a reason | 4 | The institution does not love you back | 3 |

fix intentionally; leadership requires us to develop skills we did not benefit from earlier in our careers; and that institutions make decisions based on economics and other factors, while individuals take emotions into account.

Because LEADS participants are mid- to senior-career faculty, early- and mid-career axioms represent ideas respondents would have liked to know at that stage. The group shared the senior-career axioms as beneficial to their current career stage.

While it can be challenging to recruit family physicians into leadership positions, LEADS motivated some fellows to seek chair positions and helped others learn about what they want to do with their careers. LEADS also taught us that all family physicians in academic medical centers can lead, even if it is not as a chair. We hope these LEADS axioms are helpful to readers as they reflect and plan their careers in family medicine and may have broad use across all medical specialties.

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**From the Association of Family Medicine Residency Directors**

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## FROM FLOOR TO "SOAR" – AIMING FOR EVIDENCE-BASED RESIDENCY INNOVATION

Funding for graduate medical education (GME) costs the American public approximately $20 billion per year.[1] While this funding reflects a positive investment in the health of Americans, has it resulted in significantly decreased health care costs, improved patient experience, improved health of populations, improved clinician well-being, and advances in health equity? This "Quintuple Aim" of health care is embedded in the definition of GME in family medicine,[2] yet by most measures, our return on investment has been poor indeed.[3]

From 2017-2019, the Board on Health Care Services of the National Academies of Sciences, Engineering, and Medicine agreed that the goals of GME are to train physicians who:

- provide excellent, cost-effective care
- address the US population's physician workforce needs (regarding specialty distribution, geographic distribution, and diversity)
- advance biomedical and health systems science
- contribute to leadership in health care[4]

We in family medicine willingly share our innovations, methods, and curricula in meetings and member forums, without particular synergy or organized purpose. Enter the collaborative effort of SOAR, Strengthening Outcomes and Assessments in Residency. This initiative between the Association of Family Medicine Residency Directors (AFMRD) and the American Board of Family Medicine (ABFM) began in 2023, with the goal of enabling family medicine residency programs to harness one another's successes and the wealth of data available to the ABFM to grow in the direction of greater social and community accountability.[5]

SOAR has used 3 primary mechanisms to advance this lofty goal:

- Appreciative inquiry: At the last 2 AAFP Residency Leadership Summit meetings, many residency leaders met in a preconference workshop. We heard from leaders whose program outcomes indicated they were positive examples in chosen focus areas (eg, care of children and behavioral health care), who had been invited to reflect on the uncommon practices/behaviors which led to those outcomes. Attendees were challenged to apply these innovations, and design and plan implementation of activities in their own programs.
- SOAR Scholars: The inaugural SOAR Scholars have completed their year of study. Dr Alex Reedy Cooper examined the relationship between Catholic affiliation of a sponsoring institution and GME outcomes, and Dr Varshaben Songara

compared the milestone progression for international and US medical graduates. They will be reporting their findings in the coming year.

• Communities of practice: These are learning networks, with a focused, well-defined purpose. Built on a foundation of trusted relationships, members learn and develop practice based on existing knowledge in order to generate/discover new knowledge. SOAR has been working to create platforms and environments which will enable such communities to develop the trust, mutual respect, reciprocity, and commitment to surface innovative residency structure and experiment together.[6]

In family medicine, our core purpose is to heal patients and communities. In order to meet that call, our vision is for SOAR to become a hub which helps program directors help each other to standardize our training efforts AND to innovate in meaningful ways. Working together, we can SOAR to accomplish what is most needed—to train physicians who are equipped and empowered to make the Quintuple Aim a reality for every person.

*Barbara H. Miller, MD, FAAFP, and Jay Fetter, MSHA*

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**From NAPCRG**

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## PBRNS ARE BACK, BABY!

On June 16, 2024, Starfield VI Summit, supported by NAPCRG, brought together 50 practice-based research network (PBRN) leaders and government officials to imagine how PBRNs can generate relevant new knowledge to advance health in the current moment of challenge and opportunity.

### New Opportunities

Using an appreciative inquiry approach, participants celebrated the substantial contributions of PBRNs to moving research from the ivory tower to the settings where most people get most of their care most of the time. The conference identified ripe new opportunities that have the potential to rejuvenate PBRNs as a source of new knowledge that is relevant to patients and the primary care practices that serve them. These opportunities include:

• The NIH Director is investing $30 million to advance the ability of rural Americans to participate in NIH research, and sees PBRNs as the way to make this happen.[1] The American Diabetes Association recently hired longtime PBRN leader Kevin Peterson as their VP for Primary Care and is investing in PBRN research, supporting DARTNet Institute to engage PBRNs.[2] AHRQ, which always has tried to do a lot with a little to support PBRNs, has been on a listening tour and is developing learning modules to support PBRNs.[3]

• National Institute of General Medical Sciences is supporting the Clinical & Translational Research Networks and is requiring these networks to have a PBRN.[4,5] PCORI's requirement of real stakeholder engagement and Community Engaged Research framework and their substantial funding provide opportunities for PBRNs that are increasingly recognized.[6]

### Top-Down AND Bottom-Up

This moment of opportunity comes on the heels of substantial challenges in practice autonomy, administrative burden, infrastructure support, and workforce. These challenges have made PBRNs an increasingly top-down enterprise, with decision making held in the hands of funders and academic partners. This imbalance of top-down leadership and power has strangled the most vital aspects of PBRNs[7]—the wisdom of those on the frontlines of caring for people in primary care, and their commitment to advocate for them.[8] The Starfield VI Summit recognized that successful PBRNs have both top-down and bottom-up leadership.[9] For this current moment of opportunity to be successful, PBRNs need to increase support for clinicians and practices to lead the generation of knowledge that is relevant to the needs of the patients and communities they serve.

### Reinforcing the Foundation

We have an opportunity to think beyond cultivating individual pathways for research career development. We can and must optimize infrastructure that can be tapped into or built to meet the needs of primary care research, engage the potential of the breadth of primary care practices across the United States, and bolster PBRNs with educated and engaged membership. This moment calls for initiatives to address local capacity needs with regional or discipline-wide solutions, PBRN training for practice teams, and raising awareness about how to participate in PBRN research.

### Leadership From Primary Care Organizations

If this moment of opportunity is to yield the hoped-for gains in new knowledge to support improved health care, equity, health, and primary care's vital contribution, then primary care organizations, particularly those in family medicine, must take on the mantle of leadership to bring their experience with PBRN "living laboratories" to inform new investment in PBRNs.[10] To realize the potential of PBRNs, many networks will need to step up their data and research infrastructure. It is critical that primary care practice-based research networks be more than recruitment sites for centrally controlled clinical trials. They are sources of the wisdom of what matters most for caring for whole people in the context of their families and communities. That wisdom must be supported if PBRNs are to be successful.

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## NEW AAFP PRESIDENT CHARTS ACADEMY'S COURSE AT FMX

Jen Brull, MD, FAAFP, of Fort Collins, Colorado, was installed as AAFP president September 25, 2024 during the Congress of Delegates in Phoenix. A few hours later, she addressed thousands of her peers in a mainstage event at the Family Medicine Experience. Brull offered an early look at the Academy's FY26-FY28 strategic plan, focusing on efforts related to advocacy, physician well-being, payment, and workforce development.

Brull's inaugural address is transcribed below, and you can watch a video that preceded the speech at **https://aafp.widen.net/view/video/ptfvhi47fj/FMX-2024-Dr.mp4?u=ozy2ed**:

Hello, family medicine! What an amazing day to be a family physician!

I am so joyful to be here today with my family. There is a pretty amazing group of people who love and support me sitting right up front, and I know this whole room is full of family—family physicians who share my heart and my passion for finding a path to better health for everyone. We are all in this together: we're taking chances, lifting each other up, and connecting for a better future.

Each of us has a personal map. It traces our journey, marks key destinations, and provides direction to the next place we are headed. You all just learned about my map—and my "pins"—the places and events that brought me to this moment. I am so excited to have arrived at this place and time—this day, and becoming the AAFP president, will always be one of those memorable "pins" on the map of my life.

But this "pin" isn't a stopping point. It's the beginning of a journey we'll take together over the next year. Because what lies ahead isn't about me; it's about all of us and what we can do to shape the future of family medicine. Today, I want to share with you some of the ways we're going to make that happen.

One of the most important responsibilities of your AAFP Board of Directors is the creation of a new strategic plan

every 3 years. This critical work spans more than a year and happens in partnership with senior AAFP staff. We begin by gathering data from multiple sources: our performance against the current strategic plan, insights from our external landscape, and, most importantly, input from YOU, our members.

Over the course of the year, we dive deep into this data, taking the time to consider a breadth of perspectives, the capacity for implementation, the competencies of our team, and the priorities of our profession. We engage in robust discussions, seeking diverse and inclusive input from stakeholders because our strength lies in the broad experiences and voices that make up family medicine. Each viewpoint helps us create a plan that not only sets a clear path forward but also reflects the heart of our mission: serving our members, advancing our profession, and advocating for the patients and communities we care for.

I am thrilled to introduce the AAFP's new strategic plan, launching right around the corner in 2025. This plan was built with YOU at the center. It's ambitious, it's innovative, and over the next 3 years, the AAFP is going to make big things happen for family physicians.

First, the AAFP is committed to elevating family medicine by making family physicians an essential voice in all health care decisions. You will see us amplify our impact by continuing to increase engagement with the media, influence governmental policy through advocacy and direct input, communicate clearly the needs of family physicians to insurance companies, and strengthen patients' understanding of the value family medicine delivers. Through strategic partnerships and influence, we will ensure that the unique insights and expertise of family physicians shape health care discussions at every level. Whether it's policy reforms, payment models, or public health messaging, family doctors will be there. By positioning family physicians as trusted leaders, we not only advocate for the profession but also ensure that the health care system delivers more comprehensive, patient-centered care.

Second, the AAFP is dedicated to enhancing well-being of family physicians by fostering a sense of fulfillment in their work. We will prioritize initiatives that address the challenges of burnout, build supportive practice environments, and promote professional growth. By improving work-life balance, removing administrative burdens, and growing autonomy, we aim to create spaces where family physicians can not just survive, but thrive. Through a combined training approach to wellness and leadership, we will empower family doctors to find renewed joy and purpose in their calling, and best of all, to help others find this path forward. Together, we will cultivate a health care environment where family physicians feel valued, supported, and fulfilled.

Third, the AAFP is focused on improving systems that support family medicine, ensuring that payment, investment and operating models evolve to meet the needs of both today's health care landscape and today's family physicians. We will champion models that prioritize both patient outcomes and physician sustainability, like value-based care, while also advocating for improvements in existing fee-for-service structures. Whether family physicians choose to practice independently or within employment models, in a traditional practice or in an innovative model like DPC, we will work to ensure that they have access to payment systems and flexible models to enable success. Through these efforts, we will improve the viability of family medicine and enhance access to the compassionate, patient-centered care our communities rely on.

And fourth, the AAFP is focused on strengthening our future by attracting, retaining, and guiding a diverse and inclusive community of family physicians. We know that when doctors look like the communities they serve, patient outcomes are better. We are dedicated to creating pathways for individuals from all backgrounds to not only enter family medicine but to thrive and lead within it. By fostering mentorship, offering comprehensive training, and promoting leadership development, we will ensure that every family physician has the tools and support needed to build a rewarding career. For every member of AAFP, we are committed to nurturing a sense of belonging where your voice is heard, respected, and you are empowered to shape the future of health care.

Putting it all together, it looks like this. The home of family medicine—YOUR home—is going to do some amazing work in the next 3 years. Just like any home, building a brighter future requires everyone's hands and hearts, so bring your energy, your heart, and your fearless spirit, and kick off your shoes and dance!

*News Staff*
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