the Annual ACGME ADS as areas being worked on for improvement. Multiple areas of "negative outliers", especially if part of an ongoing trend, may trigger an ACGME site visit earlier than planned.

The annual ACGME resident survey is an important tool in assessing the residents' perspective of the program and one of the elements contributing to accreditation status. Preparation, clarification of program attributes and policies, and access to peer support during survey administration can result in valid, actionable data which can be used to stimulate program quality improvement and resident satisfaction.

Deborah S. Clements and W. Fred Miser

References

1. Swing SR, Beeson MS, Carraccio C, et al. Educational milestone development in the first 7 specialties to enter the next accreditation system. *J Grad Med Educ*. 2013;5(1):98-106. 10.4300/JGME-05-01-33.
2. ACGME Resident/Fellow Survey Content Areas. Published Nov 2019. Accessed Feb 14, 2021. https://www.acgme.org/Portals/0/Resident-Survey_ContentAreas.pdf
3. Resident/Fellow and Faculty Surveys. Accessed Feb 3, 2021. https://www.acgme.org/Data-Collection-Systems/Resident-Fellow-and-Faculty-Surveys
4. Adams M, Willett LL, Wahi-Gururaj S, Halvorsen AJ, Angus SV. Usefulness of the ACGME resident survey: a view from internal medicine program directors. *Am J Med*. 2014;127(4):351-355. 10.1016/j.amjmed.2013.12.010
5. Sivaram CA, Edwards C, Latif F. Differing interpretations of the ACGME survey questions by cardiovascular fellows and cardiovascular faculty. *J Am Coll Cardiol*. 2017;69(11):2517-2517. 10.1016/S0735-1097(17)35906-5
6. Caniano DA, Yamazaki K, Yaghmour N, Philibert I, Hamstra SJ. Resident and faculty perceptions of program strengths and opportunities for improvement: comparison of site visit reports and ACGME resident survey data in 5 surgical specialties. *J Grad Med Educ*. 2016;8(2):291-296. 10.4300/JGME-08-02-39
7. Holt KD, Miller RS. The ACGME resident survey aggregate reports: an analysis and assessment of overall program compliance. *J Grad Med Educ*. 2009;1(2):327-333. 10.4300/JGME-D-09-00062.1.
8. Sticca RP, Macgregor JM, Szlabick RE. Is the Accreditation Council for Graduate Medical Education (ACGME) resident/fellow survey, a valid tool to assess general surgery residency programs compliance with work hours regulations? *J Surg Educ*. 2010;67(6):406-411. 10.1016/j.jsurg.2010.09.007
9. Yock Y, Lim I, Lim YH, Lim WS, Chew N, Archuleta S. Sometimes means some of the time: residents' overlapping responses to vague quantifiers on the ACGME-I resident survey. *J Grad Med Educ*. 2017;9(6):735-740. 10.4300/JGME-D-17-00187.1

AAFP From the American Academy of Family Physicians

Ann Fam Med 2021;19:281-282. https://doi.org/10.1370/afm.2703.

NEW TOOL ADDRESSES BEHAVIORAL HEALTH DURING PANDEMIC

Family physicians and other primary care clinicians who have been seeing more cases of depression, anxiety, and ADHD during the COVID-19 pandemic have a robust new resource to help them treat patients, ensure they're reimbursed properly, and bolster their own well-being.

The free resource, *"Addressing Behavioral Health Issues During the COVID-19 Pandemic: A Comprehensive Educational Program,"* has been developed by the AAFP through a grant from Molina Healthcare. It launched at https://www.aafp.org/behavioralhealth in March 2021 with 3 videos and a Practice Hack tool. A session on putting evidence into practice was added in April 2021.

"The AAFP is excited to collaborate with Molina Healthcare to extend our educational offerings beyond family medicine to all primary care clinicians who provide mental and behavioral health care to their patients," AAFP CEO/EVP Shawn Martin said about the new resource. "Collaborations such as this allow us to broaden and strengthen primary care in the communities we serve."

The resource was developed under the guidance of Santina Wheat, MD, MPH, AAHIVS, a faculty member at Northwestern McGaw Family Medicine Residency at Humboldt Park in Chicago, and CME program chair who worked with AAFP staff to oversee various activities and educational components.

The educational series is unfolding over 6 months with a variety of tools—interactive streaming sessions, a community of practice and other activities—together designed to help family physicians take a deep dive on how behavioral health during the pandemic impacts patients, coding and billing, and their own wellness, as well as that of their teams.

The interactive streaming sessions available now include:

- *Managing Anxiety and Depression in Your Practice*, presented by Lauren Oshman, MD, MPH, and Lindsay Fazio, PhD
- *Managing ADHD in Your Practice*, presented by Ravi Grivois-Shah, MD
- *Behavioral Health Practice Transformation and Reimbursement in the Era of COVID-19*, presented by Manisha Sharma, MD

• *Behavioral Health: Putting Evidence into Practice*, presented by Lauren Oshman MD, MPH; Lindsay Fazio, PhD; Ravi Grivois-Shah, MD; Manisha Sharma, MD; and Santina Wheat, MD, MPH, AAHIVS

The new educational series is one of several CME products on behavioral and mental health produced by the Academy. The AAFP is also a member of the recently formed Behavioral Health Integration Collaborative, a group of 8 physician organizations working together to incorporate behavioral and mental health into overall health care and increase patient access to behavioral health services in the primary care setting.

AAFP News

From the American Board of Family Medicine

Ann Fam Med 2021;19:282-284. https://doi.org/10.1370/afm.2705.

LEARNING FROM COVID-19: SYSTEM BLINDNESS TO PRIMARY CARE

It has become common to observe that the COVID-19 pandemic has unmasked—again[1]—the inequities in health care that Black, Latino, and poor patients face in access to and delivery of care.[2,3] Less commonly observed is the blindness to the potential for primary care to have played a major role in response to the pandemic. We believe that this blindness has cost lives and increased suffering in communities across the country.

Primary care is the largest health care delivery platform in the country. Personal physicians[4] include family physicians, general internists, and pediatricians, with family physicians representing the largest and most widely distributed tribe of personal physicians.[5] Primary care practices also include the nurse practitioners, physician assistants, and other professionals who choose to practice in primary care. Together, in a typical year in the United States, they provide over 400,000 office visits annually, 46% of vaccinations,[6,7] and countless hours in care coordination, telephone, and other non-direct care. Additionally, tens of thousands of family physicians care for patients across the continuum of care, from hospital medical wards, to labor and delivery suites, to nursing homes and other community sites. This is what we do.

Then the pandemic hit. In a period of merely 2 weeks last March, much of primary care in the United States became virtual. This happened as hospitals shut down elective procedures and patients became fearful of coming to the office. In response to the needs of patients and communities, many family physicians developed fundamentally new approaches to care, learning how to triage office visits, develop telehealth infrastructure and protocols, protect staff and patients, while balancing personal and professional commitments and constantly adapting to rapidly changing local conditions. Family physicians and their teams often did this often without personal protective equipment.

Faced with a shortage of PPE and large increases in demand, decisions made by the CDC and states often sent PPE exclusively to emergency departments and hospitals. Weekly surveys from the Green Center document this clearly and painfully. While not a random sample, they nevertheless demonstrated that 51% of a national sample of 755 primary care practices reported major challenges to protecting themselves in March of 2020; by November, access was improved but still 32% had major problems with PPE.[8] Funneling PPE to hospitals ignored the reality that the vast majority of health care visits in the country are to primary care, even after substantial virtualization. For patients who have a relationship with a personal physician, the need for advice and care increases in a time of fear and uncertainty.

As a result, and predictably, family physicians' deaths due to COVID-19 have far outpaced other specialties. In the initial phase of the epidemic, almost 4 times as many family physicians died of COVID-19 than emergency physicians and critical care physicians combined.[9] While these data do not have denominators and must be interpreted carefully, they represent evidence of a systematic inequity in the organization of health care and distribution of lifesaving resources.

There has been a similar blindness to the role of primary care offices in providing diagnostic services and giving COVID-19 vaccinations. Most family physician offices provide a broad array of point-of-care tests for infectious diseases such as strep throat, influenza, and sexually transmitted infections. These services are offered in the context of a relationship with a trusted personal physician, who can counsel on the implications of the tests. Of course, new diagnostic technology for COVID-19 had to be developed, approved, and spread, and clinicians have had to learn to use and interpret these new tests initially without knowing the natural history of coronavirus shedding. But what emerged, and is still very common, is a "diagnostic center" approach in which patients often use drive-through community ("tent clinics") or pharmacy-based testing that are largely removed from personal interpretation, patient education, and implications. The lesson for patients? For the most feared disease of this generation, don't go to your family physician for diagnosis. You are