the national family medicine organizations that dedicated the cornerstone funding to launch this important NASEM report will see opportunities to build on their early investment and collaborate on new breakthroughs.[2]

Robert L. Phillips, Jr, MD, MSPH, The Center for Professionalism & Value in Health Care, American Board of Family Medicine Foundation; Jennifer DeVoe, Department of Family Medicine, Center for Primary Care Research and Innovation, Oregon Health & Science University; Alex H. Krist, MD, MPH, Family Medicine and Population Health, Virginia Commonwealth University

References

1. Newton WP, Baxley E, Bazemore A, Magill M. From ABFM: implementing a national vision for high quality primary care: next steps. *Ann Fam Med*. 2021;19(6):564-566. 10.1370/afm.2058
2. National Academies of Sciences, Engineering, and Medicine. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care.* The National Academies Press; 2021.
3. Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, eds. *Primary Care: America's Health in a New Era.* National Academy Press; 1996.
4. Phillips RL Jr, McCauley LA, Koller CF. Implementing high-quality primary care: a report from the National Academies of Sciences, Engineering, and Medicine. *JAMA*. 2021;325(24):2437-2438. 10.1001/jama.2021.7430
5. Grumbach K, Bodenheimer T, Cohen D, Phillips RL, Stange KC, Westfall JM. Revitalizing the U.S. primary care infrastructure. *N Engl J Med*. 2021;385(13): 1156-1158. 10.1056/NEJMp2109700
6. Krist AH, Phillips R, Leykum L, Olmedo B. Digital health needs for implementing high-quality primary care: recommendations from the National Academies of Sciences, Engineering, and Medicine. *J Am Med Inform Assoc.* 2021;(ocab190). 10.1093/jamia/ocab190
7. National Academies of Sciences, Engineering, and Medicine. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care.* NASEM website. Accessed Nov 14, 2021. https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care
8. Coker TR, Perrin JM. The NASEM report on implementing high-quality primary care-implications for pediatrics. *JAMA Pediatr.* 2021; 10.1001/jamapediatrics.2021.4594
9. Well Being Trust. Federal long-term recovery and resilience plan development: mid-course update. Thriving Together Springboard. Published Apr 16, 2021. Accessed Nov 14, 2021. https://thriving.us/federal-long-term-recovery-and-resilience-plan-development-mid-course-update/
10. Assistant Secretary for Planning and Evaluation. Health and Human Services (HHS) Data Council. US Department of Health and Human Services. Published 2021. Accessed Nov 14, 2021. https://aspe.hhs.gov/collaborations-committees-advisory-groups/hhs-data
11. Erickson SM. ACP, agencies work to prioritize primary care. Published December 2021. Accessed Nov 14, 2021. https://acpinternist.org/archives/2021/11/acp-agencies-work-to-prioritize-primary-care.htm
12. Bierman AS, Mcnellis B. Investing in primary care to ensure high-quality care for all Americans. AHRQ Views blog. Published Jul 27, 2021. Accessed Nov 14, 2021. https://www.ahrq.gov/news/blog/ahrqviews/investing-in-primary-care.html
13. National Academies of Sciences. Implementing high-quality primary care webinar series: reforming payment. Published Jun 1, 2021. Accessed Nov 14, 2021. https://www.nationalacademies.org/event/06-01-2021/implementing-high-quality-primary-care-webinar-series-reforming-payment
14. National Academies of Sciences. Implementing high-quality primary care webinar series: the future workforce. Published Jun 15, 2021. Accessed Nov 14, 2021. https://www.nationalacademies.org/event/06-15-2021/implementing-high-quality-primary-care-webinar-series-the-future-workforce
15. National Academies of Sciences. Implementing high-quality primary care webinar series: ensuring access. Published Jun 8, 2021. Accessed Nov 14, 2021. https://www.nationalacademies.org/event/06-08-2021/implementing-high-quality-primary-care-webinar-series-ensuring-access
16. National Academies of Sciences. Implementing high-quality primary care webinar series: digital health. Published June 22, 2021. Accessed Nov 14, 2021. https://www.nationalacademies.org/event/06-22-2021/implementing-high-quality-primary-care-webinar-series-digital-health
17. Cohen DJ, Dorr DA, Knierim K, et al. Primary care practices' abilities and challenges in using electronic health record data for quality improvement. *Health Aff (Millwood).* 2018;37(4):635-643. 10.1377/hlthaff.2017.1254

ADFM Association of Departments of Family Medicine
VISION, VOICE, LEADERSHIP
From the Association of Departments of Family Medicine

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

NAPCRG
From NAPCRG

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

Ann Fam Med 2022;20:95-98. https://doi.org/10.1370/afm.2784.

FROM ADFM, AFMRD, NAPCRG, & STFM: CAFM SETS GOALS FOR DIVERSITY OF LEADERS & FACULTY

A diverse workforce is critical to meeting the diverse needs of our patients. Time and again, we have seen that patients get better care from physicians who look like them, in terms of satisfaction with care, health outcomes and health system usage and expenditures.[1-5] We also know that both the family medicine workforce and the family medicine academic workforce (faculty) do not yet reflect the demographic profile of the population of our country.[6,7] To help increase the diversity of our overall workforce, we must affect change throughout the continuum of medical education, so that students see a career path in medicine by seeing mentors who look like them and career pathway options, including leadership positions. In 2016 the Council of Academic Family Medicine (CAFM) created a Leadership Development Task Force to address the lack of diversity in academic family medicine leadership, including outlining some of these pathways to leadership for underrepresented minorities and women.[8]

As follow-up to one of the recommendations set out by this Leadership Development Task Force[9] in the March 2021 issue of the *Annals of Family Medicine,* CAFM shared a baseline set of demographics for the membership of the 4 CAFM organizations along with context for tracking and sharing

these data as a way to hold our discipline accountable in achieving our goals of increasing women and minority faculty leaders in academic medicine in the United States.[10] This commentary also shared the current efforts of each of the 4 CAFM organizations toward increasing diversity and inclusion of those systemically marginalized and underrepresented in medicine (URiM) and medical leadership.

CAFM is interested in better understanding the current diversity of our organizations' members and leaders to help set appropriate goals for the future and be able to track our progress towards these goals. Having laid out the current demographics, CAFM has now defined goals for growth among women and URiM leadership and faculty in the United States, described here. CAFM recognizes that there are many pathways to leadership in family medicine[8] and a wide variety of roles for our leaders, not all of which are represented here.

These goals are intended to be a starting point for our discipline as something we can measure and compare with other currently available data. By comparing to other currently available data, CAFM is not committing to aligning with or using these data in perpetuity. For these goals, CAFM used the Association of American Medical Colleges (AAMC) definition of URiM, "those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population."[11] In our US context, this includes those who identify as Hispanic/Latinx, American Indian or Alaska Native, Black or African American, or Native Hawaiian/Other Pacific Islander. It does not include those who identify as only White or only Asian. CAFM recognizes that within the broad category of "Asian" there may subgroups who are indeed underrepresented in the medical profession and will continue to explore opportunities to gather more inclusive data as the conversation evolves.

Diversity Goals for Leaders Represented in the CAFM Organizations

For department chairs, program directors, associate program directors, clerkship directors, and research leaders, CAFM has set forth the following goals for the next few years. As noted above, these goals are meant to be a place to start and CAFM will reassess how best to grow and expand these goals as 2025 approaches. We have set a staged series of goals to help reflect the complexities of the demographic measurements and the distance we need to travel to reach ultimate success. These include a target goal, which is the level that would be desirable, and a stretch goal, which would be difficult to achieve but within some level of opportunity.

- Target goal: By 2025, increase number of females represented by 15%, increase number of those identifying as Hispanic or Latinx by 15%, and increase by 15% each the number of those identifying as (a) Native American or Alaska Native, (b) Black or African American, and (c) Native Hawaiian/Other Pacific Islander
- Stretch goal: By 2025, increase number of females represented by 20%, increase number of those identifying as Hispanic or Latinx by 20%, and increase by 20% each the number of those identifying as (a) Native American or Alaska Native, (b) Black or African American, and (c) Native Hawaiian/Other Pacific Islander

These specific goals by category are shown in Table 1. For example, for the target goal of increasing by 15%, we hope to

Table 1. Leader Demographics (Current) and Target/Stretch Goals

	Current	Target (+15%)	Stretch (+20%)
Department chairs (ADFM), n = 161, No. (%)			
Female	48 (30)	55 (34)	58 (36)
Hispanic or Latino	5 (3)	6 (4)	6 (4)
American Indian or Alaska Native	1 (1)	1 (1)	1 (1)
Black or African American	20 (12)	23 (14)	24 (15)
Native Hawaiian/Other Pacific Islander	0 (0)	1 (1)[a]	1 (1)[a]
Program directors (AFMRD), n = 593, No. (%)			
Female	246 (42)	283 (48)	295 (50)
Hispanic or Latino	30 (5)	35 (6)	36 (6)
American Indian or Alaska Native	4 (1)	5 (1)	5 (1)
Black or African American	30 (5)	35 (6)	36 (6)
Native Hawaiian/Other Pacific Islander	3 (0.5)	3 (1)	4 (1)
Associate program directors (AFMRD), n = 304, No. (%)			
Female	175 (58)	201 (66)	210 (69)
Hispanic or Latino	17 (6)	20 (6)	20 (7)
American Indian or Alaska Native	2 (1)	2 (1)	2 (1)
Black or African American	9 (3)	10 (3)	11 (4)
Native Hawaiian/Other Pacific Islander	0 (0)	1 (0)[a]	1 (0)[a]
Medical student education directors (STFM), n = 193, No. (%)			
Female	118 (61)	136 (70)	142 (73)
Hispanic or Latino	10 (5)	12 (6)	12 (6)
American Indian or Alaska Native	1 (0)	1 (1)	1 (1)
Black or African American	12 (6)	14 (7)	14 (8)
Native Hawaiian/Other Pacific Islander	1 (0.5)	1 (1)	1 (1)
Research leaders[b] (NAPCRG), n = 307, No. (%)			
Female	142 (46)	163 (53)	170 (56)
Hispanic or Latino	7 (2)	8 (3)	8 (3)
American Indian or Alaska Native	1 (0)	1 (0)	1 (0)
Black or African American	6 (2)	7 (2)	7 (2)
Native Hawaiian/Other Pacific Islander	0 (0)	1 (0)[a]	1 (0)[a]

[a] Where there were 0 individuals in a current category, we estimated the goals by increasing to what 1 individual would look like.

[b] NAPCRG does not have a field to designate research director role. For this count, research leaders were defined as those who were in the United States; indicated they were an "experienced" researcher; were a principal investigator (PI); and were not a fellow, grad student, resident, student, or patient/community member.

see an increase in chairs identifying as female from the current 30% to 34% by 2025.

In setting these goals for our own organizations, CAFM acknowledges that we do not necessarily have direct control over who is hired into these position types (especially that of department chair). However, the greatest piece of the leadership puzzle is who is in the pool of individuals who might go on to become a leader, in particular the faculty across the discipline.[8] Thus, developing these individuals to become strong and capable leaders—and then making sure we communicate about open positions—are 2 of the main tactics to help meet the leadership goals laid out above. With this framing in mind, CAFM felt that goals for the discipline to bring more diversity to the pool of faculty in family medicine were also important.

Table 2. Faculty Demographics (Current) and Target/Stretch Goals

	Current 2020 AAMC Data on Faculty in DFMs[a]	Target To Match by 2025 (2020 AAMC Matriculant Data)[b]	Stretch To Match by 2030 (2020 US Census Data)[c]
Female, %	53	52	51
Hispanic or Latino, %	7	10	19
American Indian or Alaska Native, %	0	1	3
Black or African American, %	6	8	14
Native Hawaiian/Other Pacific Islander, %	0	0	.5

[a] Calculated from Table 16 at https://www.aamc.org/data-reports/faculty-institutions/interactive-data/2020-us-medical-school-faculty. Only single-race categories quantified (no information provided on those who chose multiple races); Hispanic or Latino includes those who selected only Hispanic or Latino and those who selected Hispanic or Latino and another category.
[b] Calculated from 2019-2020 matriculants in Table A-9 at https://www.aamc.org/data-reports/students-residents/interactive-data/2021-facts-applicants-and-matriculants-data. Given that individuals could select multiple races, anyone who selected more than one of the underrepresented races included in the table is counted for each of those.
[c] Calculated from the 2020 Decennial Census, data at https://data.census.gov/.

Family Medicine Faculty Diversity Goals

The most data on faculty available for comparison are gathered by the AAMC. These data only reflect the demographics of medical school faculty and do not include faculty at residency programs who are not affiliated with a medical school, thus give an incomplete picture of the pool of those who the discipline might draw on for future leadership. Acknowledging this limitation, and restating the comment above that CAFM is not committing to using these data in perpetuity but instead as a place to start, CAFM has set forth the following target and stretch goals:

- Target goal: By 2025, match the demographics from the AAMC data on 2020 matriculants to medical school
- Stretch Goal: By 2030, match the demographics from the 2020 US Census

These specific goals by category are shown in Table 2.

Tracking and Next Steps

As noted above, CAFM will continue to explore how our demographic questions can be more inclusive, recognizing that this might impact their comparability to available data sources or to our own historical data. A new set of categories for race is being developed by the AMA; with the other family medicine organizations, CAFM will work to adopt consistent, inclusive categories when they become available.

CAFM will monitor our progress yearly, sharing data ahead of our annual in-person CAFM meeting in January of each year. To do this, each organization will gather our current data in the fall, depending on the membership cycle of that organization (ideally pulling data at the end of the last membership year instead of the new membership year which may cause inadvertent bias based on who renews early vs late in the membership cycle).

Over the last several years, each CAFM organization has been adding programs and initiatives and creating resources to address diversity and inclusion, as well as working to address bias and inclusion in our own governance structures. More about the efforts of each organization can be found in the March 2021 commentary.[10] We remain committed to this important work and ask again for all our members to complete the demographic information in their membership profiles; we need complete information to better monitor our progress!

As part of this ongoing effort, CAFM will continue discussions about what happens if we don't meet our goals for increasing diversity across the discipline for faculty and leadership. We need to reconvene the Leadership Development Task Force[9] if we are not seeing early progress to consider efforts around more resources, tools, advocacy, or other mechanisms.

Amanda Weidner, Tricia Elliott, John Franko

References

1. Jetty A, Jabbarpour Y, Pollack J, Huerto R, Woo S, Petterson S. Patient-physician racial concordance associated with improved healthcare use and lower healthcare expenditures in minority populations [published online ahead of print January 5, 2021]. *J Racial Ethn Health Disparities*. 10.1007/s40615-020-00930-4
2. Takeshita J, Wang S, Loren AW, et al. Association of racial/ethnic and gender concordance between patients and physicians with patient experience ratings. *JAMA Netw Open*. 2020;3(11):e2024583.
3. Chen FM, Fryer GE Jr, Phillips RL Jr, Wilson E, Pathman DE. Patients' beliefs about racism, preferences for physician race, and satisfaction with care. *Ann Fam Med*. 2005;3(2):138-143. 10.1370/afm.282
4. García JA, Paterniti DA, Romano PS, Kravitz RL. Patient preferences for physician characteristics in university-based primary care clinics. *Ethn Dis*. 2003;13(2):259-267.
5. Saha S, Komaromy M, Koepsell TD, Bindman AB. Patient-physician racial concordance and the perceived quality and use of health care. *Arch Intern Med*. 1999;159(9):997-1004. 10.1001/archinte.159.9.997

6. Jabbarpour Y, Westfall J. Diversity in the family medicine workforce. *Fam Med.* 2021;53(7):640-643. 10.22454/FamMed.2021.284957
7. Xierali IM, Nivet MA, Gaglioti AH, Liaw WR, Bazemore AW. Increasing family medicine faculty diversity still lags population trends. *J Am Board Fam Med.* 2017;30(1):100-103. 10.3122/jabfm.2017.01.160211
8. Coe C, Piggott C, Davis A, et al. Leadership pathways in academic family medicine: focus on underrepresented minorities and women. *Fam Med.* 2020;52(2):104-111.
9. South-Paul J, Goodell K, Coe C, et al. Leadership development taskforce final report to CAFM. Published Dec 31, 2017. Accessed Oct 28, 2021. https://www.aafp.org/dam/foundation/documents/Internal/workingparty/CAFM_Leadership_Development_Taskforce.pdf
10. Weidner A, Clements DS. CAFM leadership demographics. *Ann Fam Med.* 2021;19(2):181-185. 10.1370/afm.2678
11. Association of American Medical Colleges. Underrepresented in medicine, definition. Accessed Oct 28, 2021. https://www.aamc.org/what-we-do/equity-diversity-inclusion/underrepresented-in-medicine

NAPCRG From NAPCRG

Ann Fam Med 2022;20:98-99. https://doi.org/10.1370/afm.2778.

FROM NAPCRG: PRIMARY CARE RESEARCH THROUGH THE LENS OF NAPCRG'S TRAINEE COMMITTEE: A YEAR OF REFLECTION IN A PANDEMIC AND A CALL TO ACTION

When the world paused in 2020, ensnared in the grip of the COVID-19 pandemic, many research trainees found themselves re-examining their goals. Barriers to traditional research strategies as well as pandemic-exacerbated inequities presented new challenges and highlighted previously neglected research agendas. The NAPCRG Trainee Committee seized this opportunity to facilitate robust virtual discussions. These virtual discussions hosted diverse groups of international researchers and trainees to highlight the hurdles presented by conducting and disseminating research during a pandemic. Challenges, however, are the catalyst for change. Research provides the means to address both long-standing injustices, as well as the rapidly evolving landscape of research methodology and communication. As trainees, we are inherently focused on the future. We propose 3 critical areas where primary care researchers are the ideal leaders: seeking novel solutions to health disparities, battling mis- and disinformation, and innovating in research methodologies conducive to adapting to the new era of primary care research.

A Commitment to Health Equity

The pandemic has disproportionately impacted populations experiencing inequities globally, highlighting the need to dismantle existing barriers in health systems that perpetuate health inequities, especially racism.[1] As a committee we discussed how research can perpetuate health inequities. Through virtual discussions we have learned that tackling health equity in research is extremely complex, especially in health systems that have historically contributed to the problem. As trainees, we endeavor to be part of the solution and recognize that the status quo is no longer acceptable. To address health equity in research, we emphasize diversifying the research workforce, modeling inclusion, and amplifying researchers with diverse backgrounds and perspectives. Further, our research agendas and strategies must change, creating research objectives with health equity in mind, including patient partners with diverse backgrounds, and interrogating data and systems of data collection for bias. We challenge the primary care research community to commit to health equity and anti-racism as an integral component of research endeavors.

Communicating Research Effectively

The past year has led to an unprecedented amount of research output in a short period of time. This influx of available information bred an ever-increasing number of non-peer reviewed outlets, including social media platforms.[2] While these new avenues of communication are effective mechanisms for sharing information rapidly, they have differing standards for evidence-based review and have created substantial challenges for communicating accurate and up-to-date information. As the future of primary care research, we have a responsibility to modernize our communication approaches and we must lead the battle against mis- and disinformation that contribute to deaths worldwide. While this problem is not new, the proliferation of false information can be addressed by primary care researchers, building on relationships with patients and communities.

A New Way of Conducting Research

Although the pandemic has disrupted the delivery of health care, a variety of benefits emerged for primary care researchers including the development of novel methods for conducting research.[3] Rapid evidence reviews, implementation science, and evaluating interventions "in-flight" became the new normal. Early in the pandemic, some clinical and research trainees felt they were left on the sidelines for safety precautions; this pause in day-to-day work opened the doors for trainees to learn from experts and avail themselves of resources that may not have been accessible previously. For example, virtual communities of practice formed that created a unique platform where trainees and experts were learning together about the new context of primary care. As a group that has primarily benefited from increased access to information and mentorship, we recommend fostering these innovations in research and incorporating them as the "new normal" in conducting research.

As trainees and the next generation of primary care researchers, we are continuously considering the future of primary care research and the skills that we will need to be successful in the field. While the past year has forced us to