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

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HIGHLIGHTS OF THE INNOVATION SHOWCASE

The future of the specialty of family medicine requires continued innovation in residency training programs.[1,2] Residencies should adapt to improve care for the communities they serve. At times, programs are unclear on the ability to innovate balanced against the need to standardize given accreditation standards.[1,2]

For many years, the American Academy of Family Physicians Residency Leadership Summit has featured an "Innovation Showcase" to highlight in a rapid-fire format 10 exceptional innovations in residency education. A summary of 3 interventions from the 2022 Innovation Showcase follow. We hope that these implemented ideas encourage other family medicine educators to innovate to improve the health of patients most in need, spark a culture of safety, and care for our communities outside office walls, even on the ski slopes!

Improving Confidence in Treating Opiate Use Disorder (Z.S., L.K.)

Office-based treatment with buprenorphine-naloxone is effective for patients with opioid use disorder (OUD). Clinical experience in OUD treatment during family medicine residency increases the use of this treatment in future practice,[3] so we designed an OUD treatment curriculum incorporating independent reading of the *American Family Physician* journal article, "Opioid Use Disorder: Medical Treatment Options."[4] Residents complete a knowledge assessment after their clinical experience, then repeat the assessment in 3 months to gauge retention. Year 1 knowledge assessment results are encouraging, with 93% and 85% correct responses for the respective assessments. There was no statistical difference between measurements, indicating good knowledge acquisition and retention. Additionally, resident comfort with OUD treatment is assessed through an annual survey. Residents report confidence in their ability to treat OUD and plan to offer this treatment in future practice. Although the resources required for an office-based treatment program for OUD may limit some institutions, health systems and medical education communities should strive to increase treatment capacity in primary care given the profound return on investment for individuals.

Ignite the Spark For a Culture of Safety (E.G., A.W.)

Ensuring that our residents receive robust training in patient safety has been recognized as critical to achieving the Quadruple Aim. Our journey began in 2017 when we were selected by the Accreditation Council for Graduate Medical Education (ACGME) to participate with 8 other institutions as Pathway Leaders for Excellence in Patient Safety.

Under the guidance of ACGME patient safety (PS) and quality improvement (QI) experts and with the generous collaboration of other pathway leaders, we have created an engaging, effective, and sustainable patient safety model.

Key curricular components include:

Ignite the Spark
We create a "Culture of Safety" during orientation where new learners are inspired to transform errors and irritations into opportunities for process improvement, event reporting, and interdisciplinary analysis and collaboration.

Equip the Embers
We protect time for initial and ongoing quarterly knowledge and skills building PS/QI sessions.

Fan the Flames
We enhance interest in PS/QI activities via regular reporting back to residents regarding results of their individually reported safety events, and we enhance awareness of our residency program's PS/QI activities and outcomes via regular reporting to key stakeholders. (PS/QI newsletter)

Pass the Torch
We found sustainability through early identification of resident PS/QI catalysts who model resident-to-resident mentoring around PS/QI practices in our clinical learning environments.

Residents on Skis: The Intersection of Wilderness Medicine and National Ski Patrol (A.J.W.)

Developing our Wilderness Medicine Area of Concentration, I knew I needed a robust field experience. National Ski Patrol (NSP) offers multiple avenues for physicians to participate, but I'd need additional liability coverage to have residents ski as physician patrollers, and rotating at a resort clinic wasn't the teaching environment I had in mind. NSP offers medical professionals an opportunity to challenge themselves with the test for Outdoor Emergency Care (OEC) Technician certification; residents would then be members of the volunteer patrol, on the same level (medically speaking) as other patrollers. In 2019 we taught our first OEC Challenge Course—comprising an online question bank, one 4-hour skills night (medical school fails to teach you how to crack an oxygen tank), and a test night (a written test and scenarios). Over the last 3 years our pass rate is 100% and we have opened the course to other medical professionals, expanding the depth of medical expertise in our patrol and region. Residents can then take advantage of additional training offered through NSP—avalanche, mountain travel rescue, and on-hill scenarios. Feedback shows a positive impact on wellness and residents are practicing true wilderness medicine in a

resource-limited environment. Consider your local volunteer patrol an untapped resource.

Steven R. Brown, MD, University of Arizona College of Medicine, Phoenix Family Medicine Residency; Lance Kelley, PhD; Zach Sartor, MD, Waco Family Medicine Residency; Anna Worth, MD, Gadsden Regional Medical Center; English H. Gonzalez, MD, MPH, FAAFP, St. Vincent's East Family Medicine Residency at Christ Health Center; A. J. Weinhold MD, FAAFP, FAWM; Kasiska Division of Health Sciences, ISU-MMH Rexburg Rural Training Track

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CONFERENCE DELEGATES, AAFP LEADERS SHOW ADVOCACY ALIGNMENT AT TOWN HALL

The 2022 AAFP Leadership Conference's return to in-person assembly in Kansas City, Missouri, April 28-30, 2022 after 2 years of pandemic disruption restored twinned customs to the annual event's Town Hall: members striding up to microphones to ask questions in the same room with the leaders answering them, and the spontaneous applause generated by some of that back-and-forth.

It didn't take a query from any of the hundreds of physicians finishing their breakfasts and coffee to generate the session's 1st such clapping. In her turn delivering opening remarks, Board Chair Ada Stewart, MD, of Columbia, South Carolina, brought up a key Academy advocacy priority: safeguarding a physician-patient relationship under attack.

"We oppose any policy that limits the evidence-based practice of medicine, threatens the physician-patient relationship, and inhibits the delivery of safe, timely, and necessary comprehensive care."

Such policies, she added through the ovation she'd just sparked, "should be eliminated."

The morning's 1st speaker, AAFP President Sterling Ransone, MD, of Deltaville, Virginia, had already set the tone for touting the Academy's recent policy stances.

"As we concentrate on increased awareness of vaccines and boosters," he said, "we're seeing the immense respect that the Academy has both in Congress and within the administration. That's taken years of work from our staff to build those relationships. This is an example of where our advocacy efforts have borne fruit. It helps us deal with what we must as family physicians and, more important, help our patients."

"The Academy's approach to long COVID is going to be interesting. I've had patients with long COVID—my first ICU patient, 8 months later she couldn't remember that she was supposed to follow up with me in 2 weeks in the 20-foot walk from the exam room to the front desk. Helping these patients is going to be inherent to family medicine. We are holistic providers. Who is best situated to treat the multi-system, multi-symptom conditions? We are."

"Unfortunately, when a lot of the allowances CMS has given us expire when the public health emergency is over, we will not be reimbursed for services such as telemedicine. We've spent a lot of money developing infrastructure to provide that kind of care. The Academy is working hard to make sure we can maintain robust telemedicine services within the medical home."

The AAFP's vigorous telemedicine advocacy was, in fact, central to the Family Medicine Advocacy Summit in May, another member event that convened again in person.

So is the Academy's push to center primary care in behavioral health policy, which aims to achieve the strongest possible integration of behavioral health care in primary care settings for children and adults.

"Our goal is to find ways to incentivize the integration of primary care with behavioral health and then decrease barriers that exist for doing this," said President-elect Tochi Iroku-Malize, MD, MPH, MBA, of Long Island, New York.

"Just try to get an appointment," she added. "It's ridiculous. Beyond our patients, the pandemic has done a number on my physician colleagues. I can't even get *them* to a psychologist's office for 6 months. It's disheartening."

Following Ransone, Stewart and Iroku-Malize—and AAFP EVP Shawn Martin, who urged NCCL attendees to book tickets for FMX in September—moderator and AAFP Congress of Delegates Speaker Russell Kohl, MD, of the Oklahoma Academy of Family Physicians, opened the floor.

The first question stayed with behavioral health care and long wait times to connect patients with needed care. It ended with a simple plea: "We need help now."

"You are speaking to my heart," Iroku-Malize replied.

The member at the microphone urged the Academy to provide "educational toolkits for us as providers so that, especially in the field of child mental health care, we can stand in that gap and provide the care that's needed: best practices, knowing where to go when help is needed," and suggested advocacy for inclusion of behavioral health care as part of medical school and residency training for primary care physicians.

"That's exactly what we need to do," Iroku-Malize said. "We have CME coming. And when you do this, we must promote the fact that you do this."