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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AAFP From the American Academy of Family Physicians

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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."

Ransone added: "We must let folks know that family physicians take care of more than a third of the mental health care in this country, and we must remove the stigma of seeking behavioral health care. And we have to advocate for payment reform to ensure we're reimbursed for this care. It's on all of us to let regulators at the state level know that behavioral health care is primary care."

Another member asked for a working definition of "administrative burden."

"When we survey you, we hear from you that your No. 1 priority is administrative burden," Stewart said. "How that is defined does vary. Look at the workload, look at the number of clicks it takes to get work done. So we look to you to make sure we're addressing the key issues, because we're addressing everything related to administrative complexity. Tell your story. Tell your own story to your legislators as we advocate nationally at the holistic level."

"Our tactics include advocating with CMS to delay the appropriate use criteria requirements," Iroku-Malize added. "We're also asking CMS for interoperability efforts and digital solutions to optimize electronic health records. And we're advocating with the large insurers on the need to reduce the complexity of their requirements."

The next question illustrated why the AAFP is making a high priority of its telehealth advocacy as the public health emergency winds down, and how that work dovetails with efforts toward behavioral health care integration.

"I work as a medical director for a large health system for virtual care, and I recently spoke with a payer who said, 'How can I pay you guys the same when you're not putting a hand on a patient?'" the member began. "I had a 19-year-old patient who died by suicide recently. How much behavioral health are we taking care of? How many hands do we need to put on a patient to save lives? Now, you can put payments to a direct-to-consumer vendor, who is not in the medical home, but are those lives being saved? No. You're looking at quick cost savings as opposed to the big picture."

"We're the ones doing behavioral health care. I work in a metropolitan area, and I don't have psychiatrists I can get my patients into for 2 or 3 months. As we go to advocate, those are the stories we need to tell as we advocate. We're the ones saving lives. Family medicine should own this space."

This, too, prompted applause before Ransone answered.

"For an adult in my rural practice, it's a minimum of 3 to 6 months to get them in with a behavioral health specialist," he said. "For a pediatric case, it's 6 months to a year to get them to a psychiatrist. And even then, we get forms back from the psychiatrist's office asking what we've tried in the past, and we frequently get responses refusing to see the patient. What do you do then? I share your frustration."

"Telehealth has been helpful in my practice as we see more patients who need this care. We have to defend that territory. I've heard the same question from insurers about putting hands on patients. Why pay me the same? Because I've had 4 years of medical school, 3 years of residency and 27 years of practice, and I can make the determination when my patient actually needs to come in and have hands-on or when I need to spend an hour counseling virtually. It's a health-equity issue. The questioning of our chosen modality needs to be fought."

Kohl indicated that the last question would need to be asked and answered quickly, and so it was.

"I want to turn back to admin burden for 1 last minute," the member began. "I want you to just say yes when I ask the question, OK? Headline from *The Hill* yesterday: 'Probe finds Medicare Advantage plans deny needed care to tens of thousands.' Can we not demand CMS tell the Medicare Advantage plans to cut off prior authorization until they can get it right?"

More applause, the morning's biggest, ate into the clock as the questioner finished, "It's hurting our members, and it's hurting our members' patients."

Ransone leaned into his microphone and said, "Yes."

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THE PROMISE OF AIRE

Four-year residency programs have much to teach us, and the Accreditation Council on Graduate Medical Education (ACGME) Committee drafting new requirements for Family Medicine residencies decided to explore time-variable residency training more formally. Consequently, in December 2021, the ACGME and American Board of Family Medicine (ABFM) announced the Family Medicine Advancing Innovation in Residency Education (AIRE) program to allow longer training and facilitate innovation in residency curricula.[1] Over the last 7 months, there has been a lot of dialogue about this opportunity. This editorial builds on the white paper describing the rationale for this program, key features we are looking for, and our current thinking about how it will work.

The ACGME AIRE program[2] allows residencies to pursue innovation in return for freedom from specific program requirements and ongoing assessment of outcomes, provided that the individual residencies have approval from the appropriate ACGME specialty Review Committee and the appropriate ABMS board. In Family Medicine, our specialty has set the goal of training family physicians who can address the worsening clinical and health care problems in the United States—worsening population health outcomes, decreasing lifespan, and shameful disparities in care.[3] We