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."

News Staff
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From the American Board of Family Medicine

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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

thus seek time-variable, competency-based innovations which will add fundamentally new competencies to the broad base of family medicine residency education over 3 years. As of the writing of this editorial, the major revision of residency requirements[4] has not been finalized, but residency programs participating in the AIRE program must follow the new guidelines. Participating programs will be allowed to exceed 36 months of training, and we anticipate that some programs will seek waiver from other rules such as, for example, those limiting more independent practice near the end of training. Our hope is that the Family Medicine AIRE program will include approximately 10% of family medicine residencies, with special attention focused on rural programs. There will be a formal evaluation to inform the specialty and provide evidence for the ABFM to consider whether family medicine training longer than 3 years should be required for ABFM Board eligibility.

A Competency-Based Framework

The major revision[4] represents a significant shift toward competency-based medical education (CBME) grounded in the needs of patients, families, and communities and away from numbers of patient encounters and hours of curriculum. We expect that all AIRE applications will use a competency-based framework and be able to describe succinctly what the additional time in training will provide for medical students, residents, employers, and the public.

It is important to recognize that CBME is much more than developing thoughtful goals and objectives and a curricular map.[5] Applications should include systematic attention to the Van Melle framework[6] which is now the gold standard for competency curriculum redesign. CBME begins with explicit attention to the community needs the residency program is addressing and is grounded in a system of outcomes-based assessment. The curriculum should include a progressive development of competencies, with experiences and teaching focused on specific competencies, and ongoing assessment of learning tailored to those competencies. We expect residents to co-create their education, reviewing assessments regularly with clinical mentors and guiding their own education. The residency leadership and faculty must also commit to ongoing faculty development and a systematic approach to reviewing and improving their programs.

Developing a systematic program of assessment will require new thinking for most family medicine residencies: it is more than building the 6 ACGME competencies into standard evaluation forms! The overall goal is to assure the public and future employers that a residency's graduates are broadly competent. This in turn requires explicit assessments of the key competencies necessary for family physicians working across the continuum of care. In this regard, the draft residency standards are intimidating, identifying as many as 65 different competencies, and it is difficult to imagine setting up separate evaluation systems for each of these competences. We therefore expect residency directors to be pragmatic, selecting the most important competencies for assessment. These might include, for example, continuity and comprehensiveness of care in the family medicine center, diagnosis and management of acutely ill patients in the hospital, or management of newborns or patients at the end of life. In building the system, the perfect may become the enemy of the good: residencies should feel comfortable in repurposing existing assessments like evaluations by preceptors and video reviews of resident-patient encounters. The new expectation that "the practice is the curriculum," with ongoing measurement of access, continuity, and rates of referral will provide additional assessment of resident performance. We also believe that there must be dialogue across Family Medicine to develop priorities for sampling and assessment tools. The ACGME Family Medicine milestones version 2.0, level 4, may represent reasonable goals for residency training, as would the entrustable professional activities (EPAs) developed by the specialty in Family Medicine for America's Health.[7] The Society of Teachers of Family Medicine (STFM) is proposing a national summit to help develop consensus on the outcomes we will assess for; we are delighted with this and other efforts for the specialty to work collaboratively on residency redesign.

The Themes of Innovation

While competency assessment must be built into all AIRE proposals, the goal of the AIRE project is not just competency. The major focus should be on development of the best possible training for comprehensive family physicians. It is important to note this is not just an extension of the previous Length of Training Project. We are looking for fundamental innovation, and we are relying on the creativity and thoughtfulness of our specialty's residency directors and faculty. Over the last 3 months, we have talked with many residency educators about what they envision. So far, we see 3 different patterns of innovation.

One group is focused on increasing the degree of competence of graduating residents. The current ACGME milestone framework is built on the developmental progression initially described by Dreyfus[8] from novice to proficient to expert and its extension to mastery over a career. Most residencies currently train to "proficient." Thus, this group of residencies planning AIRE proposals aspires to move their graduates further towards expertise and mastery in some dimensions of care. Their assumption is that graduating residents will provide value with their increased skills; their challenge will be to define the experiences and assessments that will drive greater competency. For example, if a residency focuses on greater competency in continuity and comprehensiveness of care, assessments of motivational interviewing or shared decision making, referral quality, effectiveness of pharmacotherapy, or integration of ultrasound or medication-assisted treatment into continuity practice might be included.

Another approach being considered is to integrate what are currently fellowships into a 4-year program. Thus, for

example, folding a sports medicine fellowship into a traditional residency might allow broader clinical experiences, competence with more procedures and learning population interventions to increase physical activity. The ACGME fellowship requires specific rotations and assessments, and these requirements help clarify what residents get out of extended training. But participation in AIRE is not limited to incorporation of ACGME-approved fellowships. Many residencies have fellowships in surgical obstetrics or hospitalist care, or chief residencies with a focus on education skills development, and some are developing programs for future researchers or health care executives. Such programs clearly address the future needs of the specialty. Finally, there are some institutions developing many different areas of concentration.[9] Residents would have the opportunity to choose from a variety of different focus areas, all integrated within the context of a traditional residency program focused on, for example, addressing the urgent and diverse needs of rural communities. This is one of the strategies that has been so successful in the growth and development of psychiatry residency programs.

A third approach being developed is to identify clinical focus areas important to improving population health or delivery of health care. Examples include community health equity, clinical ultrasound, lifestyle medicine, HIV in primary care, street medicine and behavioral health, including MAT and cognitive behavioral therapy. Each of these areas responds to the evolving needs of our population and health care system and support graduates in addressing urgent community needs. As in the other approaches to innovation, the challenge for these residencies will be developing quality educational experiences and the assessments to ensure competence.

Building fundamental innovation into family medicine residency education will not be done in 1 year! We are acutely aware that the pandemic has had a major impact on the organization and financing of residencies as well as their associated hospital systems: it will take time to build back. In addition, new ideas, faculty development, and financing take time to put in place. We therefore plan to keep applications open for as long as is necessary. We will develop general templates and models of applications to facilitate programs' applications, and we are now beginning to plan a national collaborative modelled on I[3 10-12] and P[4 13] that will support faculty development, networking of faculty, residents, and staff, and support scholarship.

How the Family Medicine AIRE Program Will Be Organized

The ACGME and the ABFM have created a steering committee which will guide the development of the program, including an outreach and communication strategy, an efficient application process, and a strategy for evaluations. The Association of Family Medicine Residency Directors, the STFM, the Association of Departments of Family Medicine, and the American Academy of Family Physicians have liaisons to this committee, and the AIRE program will also coordinate with these organizations' initiatives to support residency redesign.

Our intent is to make the AIRE program as easy as possible to participate in, learn from, and improve both clinical care and education. Participating residencies will have the option to enroll some or all of their residents in the AIRE curriculum. They will be required to make a formal application, submit data annually about their programs, review and improve their residencies annually, and participate in a national collaborative. In return, residencies will share learning at the cutting edge of clinical and residency education transformation across geographic regions, have the opportunity for faculty, resident, and staff development and facilitation of networking and scholarship, with some support of direct costs. We are accepting applications starting this summer and plan for the first cohort of residencies to begin in July 2023. The ACGME Family Medicine Review Committee and the ABFM will review applications on a rolling basis. We welcome your ideas!

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STFM RELEASES ONLINE COURSE ON URM LEADERSHIP PATHWAYS IN ACADEMIC MEDICINE

STFM has launched URM Leadership Pathways in Academic Medicine, a new, free online course to help underrepresented in medicine (URM) faculty hone their leadership skills. "Simply becoming faculty as a URM individual is often a long and arduous path with many obstacles," said Cleveland Piggott, MD, MPH, co-author of the new online course. "Then there are barriers to obtaining positions of leadership."

The course was developed by a URM Leadership Workgroup as part of STFM's multi-year URM Initiative, supported by the STFM Foundation and the American Board of Family Medicine Foundation. The new interactive course consists of 2 modules with recorded advice from experienced faculty, plus assignments to help learners set career goals, project their leadership voices, build professional networks, and identify opportunities for career advancement.

In the fall of 2019, STFM created a URM Leadership Workgroup with objectives to:

- Increase the percentage of URM family medicine faculty in leadership positions in academic medicine
- Raise awareness of the structural barriers to URM achievement

This workgroup is made up of family medicine faculty across the country representing backgrounds inside and outside of academic medicine at various points in their academic career.

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Family medicine recognizes the need to make diversity, equity, inclusion, and antiracism part of its core values. Though a lack of racial/ethnic diversity in medicine has been a known problem for decades, the results of the 2016 Leadership Development Taskforce formed by the Council of Academic Family Medicine helped elucidate some of the particular challenges faced by underrepresented minorities (URM) and women in family medicine.[1]

It became clear to the group that they needed to create an enduring product talking about issues of URM leadership pathways and barriers in order to reach those who could not attend conferences or did not have support at their own institutions. Presentations and papers talking about these issues were a step in the right direction but were insufficient as the only means of addressing this issue. This product needed to use the principles of adult learning theory[2] to help URM physicians at all walks of life be successful.

STFM's past successful online courses provided a basic template and process to help create these modules on URM leadership pathways. To select what topics should be included, the group reviewed the literature and talked to successful leaders inside and outside of family medicine. The workgroup also brought their own experiences, challenges, and expertise to the table. "Throughout the process, attention was paid to exploring the barriers for URM faculty in balance with the potential rewards and meaning for a career as a family medicine educator," said Elizabeth H. Naumburg, MD, chair of the URM Leadership work group.

Having the modules be short and interactive was key to align with evidence-based techniques for teaching adult learners. It was important that the product be free to avoid creating barriers to access. In creating the course, URM family medicine educators were intentionally invited to share their wisdom and lived experiences as a form of virtual mentorship for each of the topics. In addition, to cement learning and make the course as interactive as possible, each topic has practical assigned activities such as learning about the promotion criteria in your institution or defining your own values and goals for your career.

Course Objectives:

- Assess the pathways to academic leadership in 4 domains
- Navigate and advance in academia by aligning opportunities with goals
- Find mentors, coaches, and sponsors
- Understand the financial impact of career choices
- Recognize what's valued for scholarship and promotion at your institution
- Find balance between your commitments and personal priorities
- Overcome isolation by building your professional networks
- Manage conflict in skillful and intentional ways
- Project your leadership voice