in the congress. Thus, the 18 states in his region (including Alaska and Hawaii) provided 30 student delegates.

"I love how educational and motivating it is to get involved in advocacy," he said. "I didn't know much about parliamentary procedure when I first got involved, but when I did experience it, I thought it was amazing."

Southwick will get to experience AAFP policymaking on a bigger stage this fall. The National Congress of Student Members elected him to serve as a student alternate delegate to the AAFP Congress of Delegates, which will be held in October 25-27, 2023 in Chicago.

"It's super exciting and humbling," Southwick said. "I saw my role as bringing the Idaho view to the Student Congress. Now I'll be bringing the student viewpoint to the Congress of Delegates."

Mentorship Matters

Aerial Petty, DO, managed 2 big accomplishments during the 3-day conference. Petty, a 3rd-year resident at New York-Presbyterian/Columbia University Medical Center, was a winner in the AAFP Foundation's Emerging Leader Institute (ELI) program, and she also was elected as a resident alternate delegate to the Congress of Delegates during the National Congress of Family Medicine Residents.

Petty's 1-year ELI project focused on integrating training related to health policy in residency curriculums. She credited her ELI mentor, former AAFP President Reid Blackwelder, MD, associate dean for graduate medical and continuing education at East Tennessee State University's Quillen College of Medicine, with her successful week.

"He gave me specific, actionable and thoughtful feedback that required me to be reflective, think outside the box and not limit myself," Petty said of Blackwelder, who also helped her make connections with others who could contribute to her project. "I got really lucky. He was so engaged and supportive throughout. He believed not only in my project, but in me. He encouraged me to run for a leadership position here."

Family Medicine Interest Group Leadership Summit

More than 80 students stuck around after the conference for the first Family Medicine Interest Group (FMIG) Leadership Summit on July 29, 2023.

Universidad Autónoma de Guadalajara School of Medicine student Ernie Rodriguez, MBA, who was elected National FMIG Coordinator during voting earlier in the day, said he hoped the new post-conference event would "inspire the next generation of family physician leaders" to establish an FMIG on their own campus or to improve the workshops and programming in an existing FMIG.

"Workshops are important," he said, "but it goes beyond didactics and clinical workshops. Innovation is needed to grow student interest in family medicine."

David Mitchell
AAFP News

From the American Board of Family Medicine

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WINNING THE PEACE: MEASURING FACULTY TIME TO SUPPORT RESIDENCY REDESIGN

In June 2023, the Accreditation Council for Graduate Medical Education (ACGME) Board of Directors decided to allow flexibility by specialty with respect to requirements for residency faculty educational time. The Family Medicine Review Committee then decided to return to the standard in place before 2019: effective July 1, 2024, each core residency faculty member will have 0.6 full-time equivalent (FTE) dedicated to residency education, including both time focused on educational tasks such as recruitment, assessment, advising, faculty development, scholarship, and time in direct supervision of residents such as precepting or supervising inpatient care. The Family Medicine Review Committee also requires 1 core residency faculty member for each 4 residents and allows flexibility in the distribution of FTE across faculty.

These changes represent the culmination of 4 years of campaigning by the entire specialty of family medicine. The door is now open—and there is potentially more time available to support the need for educational and practice transformation. Now we must "win the peace"—to take advantage of this opportunity, however, we must think carefully about how to measure faculty time. What follows lays out key issues in measuring faculty time, using an explicit bottom-up consensus approach, with estimates of average times required for clinical and other tasks. We provide a long-term example from 1 institution,[1] with hopes of eliciting discussion across the specialty.

How to measure faculty time is strategically critical to academic family medicine, and perhaps uniquely difficult for residency educators. Family medicine faculty split their time across all missions and across the continuum of care; the epidemic of burnout and pandemic-associated changes have further increased the stakes and underscored the importance of transparency and fairness. Moreover, given the declining lifespan of Americans[2] and worsening performance of our health care system,[3] the challenges of recovery from the pandemic, and the need for transformation of residency education and clinical care,[4] robust systems for measuring and planning what faculty do with their time are critical to our future.

It is important to start with definitions: what is a work week and what does a year consist of? ABFM data and other sources suggest that practicing full-time family physicians currently work 50 to 55 hours per week.[5,6] This number has dropped some over recent years, but seems to be a reasonable

benchmark for effort. If so, how many hours should be expected for full-time residency faculty, who often have more hospital call than many non-residency family physicians? Notably, the ACGME uses a 40 hours/week standard, as does the National Institutes of Health (NIH), although there is substantial room for individual and organizational interpretation. What a working year is defined as depends on local organizational rules—how much vacation and professional development time is allowed, and how many major holidays are allowed off every year. For the University of North Carolina Department of Family Medicine (UNC) in the late 1990s, we defined a year as 45 weeks: 52 weeks minus 4 weeks of vacation minus 2 weeks of professional development minus 1 week of holidays. Of note, non-academic family physicians may have less time for professional development.[7]

A shared understanding among faculty of how much time different clinical, teaching, research, and administrative activities require is also critical. Starting with continuity outpatient care, how much time does a half day of continuity practice take? Let us assume that a half day of patient care represents 4 scheduled hours of patients—often but not always the case. In addition, each half day requires time for documentation and follow-up communication. But time outside of the exam room will be strongly influenced by many variables, including complexity of cases—geriatric patients require more time than most urgent care—as well as continuity rate, electronic health record (EHR) documentation options, personal efficiency of the physician, indirect care, and need for follow-up and coordination of care the physician is responsible for. UNC Family Medicine initially assumed 1.5 hours of follow-up per 4 hours of scheduled patients, for a total of 5.5 hours or 10% time annualized over a full year. In recent years, with increases in basket work, the annualized percentage of time for a single half day of continuity has increased to 12.5% time. Of course, different residencies and different organizations will have different assumptions, based on patient population, practice organization and culture, incentive plans, and other factors.

For residency faculty, there are other assumptions which require discussion and consensus. Compared with a continuity clinic half day, what percentage of a half day in clinic is precepting? Of course, it depends on whether the faculty member is precepting 1 senior or 4 interns, and the faculty rule must average this. This may change if residencies begin to ask preceptors to do more formal assessments as a part of the shift to competency-based education, but the total amount of time is likely not as much as continuity clinic. UNC originally set that number at 4 hours, the same as a continuity clinic but with less intensity and follow-up time; other residencies may allocate specific time for reviewing and signing notes. Similarly, how many hours is being on call or attending on an inpatient service worth? This is a function of how busy the clinical setting is. Is being on call telephone call only, or do faculty typically have to go in or stay overnight? How many admissions are there on the inpatient service every day? Each residency or department must develop metrics that are transparent and fair and be willing to adjust over time. At UNC, as inpatient and intensive care unit (ICU) volume has increased in recent years, the hours and percent of time allocated for hospital work has increased. Of course, the residency core faculty role must include recruitment, assessment, coaching/advising, faculty development, and participation in clinical competency and program evaluation committee: how many hours do these require per year on average for core faculty? Finally, residency and clinical administration and scholarship require time, and there should be consensus about how much time per week or percentage annualized is appropriate according to the clinical and education needs and the mission.

The goal is to get a shared understanding across faculty and leadership of what a year of full-time work consists of for faculty and for the organization that is accurate, fair, and as public as possible given local culture. This likely requires an iterative consensus process and a willingness to adjust over time. Once done, however, and translated to specific duties for each faculty member, this approach facilitates meeting the goals of residency or department, both across missions and financially, while honoring the desires of the individual faculty member. Leadership can plan access for patients and estimate revenue, and faculty can know how many clinical half days they are responsible for and how much time they will have for other non-clinical duties. For clinical contracts, research grants, institutional roles, and administrative roles, the allocated percentage of time contracted can then drive an estimate of the hours necessary for the task. Thus full-time work over 45 weeks at 55 hours/week would be approximately 2,475 hours plus 2 weeks, or 110 hours, of professional development. A 15% contract for leading a large hospital service would be 370 hours of work over a year and a 7% obligation to teach a section in a preclinical course for medical students would represent about 175 hours of work.

This explicit bottom-up consensus-driven approach to measuring faculty time can help support faculty. In addition to predictability, this approach allows planning for part-time work or transition of roles: exactly how much time is 75% time and what are the specific responsibilities? When a new administrative role is taken on, what will the faculty member give up? Finally, this approach allows rethinking traditional approaches to what faculty do. If 2 weeks for professional development represents 110 hours, how can this time best be used? What should be done locally or at home and what done by traveling to continuing medical education (CME) courses?

Of course, faculty will have differing perceptions about how hard they are working in comparison to others! New faculty may have different understandings of what full-time work is than existing faculty, and health systems often have their own definitions of how many scheduled patient contact hours represents full-time clinical work. Faculty also vary in how well they have learned to estimate time and to use time effectively. What is important, however, is to come to consensus

about what the average work week is and how many hours/what percentage of annualized time-specific activities are, and then to be able to adjust the numbers over time as the environment changes.

It is important to note that this discussion has focused only on inputs: the faculty time that makes patient care, teaching, and scholarship possible. Residencies and departments must also identify and manage desired outputs as well as finances. Typically, this is easier for outpatient continuity care, and typically numbers of patients, work relative value units (wRVUs), or charges are used, perhaps adjusted by age, hierarchical condition category (HCC) codes/patient complexity or eventually social determinants of health. For scholarship, the currency is also easier to define—the number and quality of regional or national presentations, papers, or grants. Most challenging to measure are teaching outputs. Twenty-five years ago, the Association of American Medical Colleges (AAMC) began to promote mission-based budgeting[8] and systems of "educational value units"[9] have developed in different specialties. But these approaches have not been widely adopted. As with inputs, there must be transparency and discussion about what will be valued as outputs; the temptation to be very granular must be resisted. The perfect is the enemy of good.

In summary, the Family Medicine Review Committee rule change has opened up an important opportunity for residencies and departments to add time devoted to residency education. Measuring faculty time well is a key first step in exploiting this opportunity. Many in family medicine have experience and wisdom in addressing this issue: we look forward to the dialog, for the good of residencies and the specialty.

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REFERENCES

1. Daugird AJ, Arndt JE, Olson PR. A computerized faculty time-management system in an academic family medicine department. *Acad Med*. 2003;78(2):129-136. 10.1097/00001888-200302000-00006
2. Woolf SH, Schoomaker H. Life expectancy and mortality rates in the United States, 1959-2017. *JAMA*. 2019;322(20):1996-2016. 10.1001/jama.2019.16932
3. National Research Council, Institute of Medicine. The National Academies Collection: Reports funded by National Institutes of Health. In: Woolf SH, Aron L, eds. *U.S. Health in International Perspective: Shorter Lives, Poorer Health*. National Academies Press, National Academy of Sciences; 2013.
4. Newton WP, Magill M. It takes a village to redesign residencies. *J Am Board Fam Med*. 2022;35(2):445-448. 10.3122/jabfm.2022.02.220067
5. Leigh JP, Tancredi D, Jerant A, Kravitz RL. Annual work hours across physician specialties. *Arch Intern Med*. 2011;171(13):1211-1213. 10.1001/archinternmed.2011.294
6. Wilkinson E, Coffman M, Petterson S, Jabbarpour Y. Gender differences in reported weekly work hours among family physicians. *J Am Board Fam Med*. 2020;33(5):653-654. 10.3122/jabfm.2020.05.190462
7. O'Brien Pott M, Blanshan AS, Huneke KM, Baasch Thomas BL, Cook DA. Barriers to identifying and obtaining CME: a national survey of physicians, nurse practitioners and physician assistants. *BMC Med Educ*. 2021;21(1):168. 10.1186/s12909-021-02595-x
8. Sainté M, Kanter SL, Muller D. Mission-based budgeting for education: ready for prime time? *Mt Sinai J Med*. 2009;76(4):381-386. 10.1002/msj.20122
9. Beck Dallaghan GL, Wright ST, Plant J, Butani L, Morgenstern BZ. Educational relative value units as a measure of academic productivity: a systematic review. *Cureus*. 2023;15(4):e36995. 10.7759/cureus.36995

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

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STFM'S BEHAVIORAL SCIENCE/FAMILY SYSTEMS EDUCATOR FELLOWSHIP AND THE EMERGING LEADERS FELLOWSHIP

STFM is currently accepting applications for 2 distinct fellowship opportunities: the Behavioral Science/Family Systems Educator Fellowship and the Emerging Leaders Fellowship.

The Behavioral Science/Family Systems Educator Fellowship is a yearlong program designed for family medicine faculty members who are responsible for coordinating or teaching the behavioral science/family systems curriculum. Applicants with 1 to 5 years of faculty experience are preferred. This fellowship incorporates a structured learning curriculum comprising core content and formalized mentoring.

By participating in this fellowship, one will achieve the following:

1. Gain a deeper understanding of the medical culture.
2. Develop a personalized professional development plan.
3. Integrate essential behavioral science and family systems principles into your family medicine practice.
4. Strategize, construct, and present a scholarly project at a prominent national conference.
5. Experience professional growth through robust mentoring relationships with experienced educators and physicians specializing in behavioral science and family systems.

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Moreover, the STFM Foundation is extending the Underrepresented in Medicine Scholarship, covering the fellowship registration fee for 2 deserving participants. Refer to the application form for detailed information.

Benefits of the Emerging Leaders Fellowship offered by STFM include: