

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 budgeting⁸ 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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