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- Sports Medicine, Health and Fitness
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- Stimulant Drinks and Products
- Student Choice of Family Medicine, Incentives for Increasing
- Student-Run Free Clinics
- Substance Abuse and Addiction
- Sugar Sweetened Beverages
Access to maternity care is an important public health concern in the United States. Providing comprehensive perinatal services to a diverse population requires a cooperative relationship among a variety of health professionals, including social workers, health educators, nurses and physicians. Prenatal care, labor and delivery, and postpartum care have historically been provided by midwives, family physicians and obstetricians. All three remain the major caregivers today. A cooperative and collaborative relationship among obstetricians, family physicians and nurse midwives is essential for provision of consistent, high-quality care to pregnant women.

Regardless of specialty, there should be shared common standards of perinatal care. This requires a cooperative working environment and shared decision making. Clear guidelines for consultation and referral for complications should be developed jointly. When appropriate, early and ongoing consultation regarding a woman's care is necessary for the best possible outcome and is an important part of risk management and prevention of professional liability problems. All family physicians and obstetricians on the medical staff of the obstetric unit should agree to such guidelines and be willing to work together for the best care of patients. This includes a willingness on the part of obstetricians to provide consultation and back-up for family physicians who provide maternity care. The family physician should have knowledge, skills and judgment to determine when timely consultation and/or referral may be appropriate.

The most important objective of the physician must be the provision of the highest standards of care, regardless of specialty. Quality patient care requires that all providers should practice within their degree of ability as determined by training, experience and current competence. A joint practice committee with obstetricians and family physicians should be established in health care organizations to determine and monitor standards of care and to determine proctoring guidelines. A collegial working relationship between family physicians and obstetricians is essential if we are to provide access to quality care for pregnant women in this country.

A. Practice privileges
The assignment of hospital privileges is a local responsibility and privileges should be granted on the basis of training, experience and demonstrated current competence. All physicians should be held to the same standards for granting of privileges, regardless of specialty, in order to assure the provision of high-quality patient care. Prearranged, collaborative relationships should be established to ensure ongoing consultations, as well as consultations needed for emergencies.

The standard of training should allow any physician who receives training in a cognitive or surgical skill to meet the criteria for privileges in that area of practice. Provisional privileges in primary care, obstetric care and cesarean delivery should be granted regardless of specialty as long as training criteria and experience are documented. All physicians should be subject to a proctorship period to allow demonstration of ability and current competence. These principles should apply to all health care systems.
B. Interdepartmental relationships
Privileges recommended by the department of family medicine shall be the responsibility of the department of family medicine. Similarly, privileges recommended by the department of obstetrics-gynecology shall be the responsibility of the department of obstetrics-gynecology. When privileges are recommended jointly by the departments of family medicine and obstetrics-gynecology, they shall be the joint responsibility of the two departments. (1998) (2014 COD)

Note: This joint statement was developed by a joint task force of the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists.
AAFP Definitions for Policy Statement, Position Paper and Discussion Paper

See Also

- AAFP Public Statements

Academy policy is determined by the Board of Directors and the Congress of Delegates. There are four vehicles by which Academy policy is articulated:

1. Minutes of the meetings of the Board of Directors
2. Transactions of the Congress of Delegates
3. Policy Statements
4. Position Papers

When policy statements and position papers are under consideration, they are termed "draft" and become policy only when the Board of Directors or Congress of Delegates approves them.

Policy Statement, Definition

The term policy statement is used to designate a straightforward statement or declaration of Academy policy on a particular topic or topics. Such statements usually are short and concise and do not include background information or discussion relative to the policy. A policy statement generally would not quote facts and figures developed by outside sources and would not utilize a bibliography.

Position Paper, Definition

The primary distinction between a policy statement and a position paper is that a position paper is far more comprehensive than a simple declaration of the Academy's policy on a particular topic or topics. A position paper does set forth the Academy's policy on one or more topics. However, as the term implies, a position paper also contains background information and discussion in order to provide a more complete understanding of the issues involved and the rationale behind the position(s) set forth. A position paper frequently cites outside sources and may include a bibliography.

Discussion Paper, Definition

In addition, documents are sometimes prepared which attempt to more fully explain specific issues. These documents are called discussion papers and are defined as follows:

A discussion paper may originate from various sources, including commissions/committees and staff, and is produced for the purpose of providing balanced information on a particular topic without espousing a particular Academy position. A discussion paper does not stand by itself as a statement of AAFP policy but may be used to formulate a policy statement or position paper.

Prior to April 1995, the Academy's nomenclature and definitions for policy documents were different from the above definitions. Accordingly, policy documents produced prior to April 1995 might not conform to the above definitions and would have been classified as policy statements, position statements or white papers.
AAFP Mailing List Policy

The American Academy of Family Physicians (AAFP) has contracted with an outside company to exclusively handle all external facets of its member mailing list rental program.

Promotion of CME Activities

Organizations may rent the AAFP mailing list to promote a continuing medical education (CME) activity to AAFP members. No reference to the AAFP may be made within the promotional materials for the CME activity without prior AAFP approval.

Organizations that have been approved for a satellite CME event at the AAFP Family Medicine Experience (FMX - formerly AAFP Assembly) may rent a list of Assembly registrants for one-time use to promote the CME event. Before the mailing list is made available, the proposed promotional mailing must be reviewed by the AAFP in its final state. Mailing lists that comprise members who have registered to participate in AAFP CME activities are not available for rent by any other organization.

Other Promotional Mailings

Organizations and individuals may rent the AAFP mailing list for one-time use to market a program, product, or service. Organizations that have contracted exhibit space at the FMX may rent a list of FMX registrants for one-time use to market a program, product, or service.

Before any mailing list is made available, the proposed promotional mailing must be reviewed by the AAFP in its final state. A list will only be provided if the following criteria are met:

- The mailing promotes a program, product, or service that reasonably can be expected to be of interest to AAFP members by virtue of its relevance to the clinical and socioeconomic practice of medicine or the education of future physicians.
- The mailing is tastefully designed.
- The mailing does not make claims that have no basis in fact.
- To the best of the AAFP’s knowledge, the sponsor of the mailing is reputable and can be expected to provide the promoted program, service, or product in accordance with the information in the mailing.

Survey/ Research Projects

Organizations and individuals may rent the AAFP mailing list for the purpose of involving AAFP members in surveys and research projects. The AAFP’s Marketing Research Department must review and approve all mailed communications in their final state. This includes the following:

1. All cover letters/materials soliciting AAFP members to participate
   a. If there are multiple communications, all follow-up must be included.
   b. If the results are to be published in any format, including electronic media, participants must be informed in the cover letter.
2. A final copy of the survey instrument
3. Copies of all envelopes (including business reply envelopes [BRCs]) used in correspondence with AAFP members
   a. Envelopes may be scanned and emailed as PDFs, or faxed.
4. Any other mailed communications that will be received by AAFP members on the mailing list.

The AAFP’s Marketing Research Department will determine whether a list is provided for a survey or research project solely on the basis of the following criteria:

1. The request must be made by a reputable individual or organization.
2. The survey instrument must be designed to produce valid and reliable results.
3. The request must clearly state the objectives of the survey/research project and the intended use of the data collected.
4. The potential results must meet the following criteria
   a. Add significantly to the body of knowledge in the medical field, particularly family medicine.
   b. Have a positive benefit for AAFP members.

Note:

- The AAFP will not rent its mailing list for telephone or facsimile solicitations.
- Permission to use the mailing list for promotion or a survey/research project in no way implies an endorsement by the AAFP. The AAFP must not be mentioned in any communications regarding a survey/research project.
- The AAFP will not rent its mailing list to any political candidate.
- The AAFP will not rent its mailing list for solicitation of membership in another organization.
- All mailed communications are subject to the approval of the AAFP, which reserves the right to reject any request at any time.

(1986) (March 2015)
AAFP Mission Statement

See Also

- Family Physicians' Creed
- Family Medicine in American Health Care

The Mission of the American Academy of Family Physicians is to improve the health of patients, families, and communities by serving the needs of members with professionalism and creativity. (2004) (2014 COD)
The American Academy of Family Physicians (AAFP) may occasionally promote family medicine by participating in magazine, newspaper or website "advertorials" - also referred to as "sponsored content" "native advertising." These are information-rich ads presented in a format similar to editorial material. When presented in such a way that readers can easily distinguish paid content from editorial content, this type of advertising is helpful to readers, and can be of great service in promoting awareness of family medicine.

Where the format of such advertorial is designed and controlled by the AAFP, the AAFP will clearly label such material as advertising. Where the format is controlled by the publisher, the AAFP will ensure that the format will clearly distinguish ads from editorial content before agreeing to participate in the advertorial.

AAFP’s agreement with the publisher will further state that ads for products on topics covered in the AAFP advertorial should not be positioned with AAFP editorial content in such a way as to imply AAFP endorsement or bias toward any commercial product. Advertisers, advertising copy, and layouts must be made available to the AAFP for review upon request.

Public statements on controversial issues should be issued in the name of the president or chair of the Board of Directors of the AAFP. Policy has been established that the AAFP president is the Academy's official spokesman. Officers and directors should not make public statements on controversial issues as individuals because regardless of intent they are identified with and attributed to the AAFP. Therefore, Board members are to refrain from making public statements on controversial issues not related to the official position of the AAFP. (B1961) (2013 COD)
Concerns about confidentiality may create barriers to open communication between patient and physician and may thus discourage adolescents from seeking necessary medical care and counseling.

When caring for an adolescent patient:

- Privacy should be respected by physicians and their staff. The adolescent should be offered an opportunity for examination and counseling separate from parents/guardians.
- The physician should make a reasonable effort to encourage the adolescent to involve parents or guardians in healthcare decisions.
- Every effort should be made to maintain confidentiality and patients should be made aware that certain situations and circumstances create limitations on guaranteed confidentiality. For example, detailing billing statements and Explanation of Benefits notices may be furnished to a guarantor/parent from a third party. Further, information suggesting someone is in imminenet danger, the suspicion or evidence of abuse, and the diagnosis of certain communicable diseases all must be reported to the proper authorities.
- Family physicians should be aware of their community's standards regarding adolescent confidentiality. State laws vary, but in general, in areas of care where the adolescent has the legal right to give consent, confidentiality must be maintained.
- Family physicians using electronic medical records should consult their vendor to be certain patient portals are properly configured to meet state standards regarding confidentiality for adolescents who parents and guardians have proxy access to their records.

Ultimately, regarding confidentiality, the judgment by the physician regarding the best medical interest and safety of the patient should prevail. (1988) (2013 COD)
Adolescent Health Care, Role of the Family Physician

See also

- Adolescent Health Care, Confidentiality
- Adolescent Health Care, Sexuality and Contraception
- Adolescents, Protecting: Ensuring Access to Care and Reporting Sexual Activity and Abuse (Position Paper)
- Child Abuse
- Health Education
- Health Education in Schools

Family physicians are optimally trained, qualified and experienced in providing and addressing the health care needs of the adolescent. The special and complex needs of adolescents are well served by the family physician’s comprehensive skills, family and community orientation, and social and developmental awareness. Family physicians should promote their availability and expertise in adolescent health care to families, schools, and communities and should advocate for the physical, sexual, and mental health of all adolescents through community and legislative involvement.

Adolescent Health Care, Sexuality and Contraception

See Also

- Adolescent Health Care, Confidentiality
- Adolescent Health Care, Role of the Family Physician
- Adolescents, Protecting: Ensuring Access to Care and Reporting Sexual Activity and Abuse (Position Paper)
- Child Abuse
- Health Education
- Health Education in Schools
- Prevention and Control of Sexually Transmitted and Blood Borne Infections
- Reproductive Health Services

The American Academy of Family Physicians (AAFP) values the sexual health of adolescents in the United States. The AAFP particularly recognizes the importance of reducing the incidence of unintended teenage pregnancies; reducing sexual assault; increasing awareness of the risks and signs in adolescents regarding sex trafficking; and increasing awareness of the legal ramifications of sexuality and technology. The AAFP believes that an evidence-based approach to sexual health education will effectively address these issues, and recognizes the need for more comprehensive and effective sex education programs in the community. The AAFP endorses opt-out comprehensive sexual education in all states and does not support abstinence-only sexual education. The AAFP recommends that:

1. All sexual education programs (including programs for reproductive health, pregnancy prevention, sexually transmitted infection (STI) prevention, etc.) includes medically accurate and evidence-based information.
2. Family physicians should provide appropriate guidance and counseling to educate patients about responsible sexual behaviors that decrease the risk of unplanned pregnancy and transmission of STIs. Patient education should address signs and symptoms of STIs and the need for testing even when patients are asymptomatic.
3. Comprehensive education and counseling regarding sexual practices of adolescents should include discussion about genital, anal, oral, and other types of sexual contact.
4. Family physicians should be aware that adolescents may be exploring sexual orientation and/or gender identity, which can impact their psychosocial and physical health. Asking open-ended questions about sexual orientation and gender identity can open a dialogue about family relationships, safe sexual practices, mental health, and other issues confronting lesbian, gay, bisexual, transgender, queer, questioning, and intersex adolescents in a sensitive and accepting atmosphere.
5. Family physicians should discuss with and educate their adolescent patients on the concept of consent to sexual activity and what to do if sexual contact takes place against one's consent.
6. Family physicians should be knowledgeable about their state laws in regard to technology and sexuality and should educate adolescents about the risks of sexting and using social media in a sexual manner.
7. Adolescents receiving family planning services deserve patient confidentiality. Family physicians should be aware of any state laws where they provide care that may impact them and the reproductive rights of their patients. Updated state laws can be found through the Guttmacher Institute at https://www.guttmacher.org.
8. Family physicians are in an ideal position to encourage family members to be involved in sex education efforts. It is primarily from the family that an adolescent's values and concept of sexual and reproductive responsibility arise. Encouraging dialogue with parents or other trusted adults has been shown to positively impact outcomes of sexuality.
9. Family physicians should be actively involved in community efforts that initiate and implement effective education and prevention programs for reducing unintended teenage pregnancy, and reducing STIs; addressing sexual assault; promoting safe use of technology in expressing sexuality; and increasing education regarding sex trafficking. Health education programs from elementary to high schools should include age-appropriate reproductive health education.
10. If a family physician is uncomfortable providing these services, the patient should be referred to another clinician who is willing to provide the education and/or services.

Adolescents, Protecting: Ensuring Access to Care and Reporting Sexual Activity and Abuse (Position Paper)

See also

- Adolescent Health Care, Confidentiality
- Adolescent Health Care, Role of the Family Physician
- Adolescent Health Care, Sexuality and Contraception
- Child Abuse
- School-Based Health Clinics, Guidelines
- Health Education
- Treatment of Survivors of Sexual Assault
- Medical Necessity for the Hospitalization of the Abused and Neglected Child
- Prevention and Control of Sexually Transmitted and Blood Borne Infections
- Reproductive Health Services

As physicians and other health care professionals, we have an ethical obligation to provide the best possible care for our adolescent patients. A key tenet for all health professionals is to ensure that adolescents have access to the health services they need, including sexual and reproductive health services. A medical evaluation that addresses sexual and reproductive health includes a careful assessment for abusive or unwanted sexual encounters and the reporting of such cases to the proper authorities. Protection of children and adolescents from predatory, coercive, or inappropriate sexual contact is an important goal of all physicians and health professionals. In meeting our ethical obligations to our adolescent patients, as well as to all of our patients who are children under the age of majority, we rely on our professional judgment, informed by clinical assessment, training and experience, to address a patient’s health conditions or a sensitive situation.

As the primary providers of health care to adolescents, we also have an obligation to make every reasonable effort to encourage adolescents to involve parents in their decisions, as parental support can, in many circumstances, increase the potential for dealing with the adolescent’s needs on a continuing basis. If communication between the adolescent and parent cannot be facilitated, access to confidential health care for the adolescent patient must be ensured.

Laws requiring the reporting of sexual abuse exist in every state. There has been a recent trend in using these laws to require the reporting of consensual sexual activity by adolescents. In keeping with the medical and ethical responsibilities that we uphold, the American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG), the Society for Adolescent Medicine (SAM), support the following guidance and principles for our professional members and for broad consideration in the development of public policy:

- Sexual activity and sexual abuse are not synonymous. It should not be assumed that adolescents who are sexually active are, by definition, being abused. Many adolescents have consensual sexual relationships.
- It is critical that adolescents who are sexually active receive appropriate confidential health care and counseling.
- Open and confidential communication between the health professional and the adolescent patient, together with careful clinical assessment, can identify the majority of sexual abuse cases.
- Physicians and other health professionals must know their state laws and report cases of sexual abuse to the proper authority, in accordance with those laws, after discussion with the adolescent and parent, as appropriate.
- Federal and state laws should support physicians and other health care professionals and their role in
providing confidential health care to their adolescent patients.

- Federal and state laws should affirm the authority of physicians and other health care professionals to exercise appropriate clinical judgment in reporting cases of sexual activity.

Supporting Commentary

State requirements for reporting sexual abuse and sexual activity vary: Every state has laws that require the reporting of child abuse, including sexual abuse, and every state also has laws that specify when sexual activity with a minor is illegal. Most states utilize age parameters in defining whether consensual sexual intercourse with a minor is illegal under the state’s criminal code; these laws are often referred to as “statutory rape” laws. The state child abuse reporting laws vary widely in terms of whether or not they require reporting consensual sexual activity of a minor – or “statutory rape” – as child abuse.

Most states have laws allowing minors to consent to selected categories of medical care without parental consent. Examples include reproductive health services leading to the diagnosis and treatment of sexually transmitted infections (STI) and the diagnosis of pregnancy. These laws give physicians and other health care professionals the opportunity to practice medicine that responds to the best interest of their patients.

State requirements have a significant impact on adolescents, their health and their families: Physicians and other health care professionals confront difficult choices in meeting their ethical obligations and complying with applicable laws. They are bound by their state reporting requirements. The core ethical obligation in light of these pressures to ensure that their patients are protected from harm and that they will receive essential health care and support at present and in the future. State reporting requirements may be in conflict with a health care professionals personal beliefs, yet adherence to this core ethical obligation while practicing within the law is essential.

However, well-intentioned but rigid laws can lead to outcomes that are both unintended and potentially damaging to the health of an adolescent. When a state’s laws require that sexual intercourse with a minor be reported to law enforcement or child welfare agencies, a sexually active adolescent in a consensual relationship may be placed in the untenable situation of forgoing essential health care (e.g., contraception, screening or treatment for sexually transmitted diseases, etc.) or, if he or she seeks that care, being reported to state authorities. Also, the laws often do not take into consideration varying circumstances such as cases in which parents know about the relationship in which the adolescent is involved. In these situations, the legal implications for the parent may be considerable. A parent who knows about an adolescent’s consensual sexual relationship and assists him or her in seeking health care may be reported under state abuse or neglect laws. Laws should neither interfere with an adolescent’s access to confidential health care nor a parent’s ability to provide health supervision to his or her child.

A significant number of adolescents are sexually active: According to the 2003 Youth Risk Behavior Surveillance Survey, 32% of 9th graders, 41% of 10th graders, 52% of 11th graders, and 61% of 12th graders have ever had sexual intercourse (CDC 2004). [Centers for Disease Control and Prevention, Surveillance Summaries May 21, 2004. MMWR 2004:53 (No. SS02)] Among adolescent girls who are sexually active, more than two-thirds have sexual partners who are the same age or only a few years older, (iii). Enforcement of “statutory rape” and child abuse reporting laws could potentially impact a very large number of adolescents.

Open communication between the health professional and the adolescent is essential. Physicians and other health professionals should ensure that the adolescent has not voiced or otherwise indicated to his or her partner that sexual activity was unwanted or undesirable and that the partner is not placing physical or emotional pressure on the adolescent. Physicians and other health professionals should encourage communication about sexual decision-making between adolescents and their families, and should counsel sexually active adolescents about potential health risks.

The vast majority of reportable cases of sexual abuse and sexual coercion are identifiable through careful clinical assessment. These cases include adolescents in a sexual relationship with a family member, a person of authority (e.g., teacher, leader of a youth organization, etc.), or a member of the clergy. Also included are adolescents who are incapacitated by mental illness, mental retardation, drugs, or alcohol, and
are unable to comprehend, make informed decisions about, or consent to, sexual activity. In addition, any intimate relationships that are violent should be considered abusive. Physicians and other health professionals must know their state laws and report such cases to the proper authority, in accordance with state law, after discussion with the adolescent and parent, as appropriate.

The age of the sexually active adolescent, the degree to which the adolescent understands the consequences and responsibilities of sexual activity, and the discrepancy in years between the age of the adolescent and his or her partner are important considerations that must factor into reporting decisions. While a wide discrepancy in age between partners is of concern when caring for the adolescent patient, partner age, by itself, is not indicative of exploitation or abuse. Verbal and physical coercion as well as alcohol and drugs are a few of the strategies used by sexual predators to victimize adolescents. However, sexual abuse and exploitation of an adolescent may occur in any relationship including those where the partners are the same age, younger or older.

It is essential that adolescents have access to confidential health care. The issue of confidentiality of care is a significant access barrier to health care. A recent study of girls under age 18 attending family planning clinics found that 47% would no longer attend if their parents had to be notified if they were seeking prescription birth control pills or devices, and another 10% would delay or discontinue sexually transmitted infection (STI) testing and treatment (Reddy 2003). Mandatory reporting of sexual activity will likely raise barriers and prevent adolescents from seeking health care, thereby exposing them to preventable health risks (e.g., pregnancy, sexually transmitted disease, suicide). The long-term consequences of limiting access to health care for sexually active adolescents may include an increase in the prevalence of STIs, a rise in unintended teen pregnancy, and escalation in the number of mental and behavioral health issues, including the potential of partner violence. If these and other conditions are not diagnosed early and treated appropriately, adolescents may suffer adverse health outcomes.

Adolescents can have a range of problems, including some of such severity as to jeopardize their development and health, their future opportunities, and even their lives. These issues may be independent of, or related to, sexual activity. However, until a physician or health professional can meet with and make a professional assessment of the individual adolescent, these issues can not be identified or addressed.

Legal requirements and interpretation of laws that impede the provider/patient relationship are detrimental to adolescents. The medical community has a long-standing commitment to ensure appropriate protection of confidentiality for their adolescent patients. Physicians and other health care professionals are on the front line in assessing the individual emotional, physical, and behavioral needs of adolescent patients. From this unique vantage point, we are able to provide care and counseling to our young patients and to determine the appropriate course of action required in each circumstance, including whether and when to abrogate an adolescent patient’s confidentiality. Federal and state laws should allow physicians and other health care professionals to exercise appropriate clinical judgment in reporting cases of sexual activity, (e.g., life-threatening emergencies, imminent harm, and/or suspected abuse). Ultimately, the health risks to adolescents are so compelling that legal barriers should not stand in the way of needed health care.

Resources

Confidentiality in Adolescent Health Care – consensus statement by AAP, AAFP, ACOG, NAACOG-The Organization for Women’s Health, Obstetric, Gynecologic, and Neonatal Nurses; and the National Medical Associations.

Adolescent Health Care (Confidentiality) – policy of the American Academy of Family Physicians (2001)

AMA policy H-60.965 - Confidential Health Services for Adolescents

AMA policy H-515.989 - Evidence of Standards for Child Sexual Abuse


Advertising Policies and Principles

The American Academy of Family Physicians (AAFP) accepts advertising in certain of its publications including (but not limited to) professional journals and web sites, meeting and convention publications, and direct-to-patient/consumer publications and web sites. Advertising revenue is used to support the activities of the AAFP.

The appearance of advertising does not indicate or imply endorsement of the advertised company or product, nor is advertising ever allowed to influence editorial content. Members and patients count on the AAFP to be an authoritative, independent voice in the world of science and medicine. Public confidence in our objectivity is critical to carrying out our mission.

The AAFP adheres to the code set forth by the Council of Medical Specialty Societies (CMSS) Code for Interactions With Companies, Standards for Advertising (Section 9.1) which states:

“Advertising in all Society publications should be easily distinguishable from editorial content (e.g., through labels and color-coding). Advertising should not be designed to look like scientific articles. In Society Journals, the placement of Advertising adjacent to articles or editorial content discussing the Company or product that is the subject of the ad should be prohibited. Advertising in Society Journals should be subject to review by the Editor-in-Chief and overseen by the Society. Society Journals and other Society publications that publish Advertising for CME activities or provide activities through which readers can earn CME credits should also comply with ACCME requirements for Advertising set out in the Standards for Commercial Support.”

Advertising Acceptance

1. The AAFP has the right to refuse any advertisement that, in its sole discretion, is incompatible with its mission or inconsistent with the values of members, the publication/web site or the organization as a whole, and to stop accepting any advertisement previously accepted. Ads are subject to review by the editor and others at the AAFP. In no case shall separate agreements with the AAFP or its subsidiaries supersede this policy.

2. Advertising for the following categories is prohibited:
   - Alcohol
   - Tobacco
   - Weapons, firearms, ammunition
   - Fireworks
   - Gambling and lottery
   - Pornography or related themes
   - Political and religious advertisements
   - Advertisements that claim to have a “miracle” cure or method
   - Advertisements that make unsubstantiated health claims for the products advertised
   - Advertisements directed at children

3. Advertisements new to AAFP may require pre-approval before they can appear. Refer to the individual publication ad policies or call your advertising representative for more information.

4. Advertisers may be required to submit supporting documentation to substantiate claims. For products not regulated by the FDA or other government agency, technical and/or scientific documentation may be required.

5. Ads for products not approved by the FDA that make any kind of health claims must carry the following disclaimer: “These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease.”
6. While the AAFP welcomes and encourages information-rich advertising, advertisements, advertising icons and advertiser logos must be clearly distinguishable from editorial content and may require special labeling to distinguish them as such.

7. In AAFP professional (physician-directed) publications and web sites, the intentional placement of advertising adjacent to articles discussing the company or product that is the subject of the ad is prohibited.

8. Advertisements may not imply endorsement by the AAFP or its publications/web sites except as may be provided for under a separate agreement—in which case advertising must be pre-approved to ensure adherence to the letter and spirit of that separate agreement.

9. The full rules for any market research or promotion associated with an advertisement must be displayed in the ad or available via a prominent link.

10. The following online advertising formats are prohibited:

   - Pop-ups and floating ads.
   - Advertisements that collect personally identifiable information from visitors without their knowledge or permission.
   - Ads that extend across or down the page without the visitor having clicked or rolled-over the ad.
   - Ads that send visitors to another site without the visitor having clicked the ad.

AAFP’s published advertising policies are not exhaustive and are subject to change at any time without notice.

Additional policies specific to individual AAFP publications and web sites may also apply; please additionally refer to those advertising policies for more details.

- Online Journal Advertising: [http://www.aafp.org/journals/afp/advertisers/rates-policies/online-policies.html](http://www.aafp.org/journals/afp/advertisers/rates-policies/online-policies.html)

Please contact your AAFP representative(s) for additional policies that may be in effect for any publications not listed here.

(VPs, October 2010) (May 2016 BOD)
Advertising: Youth Products

See also

- Alcohol Advertising and Youth (Position Paper)
- Direct-to-Consumer Advertising of Prescription Pharmaceuticals, Nonprescription Medications, Health Care Devices, and Health-Related Products and Services
- AAFP Promotions: Print Advertorials

The AAFP endorses the concept that advertising campaigns should promote healthy lifestyles. The AAFP is also opposed to targeting youth with advertising that relies on sexually suggestive or violent themes. (1987) (2012 COD)
Aging

See Also

- Long-Term Care
- Long-Term Care Facilities, Continuity and Coordination of Care
- Long-Term Care Facilities, Criteria for Medical Directors
- Certificates of Added Qualification
- Ethics and Advance Planning for End-of-Life Care
- Elder Mistreatment

The AAFP continues to support research, faculty development, continuing medical education and residency training in problems of aging and care of the aged. (1981) (2013 COD)
Alcohol Advertising and Youth (Position Paper)

Alcohol and Youth—Morbidity, Mortality, and Statistics

Although alcohol consumption decreased modestly among individuals 12-20 years of age between 1991 and 2005, alcohol use remains a major public health problem among youth. Current alcohol use among high school students remained steady from 1991 to 1999 and then decreased from 50% in 1999 to 45% in 2007. In 2007, 26% of high school students reported episodic heavy or binge drinking (consumption of at least five alcoholic beverages in a single sitting). Over 74% of high school students have had at least one alcoholic drink and over 25% tried alcohol before age 13. This is particularly worrisome because youth who begin drinking at age 15 are four times more likely to become alcoholics than those who begin drinking at age 21.

Alcohol consumption among youth translates into significant morbidity and mortality. Motor vehicle crashes are the leading cause of death among those younger than 25 years old; alcohol is a factor in 41% of deaths in car crashes. In 2007, 11% of high school students reported driving a car or other vehicle during the past 30 days when they had been drinking alcohol. In addition, 29% of students reported riding in a car or other vehicle during the past 30 days driven by someone who had been drinking alcohol. The second and third leading causes of death in this age group are homicides and suicides, 20% to 40% of which involve alcohol. Overall, alcohol consumption is the third leading cause of death among Americans, and it represents a financial burden on the United States of about $185 billion (1998 estimates) each year.

Miller and Levy estimate that underage drinking accounted for at least 16% of all alcohol sales in 2001, leading to 3,170 deaths and 2.6 million other harmful events in that year alone. The annual economic costs in their analysis includes $5.4 billion in direct medical costs, $14.9 billion in work and other resource losses, and $41 billion in lost quality of life.

A growing body of literature shows that alcohol advertising is an important factor related to alcohol consumption among youth. Research has now established that alcohol advertisements target youth, result in increased alcohol consumption, and add to morbidity and mortality.

Exposure to Alcohol Advertising

Before graduating high school, students will spend about 18,000 hours in front of the television—more time than they will spend in school. During this time they will watch about 2,000 alcohol commercials on television each year. Alcohol advertisements reach youth not only through television, but also through other varied media, such as billboards, magazines, sports stadium signs, and on mass transit such as subway systems. In all, youth view 45% more beer ads and 27% more liquor ads in magazines than do people of legal drinking age.

According to the Center on Alcohol Marketing and Youth at Georgetown University, alcohol companies spend nearly $2 billion very year on advertising in the United States. Between 2001 and 2007, there were more than 2 million television ads and 20,000 magazine ads for alcoholic products. This heavy advertising effort leads to significant youth exposure.
The Center analyzed the placements of over 2 million alcohol advertisement placements on television between 2000 and 2007 and over 19,000 alcohol ads placed in national magazines between 2001 and 2006. In 2007, approximately 20% of television alcohol advertisements, almost all of which were on cable television, were on programming that youth ages 12 to 20 were more likely to view than adults of legal drinking age. In fact, alcohol advertising increased 38% between 2001 and 2007. For young people, large and increasing television exposure has unfortunately offset reductions in exposure in magazines in recent years.

Many authors find that alcohol advertisements frequently reach or specifically target teens not only through television and magazines, but also through other varied media such as radio, P/PG movies, billboards, and sports stadium signs.

For example, a 2009 Journal of Adolescent Health study found that the ratio of the probability of a youth alcoholic beverage type to that of a non-youth alcoholic beverage type being advertised in a given magazine increased from 1.5 to 4.6 as youth readership increased from 0% to 40%.

**Youth as Targets of Alcohol Advertising**

Although the alcohol industry maintains that its advertising aims only to increase market share and not to encourage underage persons to drink, research suggests otherwise. Alcohol advertisements overwhelmingly connect consumption of alcohol with attributes particularly important to youth, such as friendship, prestige, sex appeal and fun.

The alcohol industry used cartoon and animal characters to attract young viewers to alcohol in the 1990s, with frogs, lizards and dogs, which were overwhelmingly admired by youth. In 1996, for example, the Budweiser Frogs were more recognizable to children aged 9-11 than the Power Rangers, Tony the Tiger, or Smokey the Bear. Many alcohol advertisements use other techniques oriented toward youth, such as themes of rebellion and use of adolescent humor. A study of alcohol advertising in South Dakota, for example, found that exposures in 6th grade predicted future intention to use alcohol.

It is telling that youth report alcohol ads as their favorites, especially when so many different products vie for their attention. These compelling advertisements become the new teachers of youth. One study found, in fact, that 8-12 year olds could name more brands of beer than they could U.S. presidents. In markets across the US, increased alcohol advertising exposure and dollars spent on these ads on television increased the consumption of alcoholic beverages among youth and young adults. It is not surprising that underage drinkers consume about 25 percent of all alcohol in the United States.

**Low Income and Minority Groups as Targets**

African-American youth generally have increased exposure to alcohol advertisements as compared to the youth population as a whole. In 2004, African-American youth viewed 34% more magazine alcohol advertisements per capita than youth in general and heard 15% more radio ads. Further, they were also heavily exposed to alcohol ads on the top 15 highly viewed television shows viewed by African-American audiences. It appears that this increased exposure, at least through television, may be due in part by the viewing patterns of African-American youth rather than necessarily from targeted marketing by the alcohol industry.

In addition to print media exposure, researchers have found that alcohol advertising is disproportionately concentrated in low-income minority neighborhoods. One study found that minority neighborhoods in Chicago have on average seven times the number of billboards advertising alcohol as do Caucasian neighborhoods. Another 2009 study in Chicago demonstrated that youth attending a school with 20% or more Hispanic students were exposed to 6.5 times more outdoor alcohol advertising than students.
attending schools with less than 20% Hispanic students. In a 2008 study, alcohol billboards in Atlanta, Georgia were more prevalent in neighborhoods that were 50% or more African-American.

Such concentration of alcohol advertising and availability likely translates into increased problems associated with alcohol use in these communities, as well as increased intentions among exposed youth to use alcohol.

**Increased Consumption**

There is ample evidence from experimental, economic, survey, longitudinal, and systematic review studies to demonstrate that the degree of youth alcohol advertising exposure is strongly and directly associated with intentions to drink, age of drinking onset, prevalence of drinking, and the amount consumed. A 2004 prospective study conducted by the University of Southern California showed that a one standard deviation increase in viewing television programs containing alcohol commercials in seventh grade was associated with an excess risk of beer use (44%), wine/liquor use (34%), and 3-drink episodes (26%) in eighth grade.

In another large longitudinal study published in 2006 of individuals 15 to 26 years of age found a direct correlation between the amount of exposure to alcohol advertising on billboards, radio, television, and newspapers with higher levels of drinking and a steeper increase in drinking over time.

Studies also find that adolescent exposure to alcohol-branded promotional items is associated with current drinking or predict future drinking. In one study, these students were three times more likely to have ever tried drinking and 1.5 times more likely to report current drinking.

Statistical and economic analyses also support the relationship between alcohol advertising and consumption. In Sweden in the 1970s, a ban on alcohol advertising resulted in a 20% decrease in the consumption of alcohol. Expenditures on alcohol advertising have also been shown to parallel alcohol consumption in the United States. Early reviews of the literature concluded that alcohol advertising increases consumption, though the magnitude was (and remains) in question. A recent RAND corporation review affirms those conclusions, noting that early exposure to beer ads had subsequent effects in mid-adolescent consumption. This study also found that in-store beer displays and advertising seemed to have more attraction to youth who had never used alcohol, while young drinkers were more influenced by magazine and entertainment venue advertising and promotion.

**Alcohol-related Morbidity and Mortality: Policy Implications**

Studies have also concluded that alcohol advertising leads to increased morbidity and mortality associated with alcohol. One study used econometric data to estimate the specific impact of alcohol advertising on mortality caused by motor vehicle accidents in the United States. The author concluded that, if a ban were placed on alcohol advertising on television, motor vehicle accident deaths would decrease by between 2,000 and 10,000 each year. The author further suggested that elimination of the tax benefits associated with alcohol advertising would likely result in a 15% decrease in alcohol advertisements, saving an estimated 1,300 lives annually, again due to a decrease in motor vehicle accident deaths alone. This author and others add that counter-advertising campaigns and educational efforts have been shown to diminish the effect of alcohol advertising.

**Future Directions**

Considering the important public health concerns related to alcohol, the prevalence of underage drinking, and the association between alcohol advertising and alcohol use, it would be prudent to increase efforts to curb the negative effects of alcohol advertising. Such efforts should include a multifaceted approach with
three primary goals:

- To reduce the total amount of alcohol advertising
- To remove content appealing to youth in remaining alcohol advertising
- To offer powerful educational programs and counter-advertisements painting more realistic pictures of the effects of alcohol

More specifically, it is suggested that:

- Federal, state and local authorities significantly limit alcohol advertising
- Tax advantages related to alcohol advertising be eliminated
- Alcohol advertising be strictly regulated, with removal of content and format geared toward underage audiences, minority groups and the poor
- Alcohol advertising be limited in public venues such as sporting events which are commonly attended by youth, as well as magazines and other media primarily viewed by youth
- More federal, state, and local funding be allocated to educational efforts that relate the negative effects of alcohol to children
- Media literacy programs helping youth to better understand and resist alcohol advertising counter-advertisements illustrating the dangers of alcohol use

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Ancillary Medical Personnel

See also

- Health Workforce Credentialing
- Non-Physician Providers, Family Physician Training With

The AAFP reaffirms the responsibility and authority of the physician to judge the competency of the ancillary medical personnel in his/her employ and to train such personnel in basic medical procedures. A physician may provide the opportunity for ancillary medical personnel who work under his/her supervision to benefit from educational programs offered by organizations representing such personnel. However, competency in a specific field shall not necessarily be determined by “certification” nor be subject to credentialing by external entities. (1977) (2013 COD)
Antibiotics

The American Academy of Family Physicians (AAFP) recognizes inappropriate use of antibiotics as a risk to both personal and public health and encourages only the appropriate use of these medications. (1997) (2010)

As a strong proponent of patient-centered evidence-based care, the AAFP encourages members to be judicious with antibiotic prescribing. Examples would include inappropriate antibiotic prescribing for the management of otitis media and sinusitis, as noted in the Choosing Wisely Campaign recommendations. However, the AAFP acknowledges that all antibiotic prescribing should be based on best practices. (2015 COD)
Antibiotic Resistance, Food Production and Human Health

Due to the serious human health consequences of non-therapeutic antibiotic use, the American Academy of Family Physicians advocates:

1. Restricting antibiotic use in farm animals to treatment of established disease;
2. Requiring that industry will provide proof of efficacy and a positive cost/benefit analysis for any antibiotics used in food production with the analysis taking into account the ultimate costs to human health with such analysis including not only economic but morbidity and mortality costs; and
3. Supporting Federal legislation intended to accomplish these measures.

(HP/S) (2015 COD)
Antisubstitution Laws

See Also

- Pharmacists (Position Paper)

The AAFP opposes the repeal or dilution of any state or national antisubstitution laws or regulations governing the filling of the physician's medical prescription by a pharmacist. (1970) (2013 COD)
Area Health Education Centers

See also

- Rural Health Care, Access to
- Rural Health Care, "First Responder" Training
- Rural Health Care in Medical Education
- Maternal/Child Care (Obstetrics/Perinatal Care)

Area Health Education Centers (AHECs), authorized under Section 751 of the Public Health Service Act, are designed to assist health professional schools to improve the distribution, supply, quality, utilization, and efficiency of health personnel in scarcity areas through the efficient use of regional educational resources. The AAFP supports the activities of AHECs, specifically as they relate to encouraging student interest in family medicine, establishing new and supporting existing family medicine residencies, assisting rural family physicians in meeting their continuing medical education needs, and educating family physicians as leaders of multidisciplinary health care teams. (CGA) (B1990) (2013 COD)
Athletic Performance-Enhancing Drugs

SEE ALSO

- Substance Abuse and Addiction
- Physical Activity in Children
- Sports Medicine, Health and Fitness

The AAFP recommends the use of drugs or blood products for intended medical purposes and not solely for the enhancement of athletic performance. This would include, but not be limited to, anabolic-androgenic steroids, human growth hormone, stimulants, erythrocyte stimulating agents, blood transfusions, and diuretics. (1987) (2013 COD)
Backpack Safety in Children

The American Academy of Family Physicians (AAFP) recommends children not carry over their shoulder backpacks greater than 15 percent of their body weight. This figure may vary (i.e., 10 to 20 percent) depending on the child’s body strength and fitness. (July BOD 2013) (2013 COD)
Boxing, Sport of

See Also

- Physical Activity in Children
- Sports Medicine, Collision Sports
- Sports Medicine, Health and Fitness
- Ultimate Fighting and Disabling Competitions

The American Academy of Family Physicians recommends its members make greater effort to inform their patients about the risks associated with amateur boxing, discourage their patients from participating in professional boxing and communicate their opposition to professional boxing. (1984) (2013 COD)
Breastfeeding is the physiological norm for both mothers and their children. Breastmilk offers medical and psychological benefits not available from human milk substitutes. The AAFP recommends that all babies, with rare exceptions, be breastfed and/or receive expressed human milk exclusively for the first six months of life. Breastfeeding should continue with the addition of complementary foods throughout the second half of the first year. Breastfeeding beyond the first year offers considerable benefits to both mother and child, and should continue as long as mutually desired. Family physicians should have the knowledge to promote, protect, and support breastfeeding. (1989) (2012 COD)

Please refer to the AAFP's position paper on Breastfeeding for more information on the family physician's role in supporting breastfeeding. This paper reviews the evidence in support of breastfeeding, recommendations for clinical management of breastfeeding, the use of formula in breastfeeding infants, and resources for promoting a breastfeeding friendly office.
Breastfeeding Accommodations for Trainees

See also

- Maternal/Child Care (Obstetrics/Perinatal Care)
- Breastfeeding (policy statement)
- Breastfeeding (Position Paper)
- Hospital Use of Infant Formula in Breastfeeding Infants

The American Academy of Family Physicians (AAFP) supports that all babies, with rare exceptions, should be breastfed and/or receive expressed human milk exclusively in the first six months, and this should continue with complementary foods as long as mutually desired. Family medicine training programs should, therefore, promote and support institutional policies to provide appropriate accommodations to allow trainees to securely breastfeed and/or express breast milk as needed during designated duty hours. (COE) (May 2013) (2013 COD)
Breastfeeding, Family Physicians Supporting (Position Paper)

See also

- Breastfeeding (Policy Statement)
- Breastfeeding Accommodations for Trainees
- Maternal/Child Care (Obstetrics/Perinatal Care)
- Hospital Use of Infant Formula in Breastfeeding Infants
- Breastfeeding Support and Resources Toolkit

Introduction

The American Academy of Family Physicians (AAFP) has long supported breastfeeding. All family physicians, whether or not they provide maternity care, have a unique role in the promotion of breastfeeding. They understand the advantages of family-centered care and are well positioned to provide breastfeeding support in that context. Because they provide comprehensive care to the whole family, family physicians have an opportunity to provide breastfeeding education and support throughout the course of life to all members of the family.

History

Throughout most of history, breastfeeding was the norm, with only a small number of infants not breastfed for a variety of reasons. In the distant past, wealthy women had access to wet nurses, but, with the industrial revolution, this practice declined, as wet nurses found higher-paying jobs. By the late 19th century, infant mortality from unsafe artificial feeding became an acknowledged public health problem. Public health nurses addressed this by promoting breastfeeding and home pasteurization of cows’ milk. In the early 20th century, commercial formula companies found a market for artificial baby milks as safer alternatives to cows’ milk. During this same period, infant feeding recommendations became the purview of the newly organized medical profession. Partially because of physician support and a vision of “scientific” infant care, the widespread use of formula as a breast milk substitute for healthy mothers and babies emerged.1, 2 Throughout the mid-20th century, most physicians did not advocate breastfeeding, and most women did not choose to breastfeed. An entire generation of women—and physicians—grew up not viewing breastfeeding as the normal way to feed babies. Despite the resurgence of breastfeeding in the late 20th century in the United States, breastfeeding and formula feeding continued to be considered virtually equivalent, representing merely a lifestyle choice parents may make without significant health sequelae.3

Currently, the World Health Organization (WHO) recommends that a child breastfeed for at least two years.4 The American Academy of Pediatrics, like the AAFP, recommends that all babies, with rare exceptions, be exclusively breastfed for approximately six months and continue breastfeeding with appropriate complementary foods for at least one year.5 The U.S. Public Health Service’s “Healthy People 2020” set national goals of 81.9% of babies breastfeeding at birth, 60.6% at six months, and 34.1% at one year.6 Targets for exclusive breastfeeding are 46.2% at three months and 25.5% at six months. The United States has not yet met its breastfeeding goals. Data published by the Centers for Disease Control and Prevention (CDC) show that, in 2011, 79% of U.S. mothers initiated breastfeeding; 49.4% were breastfeeding—and 18.8% were exclusively breastfeeding—at six months; and 26.7% were breastfeeding at 12 months.7 Although some subpopulations come close to Healthy People 2020 initiation goals, most do not, and few mothers breastfeed exclusively.7 Breastfeeding rates quoted for the United States reflect data that do not always distinguish among exclusive breastfeeding, breastfeeding with supplementation, and minimal breastfeeding.

Despite growing evidence of the health risks of not breastfeeding, physicians—including family physicians—do not receive adequate training about supporting breastfeeding.8-11 Although physicians make health recommendations about many aspects of infant care, many physicians still worry that advocating breastfeeding will cause parental guilt. However, parents may feel less guilt if they have had an opportunity to learn all the pertinent information...
and can make a fully informed decision.  

**Health Effects**

Family physicians should be familiar with the health effects of breastfeeding on women and children. The evidence concerning health effects continues to expand in terms of depth of understanding and quality of research. It is beyond the scope of this paper to review all of the primary literature. Several systematic review articles that outline the evidence supporting the role of breastfeeding in optimal health outcomes for mothers and children have been published. Because breastfeeding is the physiologic norm, we will refer to the risks of not breastfeeding for infants, children, and mothers.

A systematic review of the effects of breastfeeding on maternal and infant health found that for infants in developed countries, not breastfeeding is associated with increased risks of common conditions including acute otitis media; gastroenteritis; atopic dermatitis; and life-threatening conditions including severe lower respiratory infections, necrotizing enterocolitis, and sudden infant death syndrome. The beneficial health effects of breastfeeding persist beyond the period of breastfeeding. A WHO review showed that children who had not been breastfed had higher mean blood pressure, increased risk of type 2 diabetes, increased risk of obesity, and lower scores on intelligence tests. Children who are not breastfed are also at an increased risk of type 1 diabetes, asthma, and childhood leukemia.

The evidence base also supports the importance of six months of exclusive breastfeeding (when compared with four months) as protection against gastrointestinal tract and respiratory tract infections, including otitis media and pneumonia.

Maternal health outcomes also are affected positively by breastfeeding. In the short term, the data on postpartum weight loss suggest that the role of breastfeeding is minor compared with diet and exercise, although studies suggest that at least six months of exclusive breastfeeding may increase maternal weight loss. Another study suggested that longer duration of breastfeeding led to greater sustained weight loss. Not breastfeeding is associated with an increased risk of postpartum depression. In the longer term, for women in developed countries, not breastfeeding is associated with increased risks of type 2 diabetes, breast cancer, ovarian cancer, hypertension, and cardiovascular disease.

Breastfeeding also has broader economic and social benefits. Health care costs for both children and mothers are increased when breastfeeding duration is suboptimal. Breastfeeding may protect against child neglect and abuse. In addition, breastfeeding helps protect the environment because it involves no use of grazing land for cows, no product transportation or packaging, and no waste.

**Key Recommendations**

1. Almost all babies should be breastfed or receive human milk exclusively for approximately six months. Breastfeeding with appropriate complementary foods, including iron-rich foods, should continue through at least the first year. Health outcomes for mothers and babies are best when breastfeeding continues for at least two years. Breastfeeding should continue as long as mutually desired by mother and child.

2. Medical contraindications to breastfeeding are rare. The CDC still discourages breastfeeding by HIV-positive women in the United States. HIV-positive women in areas with high rates of infant diarrhea and respiratory illness are encouraged to breastfeed exclusively for six months. When mothers and babies are treated adequately with antiviral medications, breastfeeding exclusively for six months, with continued breastfeeding for 12 months, may be considered. Women who have HIV who do not have access to treatment are discouraged from breastfeeding if replacement feeding is acceptable, feasible, affordable, sustainable, and safe. Breastfeeding is contraindicated when the mother has human T-cell lymphotropic virus type I or type II. Infants who have type 1 galactosemia should not be breastfed; some other inborn errors of metabolism may require feeding modification. If there are active herpes simplex lesions on the breast, the infant should not feed from that side until the lesions heal. Mothers who have active untreated tuberculosis or active varicella in the newborn period should be separated from their babies, although the

breast milk may be fed to the infant. Maternal use of drugs of abuse, antimetabolites, chemotherapeutic agents, or radioisotopes may contraindicate breastfeeding. Most maternal conditions can be treated with medications that are safe for breastfeeding.  

3. Birthing centers and hospitals need to incorporate baby-friendly principles. Babies should be kept skin-to-skin with the mother at least until the first successful breastfeed. Perinatal care practices should support breastfeeding, optimally following the “Ten Steps to Successful Breastfeeding” (see Appendix 6), and mothers and babies should receive care from health care professionals knowledgeable about breastfeeding.  

4. Formula supplementation of breastfed babies should occur only when medically indicated. Family physicians should not undermine breastfeeding by providing formula samples or coupons to breastfeeding mothers.  

5. Breastfeeding babies and mothers should be seen for follow-up within a few days after birth. Family physicians and all health care professionals who regularly care for mothers and babies should be able to assist with normal breastfeeding and common breastfeeding challenges. When challenges exceed the expertise of the family physician, patients should be referred to someone with a higher level of expertise, such as an International Board Certified Lactation Consultant.  

6. Family physicians should establish a breastfeeding-friendly office, even if they do not provide maternity care. Family physicians should advocate for breastfeeding and provide education about breastfeeding throughout the course of life and for the entire family. Family physicians may provide prenatal care and labor support, deliver the infant, help in the prompt initiation and continuation of breastfeeding, and continue caring for the baby and family. Breastfeeding education and support can be integrated into these visits. Family physicians have the unique opportunity to emphasize breastfeeding education beginning with preconception visits and continuing through prenatal care, delivery, and postpartum care, and during ongoing care of the family. Encouragement from a physician and other family members, especially the baby’s father and maternal grandmother, are important factors in the initiation of breastfeeding. While caring for a mother’s immediate and extended family, a family physician should remind her social support system to encourage breastfeeding.  

7. With all of the health advantages of breastfeeding for mothers and children, as well as its economic and ecological impacts, breastfeeding is a public health issue, not merely a lifestyle choice. Family physicians should work in their communities to advocate removal of barriers to breastfeeding. This could include overcoming cultural issues, encouraging breastfeeding-friendly workplaces, advocating for adequate paid maternity leave, and protecting the right to breastfeed in public.  

8. Medical schools and family medicine residencies should include appropriate curricula in lactation physiology and breastfeeding management so that family physicians are adequately trained to provide care to breastfeeding mothers and infants. Medical trainees who are breastfeeding should be given support to attain their breastfeeding goals.

Further information and resources may be found in the following appendices:

Appendix 1: Recommendations for Clinical Management
Appendix 2: Additional Breastfeeding Considerations
Appendix 3: Education of Medical Students and Family Medicine Residents
Appendix 4: AAFP Policies Related to Breastfeeding
Appendix 5: Resources for Family Physicians and Other Health Care Professionals
Appendix 6: National and International Breastfeeding Initiatives

Prepared by the AAFP Breastfeeding Advisory Committee
Anne Montgomery, MD, MBA, FAAFP, FABM*, IBCLC† - Chair
Alicia Dermer, MD, FABM, IBCLC
Anne Eglash, MD, FABM, IBCLC
Michelle Quiogue, MD, FAAFP
Rebecca B. Saenz, MD, IBCLC, FABM
Timothy J. Tobolic, MD, FABM
*Fellow of the Academy of Breastfeeding Medicine
†International Board Certified Lactation Consultant

Special thanks to the AAFP Staff:
Julie Wood, MD, FAAFP, FABM, IBCLC
Jennifer Frost, MD
Bellinda Schoof  
Diana Swafford  
Melanie Bird, PhD

And to the members of the 2014 AAFP Commission on Health of the Public and Science:  
Steven Brown, MD – Chair  
With assistance from Max Romano, MD, MPH

References

24. Jager, S., et al., Breast-feeding and maternal risk of type 2 diabetes: a prospective study and meta-
Appendix 1: Recommendations for Clinical Management

SPECIFIC CLINICAL RECOMMENDATIONS

1. Preconception and prenatal education

1. Address the infant feeding decision before conception or as early in pregnancy as possible; women make their decision about breastfeeding very early. Prenatal intention to breastfeed has an influence on initiation and duration of breastfeeding. Continue to bring up the issue of infant feeding throughout the prenatal period.1

2. Determine the mother's intent and any concerns or misconceptions she may have. Provide appropriate education and anticipatory guidance to encourage her to consider breastfeeding and determine what support she will need to make and carry out this decision.2

3. Elicit any factors in the family medical history that may make breastfeeding especially important (e.g., atopic diseases, diabetes, obesity, cancers) and advise the woman of these factors.3

4. Elicit any risk factors for potential breastfeeding problems and any medical contraindications to lactation. Provide appropriate support and education.4

5. For multiparous women, document the duration of lactation for each infant, reasons for weaning, and any problems that occurred. (We suggest the history be documented with the labor history of each infant.) For
the current pregnancy, document a plan for intervention, including lactation consultation where indicated, on the prenatal form.1

6. Encourage the participation of the mother’s support persons and educate them as appropriate. Remember that anyone at the prenatal visit or hospital stay is likely to have influence over breastfeeding and other health care decisions.5, 6

7. Recognize the feelings of relatives who did not breastfeed or who weaned prematurely. Encourage them to learn what is known about breastfeeding for the optimal health of the mother and baby.7

8. In a culturally sensitive manner, encourage the woman and her support persons to attend breastfeeding classes and/or support group meetings during the prenatal period.1, 6, 7

9. Provide the woman with accurate, noncommercial breastfeeding literature and recommendations for accurate lay breastfeeding resources (e.g., books, websites).6

10. Educate women about the potential breastfeeding problems associated with the use of intrapartum analgesia and anesthesia. Encourage the use of a labor support person (i.e., a doula).8-10

2. Intrapartum support

1. Provide appropriate labor support intended to minimize unnecessary analgesics or anesthesia.11

2. If mother and baby are stable, facilitate immediate postpartum breastfeeding. Minimize separation of mother and infant, and wait until after the first breastfeeding to perform routine newborn procedures such as weighing, ophthalmic prophylaxis, and vitamin K injection.12, 13

3. Provide warming for the stable newborn via skin-to-skin contact with the mother, covering mother and baby if necessary.12

3. Early postpartum education and support

1. Advocate for 24-hour rooming in for mother and baby.15

2. Encourage the mother’s support persons to provide optimal opportunities for breastfeeding.7

3. Ensure that breastfeeding is being adequately assessed on a regular basis by qualified professionals. Advocate for lactation consultation services at all hospitals where maternal and infant care is provided.4, 14, 16, 17

4. Educate mothers about the importance of frequent, unrestricted breastfeeding with proper positioning and latch.16

5. Help mothers recognize the baby’s early feeding cues (e.g., rooting, lip smacking, sucking on fingers or hands, rapid eye movements) and explain that crying is a late sign of hunger. Help mothers also recognize signs that the baby is satisfied at the end of a feeding (e.g., relaxed body posture, unclenching of fists).18

6. If mother and baby need to be separated, assist with maintenance of breastfeeding and/or ensure that mother receives assistance with expressing milk. Encourage mother to begin expressing her milk within two hours after being separated from her infant.18

7. At hospital discharge, provide mothers with clear verbal and written breastfeeding instructions that include information on hunger and feeding indicators, stool and urine patterns, jaundice, proper latch and positioning, and techniques for expressing breast milk.14, 16, 18

8. Educate mothers about the risks of unnecessary supplementation and pacifier use.14, 16, 18

9. Avoid the use of discharge packs containing formula samples and formula company advertising or literature.19

10. Ensure that the mother and baby have appropriate follow-up within 48 hours of discharge and provide the mother with phone numbers for lactation support.4, 20, 21

11. Identify breastfeeding problems in the hospital and assist the mother with these before discharge.16, 18

12. Develop an appropriate follow-up plan for any identified problems or concerns.16, 18

13. Provide the family with information about breastfeeding support groups in the community.16, 18

4. Ongoing support and management

1. Evaluate the mother and baby within 24-72 hours after hospital discharge to assess adequacy of milk
intake, newborn jaundice, and breastfeeding concerns. See the mother and baby within 24 hours after hospital discharge if breastfeeding was not going well in the hospital.

2. Continue to support breastfeeding throughout the first year of life and beyond at well-child and other visits. Encourage exclusive breastfeeding for the first six months of life.4

3. Be knowledgeable about prevention and management of common breastfeeding challenges.22

4. Educate office staff on breastfeeding topics so that they can provide optimal breastfeeding triage and support.7

5. Develop a working relationship with professionals with expertise in lactation issues, such as International Board Certified Lactation Consultants. Consult when breastfeeding concerns exceed your level of expertise.

6. Encourage mothers who are returning to work to continue to breastfeed.7

7. Encourage mothers who do not feel they can continue to exclusively breastfeed to continue partial breastfeeding as long as possible.

References


Appendix 2: Additional Breastfeeding Considerations

Infant Illness

Ill infants benefit from breastfeeding and/or consuming breast milk. These infants often will have poor suck, appetite, and alertness and often need supplementation, ideally with the mother’s own expressed milk or pasteurized human milk from a donor. Neonatal illnesses such as hyperbilirubinemia and hypoglycemia may be due to poor milk transfer and warrant an urgent consultation with a skilled lactation consultant. Any necessary supplementation should be with the mother’s own expressed milk or with pasteurized human milk from a donor, and should be given by a method least likely to interfere with breastfeeding. The mother’s own milk supply should be protected and/or increased by adequate pumping or manual expression. Infants born with defects such as cleft lip and palate may breastfeed but require consultation with an experienced lactation professional to ensure success. Infants who have other anomalies or syndromes that cause hypotonia also will benefit from such consultation. However, infants who have type 1 galactosemia are unable to breastfeed and must be on a lactose-free diet. Infants who have phenylketonuria should breastfeed, but they must receive supplementation with a low-phenylalanine formula. Breastfed infants who have phenylketonuria have better developmental outcomes compared with those exclusively fed low-phenylalanine formulas.

Maternal Illness

Maternal illness or need to take medication is an often-cited reason that women stop breastfeeding sooner than desired. Women with chronic noninfectious illnesses, including depression, may be empowered by their ability to breastfeed. For most illnesses, medication issues do not prevent breastfeeding because reasonable medication choices almost always can be made. Exceptions include treatment of breast or other cancers, which necessitates use of antimitabolites. Some newer protocols that involve chemotherapeutic agents with short half-lives may necessitate only temporary weaning, and breastfeeding may be resumed after five half-lives. Each agent should be individually assessed.

Women who have severe trauma or acute life-threatening illness may be too ill to nurse or express milk. If maternal illness causes separation, assistance with maintaining lactation should be provided.

Maternal anesthesia rarely contraindicates breastfeeding. Local anesthetics enter the bloodstream in minute quantities, too small for significant amounts to enter the mother’s milk. Most agents used for general anesthesia, including those used for inducing anesthesia, have short half-lives and clear the maternal circulation rapidly. There is no need to delay breastfeeding after general anesthesia for a procedure done within the first two to three days postpartum (e.g., tubal ligation) because the amount of colostrum is too small to carry a significant quantity of the anesthetic agents. For surgical procedures done later, the decision about resuming breastfeeding depends on the condition of the infant. Mothers of healthy term neonates can resume breastfeeding once they are awake and able to hold the infant. In the case of a preterm or otherwise compromised neonate, pumping and discarding the milk for 12 to 24 hours after the procedure may be warranted.

It is rarely necessary to interrupt breastfeeding for radiologic procedures. The radioiodides used as intravenous contrast agents for some radiography and computed tomography scanning have an extremely short half-life and virtually no oral bioavailability. Therefore, they pose an insignificant risk to a breastfed infant. Similarly, gadopentetate used as contrast for magnetic resonance imaging (MRI) has such minimal excretion in the milk—and even lower oral absorption—that only extremely small amounts are available to the nursing infant. The knowledgeable family physician can reassure patients undergoing such procedures that there is no need to interrupt breastfeeding and may need to intervene on a patient’s behalf if the radiologist recommends temporary cessation based on misleading manufacturer’s literature. Similarly, most diagnostic procedures using radioisotopes do not require interruption of breastfeeding. However, there are some that may require temporary interruption or—rarely—cessation of breastfeeding. References are available that outline the effects of various

References

For most diagnostic radioactive scanning, it is possible to find a radioisotope that does not require interruption, or at least one with the shortest half-life. The duration of breastfeeding cessation would be five times the half-life. The breastfeeding mother has the option of pumping and storing her milk before the procedure. To maintain her supply, the mother should continue to express her milk after the procedure. She may discard this milk until it is safe to resume breastfeeding, or she has the option of storing this milk in a freezer that is not opened often. Once all of the radiation is gone, this milk can be given to the baby. The nuclear medicine radiologist can guide the mother regarding when the radioactivity would be depleted in the milk; the milk may be tested for residual radioactivity.

**Breast Surgery**

Some women who have had breast augmentation may not be able to produce sufficient amounts of milk. Some of these women may have had insufficient breast tissue before surgery. However, augmentation surgery itself may cause additional breastfeeding problems. Breast reduction surgery may increase the risk that a woman will not be able to produce sufficient milk, although newer surgical techniques that do not disrupt neurovascular supply and ductal architecture (e.g., inferior pedicle technique) are less likely to cause problems. Breast biopsy with circumareolar incision can interfere with milk supply and transfer in the affected breast. Women who undergo this procedure should be encouraged to breastfeed, but mother and baby need to be followed closely to ensure that the infant has an adequate milk intake. Women who develop a suspicious breast mass during lactation should not wean for the purpose of evaluating the mass. Mammography and breast mass biopsy can be done without interfering with lactation. A milk fistula occasionally develops after breast surgery during lactation; this condition is benign and generally resolves without intervention.

An MRI may provide additional information about lactating breasts. Family physicians should assist their patients with decisions about breast surgery. They should communicate with the surgeon to advocate for their patient’s future breastfeeding needs and breastfeeding conservation surgeries whenever medically feasible.

**Infectious Diseases**

For most maternal infections, breastfeeding helps protect the infant against the disease or decreases the severity of the illness because of anti-infective components in human milk. Only a few maternal infections preclude breastfeeding.

In the United States, women who have human immunodeficiency virus (HIV) are currently advised not to breastfeed because of the potential risk of transmission to the child. In countries with high infant mortality rates caused by infectious illnesses or malnutrition, the benefits of breastfeeding may outweigh the risk of HIV transmission. Additionally, recent studies suggest that a combination of exclusive breastfeeding for six months and antiretroviral medications may decrease the risk of transmission.

Two other infections that are less prevalent in the United States but also contraindicate breastfeeding are human T-cell lymphotropic virus (HTLV) type I and type II, and untreated brucellosis.

Most infections do not preclude breastfeeding, but in a few specific infections, certain considerations apply. In women who have active tuberculosis, the mother and infant should be separated until both are receiving appropriate anti-tuberculosis therapy, the mother wears a mask, and the mother understands and is willing to adhere to infection control measures. The mother's expressed milk may be given to the infant. Once the infant is receiving isoniazid, separation is not necessary unless the mother has possible multidrug-resistant Mycobacterium tuberculosis, or has poor adherence to treatment and direct-observation treatment is not possible. During active herpes simplex outbreaks, it is safe for a woman to nurse unless she has lesions on her breasts. It is recommended that she not nurse from the affected breast until lesions resolve. Babies born to mothers who develop chickenpox within five days antepartum or within two days postpartum are at risk of more serious chickenpox infections. It is recommended that baby and mother be separated until the mother is no longer infectious, but expressed milk may be supplied, as long as the milk does not come into contact with active lesions. Transmission of hepatitis C through human milk has not been established. The risk of infection from mothers with hepatitis C is the same in breast- or bottle-fed infants. However, bleeding or cracked nipples may put an infant at risk of transmission of the virus.
Additionally, mothers acutely infected with H1N1 virus should be isolated from their infants during the febrile period, but their milk is safe to provide to their infants. Some other uncommon serious maternal infections, such as Ebola virus and brucellosis, may require temporary interruption of breastfeeding.

Medication and Substances

Almost all prescription and over-the-counter medications taken by the mother are safe during breastfeeding. Several resources are available to help estimate the degree of drug exposure an infant will receive through breast milk. Physicians must weigh the risks of replacing breastfeeding with artificial feeding against the risk of medication exposure through breast milk. Even a temporary interruption in breastfeeding carries the risk of premature weaning, with the subsequent risks of long-term artificial feeding. There are very few substances for which breastfeeding should be stopped. Generally, it is recommended that breastfeeding be interrupted if the mother ingests most drugs of abuse, antimetabolite medications such as chemotherapeutic agents, and certain radioactive compounds. Among antidepressants, cardiovascular medications, immunosuppressants, and many other classes of medications, certain drugs are preferred over others for lactating women. In a particular class of medications, it is best to choose a drug that has the least passage into breast milk, a shorter half-life, fewer active metabolites, and/or is used locally rather than systemically. Physicians should counsel patients before ordering medications or procedures. Often, patients will be counseled inappropriately by well-meaning health care professionals to “pump and dump” or to stop breastfeeding based on old information or package inserts. Family physicians should be aware of up-to-date information and advocate for patients to continue breastfeeding safely. Some medications and substances, such as bromocriptine, cabergoline, pseudoephedrine, and estrogen-containing oral contraceptives, are known to decrease milk supply. Contraceptive alternatives for breastfeeding mothers are discussed below (see Contraception in the Breastfeeding Mother section).

Contraception in the Breastfeeding Mother

Breastfeeding mothers have a number of options for contraception. The lactational amenorrhea method has been shown to be highly effective when practiced according to three specific criteria: 1) exclusive breastfeeding takes place without routine supplements or delays in feedings; 2) infant is younger than six months; and 3) menses have not returned (i.e., no bleeding after 56 days postpartum). In a Cochrane analysis of 13 studies that met inclusion criteria, the pregnancy rates at six months ranged from 0.45% to 2.45%. In the absence of any one of these three criteria, this method is unreliable and additional precautions are needed. Mothers who wish to avoid contraceptives can be instructed in fertility awareness methods; however, menses may remain irregular during lactation, which makes use of these methods more challenging.

Contraceptive options that may be used once the lactational amenorrhea method is ineffective include barrier methods, intrauterine devices (IUDs), and hormonal contraceptives. The main advantage of barrier methods (e.g., condoms, diaphragms) is the lack of potential adverse effects to the nursing infant, whereas their main disadvantage is lower effectiveness. They may have their greatest use as a complement to lactational amenorrhea or fertility awareness methods. Diaphragms must be refitted at least six weeks postpartum prior to use. Copper IUDs are an excellent choice for breastfeeding mothers because of their effectiveness and low risk of adverse effects in the infant. As in nonlactating women, they are not recommended for women with multiple partners or for those who have a history of sexually transmitted infections.

Hormonal methods may be prescribed for breastfeeding mothers but generally are not considered as first-line agents, especially in the early weeks postpartum before the establishment of the maternal milk supply. Studies suggest that progestin-only methods, including injectable medroxyprogesterone acetate, do not decrease milk supply when started after initiation of lactation. However, many anecdotal reports link hormonal contraceptives to a decrease in milk supply, and a Cochrane review found that the data are inconsistent and limited. In particular, many of the studies do not consider exclusivity of breastfeeding. Progestin-only methods including the “mini-pill,” injectable depot medroxyprogesterone acetate, etonogestrel subdermal implant, and progestogen-containing IUD are best started after the milk supply is well established. If there are concerns about milk supply,
it may be best to start with the mini-pill because the other forms are not easily reversible. Studies of the effects of combined oral contraceptives are of poor quality and show inconsistent results regarding effects on breastfeeding and infant weight gain.\textsuperscript{39} Hormonal methods are best avoided in mothers with existing or previous low milk supply, a history of breast surgery, multiple or preterm birth, or compromised maternal or infant health. Mothers who choose to use hormonal methods should be encouraged to breastfeed, and infant growth should be monitored.

**Tobacco and Alcohol Use**

Infants should not be exposed to cigarette smoke. Children of mothers who smoke cigarettes have elevated cotinine levels in their urine compared with children of nonsmoking women. Nursing women who smoke pass a significant amount of cotinine through breast milk to the baby, such that the baby’s cotinine levels are higher than those of babies exposed to passive cigarette smoke only.\textsuperscript{40-42} Babies who are breastfed immediately after their mother smokes demonstrate changes in their sleep and wake patterns.\textsuperscript{42} Breastfeeding infants who bed share with parents who smoke have a higher risk of sudden infant death syndrome (SIDS).\textsuperscript{43} Breastfeeding women who smoke are at risk of insufficient milk supply because of the negative effect of nicotine on prolactin levels.\textsuperscript{44} Women who breastfeed are advised not to smoke, but if they cannot quit, it is probably still more valuable to breastfeed, although they should be advised not to smoke in the infant’s environment, to smoke as little as possible, and to smoke immediately after nursing (rather than before) to minimize the nicotine levels in their milk. Breastfeeding women can use nicotine supplements to aid in tobacco cessation, although it is best to use the lowest possible dose because of the adverse effects of nicotine on the infant and maternal milk supply.\textsuperscript{29}

Alcohol passes easily into breast milk but is also cleared from breast milk as rapidly as it is cleared from the bloodstream. Although it is safest for nursing mothers to consume no alcohol, small amounts of alcohol (e.g., one serving of wine or beer per day) appear to be safe. It is ideal for the mother to wait 2 to 2.5 hours after finishing the alcoholic beverage to nurse again.\textsuperscript{29}

**Toxins and Pollutants in Infant Feeding**

Infant exposure to toxins and pollutants occurs primarily through feeding and air. Breastfeeding women without specific occupational or other known poisonous exposures to pollutants may nevertheless be found to have a variety of polluting chemicals in their bodies.\textsuperscript{45} Some of these chemicals may be transferred to fetuses in utero and possibly to infants postnataally through breast milk, as well as through formula and complementary foods.

While breast milk receives much scrutiny and media coverage about the toxins it contains, it is important to understand that infant formula (primarily cow's milk and soy) also contain many of the same toxins, as well as manufactured substances that are added by the formula industry. Many of these manufactured substances (e.g., docosahexaenoic acid [DHA], arachidonic acid [ARA]) have been determined to be “safe” by the U.S. Food and Drug Administration (FDA); however, there is no proof of their benefit to infants in infant formula.\textsuperscript{46} Infant average daily dose exposures by inhalation of volatile organic compounds (VOCs), such as benzene, toluene, and methyl tertiary butyl ether (MTBE), have been found to exceed human milk ingestion rates by 25- to 135-fold.\textsuperscript{47}

Women who breastfeed are concerned about chemicals in breast milk. Reporting of chemicals in breast milk may lead to early termination of breastfeeding.\textsuperscript{48} It is important that family physicians educate parents that formula contains many of the same toxins, phthalates, heavy metals, and pesticides, and potentially many more. By using formula, they do not reduce exposure to environmental toxins. The risk of cancers and less-than-optimal neurologic development remains higher in formula-fed babies compared with breastfed babies in similar environments.\textsuperscript{49, 50}

Women who have average environmental exposure do not need to worry about having their milk screened for pollutants. For women who have known poisonous exposures, testing of breast milk may be necessary. Bisphenol A (BPA) is a common chemical used to make many plastics, including baby bottles. Further study is needed on the exact effects of BPA in humans. BPA-free bottles do exist, and parents may choose to use those to limit exposure.\textsuperscript{51}

Concerns have been raised about heavy metal toxins—primarily mercury—in fish, causing some to reduce fish
consumption during pregnancy and lactation. However, there appear to be beneficial effects on cognitive development in children with increased consumption of fish. The Environmental Protection Agency (EPA) now encourages women to eat more fish that are lower in mercury. The EPA maintains information on mercury levels in fish (www.epa.gov/waterscience/fish), and most states, U.S. territories, and Native American tribes provide information on mercury levels in fish. The FDA and EPA are in the process of updating their recommendations regarding fish intake. Information about the draft update may be found at www.gpo.gov/fdsys/pkg/FR-2014-06-11/pdf/2014-13584.pdf.

In addition to the concerns about the effect of toxins on infants, consideration needs to be given to the effect that environmental toxins, as well as medical, biologic, and even social toxins, have on lactogenesis, an area that has had little study.

Although the presence of toxic chemicals in humans’ fetal environment and milk signals the urgent need to reduce community exposure to these pollutants, the weight of the evidence indicates that breastfeeding remains the healthiest option for mothers and babies.

**Employment**

Family physicians have an opportunity and responsibility to promote breastfeeding in the workplace as community leaders, business owners, supervisors, and/or employees. Research suggests that a key reason for low breastfeeding rates lies in employment and the lack of paid maternity leave in the United States. American mothers who plan to continue their jobs are forced to make a relatively rapid return to employment. Federal law currently provides mothers reasonable break times to express milk in a private, non-bathroom location for one year after the child’s birth.

Providing lactation support is not only highly desired by breastfeeding employees who return to work after childbirth; it also can improve a company’s return on investment by saving money in health care and employee expenses. Employer benefits include:

- Lower medical costs and health insurance claims for breastfeeding employees and their infants (up to three times less for breastfeeding employees)
- Reduced turnover rates (86% to 92% of breastfeeding employees returning to work after childbirth when a lactation support program is provided compared with the national average of 59%)
- Lower absenteeism rates (up to half the number of one-day absences)
- Improved productivity
- Higher employee morale and loyalty to the company

Resources to help family physicians educate employers in their communities are available. The Business Case for Breastfeeding is a comprehensive program designed by the U.S. Department of Health and Human Services to educate employers about the value of supporting breastfeeding employees in the workplace. The program highlights how such support contributes to the success of the entire business. The Business Case for Breastfeeding offers tools to help employers provide worksite lactation support and privacy for breastfeeding mothers to express milk. The program also offers guidance to employees’ rights and responsibilities regarding breastfeeding and working.

**Pumping, Expressing, and Storage Guidelines**

Expressing milk can be accomplished in various ways. The optimal method varies with the length of the mother’s absence from the infant and maternal preference. For occasional brief absences, hand expression and/or the use of a hand pump is usually sufficient. The longer and more frequent the separations, the more important it is for the mother to use a hospital grade double-pumping electric pump. This is especially important in cases of maternal-infant separation caused by illness or prematurity and maternal return to full-time work in the absence of on-site day care. To avoid a significantly reduced milk supply during the work week, mothers who work full-time can try frequent breastfeeding when they are with their infants, pumping at a frequency as close to the feeding frequency as possible, and instructing the infant caregiver not to feed a full bottle to the infant shortly before the mother’s arrival to pick up the infant. Furthermore, bottle-feeding may cause an excessive volume of milk to be taken by the infant, putting additional pressure on the mother to pump larger volumes. To prevent
this, the caregiver may be instructed in techniques that minimize the amount of milk the infant takes from a bottle at each feed, which include the “paced bottle-feeding” method, cue-based feedings, and frequent breaks during a feeding. Mothers whose milk ejection reflex is inhibited at work can be encouraged to use an item of the infant’s clothing and/or the infant’s picture as a stimulus and to ensure as comfortable an environment as possible for pumping.5

Mother’s milk can be stored safely for longer periods than were previously recommended.58 For working mothers with healthy, term infants, the milk can be stored at room temperature for six to eight hours, in an insulated cooler bag with ice packs for 24 hours, and in the refrigerator for up to five days. Milk can be stored in a freezer for up to six months. Storing milk in a freezer for up to 12 months may be acceptable. Small amounts of milk can be added to previously expressed milk, but the fresh milk should be chilled before adding to already frozen milk. Room should be left in the container for expansion during freezing.59

The best storage containers are hard plastic or glass containers. It is best to avoid clear plastic containers because of the possible leaching of BPA into the milk during warming. Warming and thawing of milk should not be done in the microwave. Thawing can be accomplished by placing the frozen milk in the refrigerator overnight, or with the use of a bowl of warm water or running warm water.59 Once thawed, the milk should not be refrozen but can be stored in the refrigerator for 24 hours. Because any thawed milk that has been partially consumed must be discarded, it is advisable to use small containers to avoid unnecessary waste.

Supplementation

Routine supplementation of healthy, term breastfeeding infants is not recommended unless medically indicated. Mothers who supplement their nursing infants with infant formula are at risk of a decrease in their milk supply caused by decreased demand. In addition to potential loss of milk, supplementation should be used only when medically indicated60 because it can also interfere with other psychosocial and neurodevelopmental benefits of breastfeeding. (Note the American Academy of Family Physicians [AAFP] policy on Hospital Use of Formula in Breastfeeding Infants in Appendix 4). Common situations that require infant supplementation include infant hypoglycemia not responsive to breastfeeding, insufficient maternal milk supply, delay in lactation, excessive infant weight loss, infant illness such that feeding at the breast is not effective, and maternal-infant separation.61

Supplementation may be done with expressed mother’s milk, pasteurized human milk from a donor, or infant formula. Methods of supplementation include cup feeding, finger feeding with a syringe attached to a feeding tube, using a supplemental feeding tube at the breast, and bottle feeding. One method is not necessarily more suitable than another, and the choice of method depends on individual evaluation of the mother-infant pair. Parents need professional guidance when supplementation is necessary, and consultation with a certified lactation consultant or other knowledgeable health care professional is recommended.

Sunlight has historically been the primary source of vitamin D for humans. Human mothers and babies receive much less sun exposure than they historically did because of urban/indoor lifestyles, migration, and sun avoidance or use of sunscreens to prevent skin cancer. Human milk contains low levels of vitamin D, leaving breastfed babies, especially dark-skinned babies, at increased risk of rickets. It is recommended that all babies receive 400 IU of vitamin D supplementation daily beginning soon after birth. Babies receiving 500 mL or more of vitamin D-fortified infant formula do not need additional vitamin D supplementation.62 Recent studies suggest that it may be possible to supplement breastfeeding mothers to a high enough level to meet the needs of the breastfeeding infant through mother’s milk.63 It is also important to supplement pregnant women so that babies are born with sufficient vitamin D levels.64

Breastfeeding and the Preterm Infant

The period following the birth of a premature infant can be overwhelming for families. The advice and support of a trusted family physician can be invaluable to parents confronted with unforeseen decisions and numerous uncertainties. Some relatively mature preterm infants may be able to breastfeed right away. Family physicians can provide immediate guidance on maintaining lactation when mother-infant separation is required.

Preterm human milk differs from term human milk, in that it has a higher concentration of protein, immunoglobulin A, infection-fighting cells, immune modulators, and anti-inflammatory factors, and it provides
short- and long-term health advantages for preterm infants. Premature infants who receive their mother’s milk have a decreased risk of necrotizing enterocolitis, improved gut motility and maturation, improved neurodevelopmental outcomes and reduced rates of sepsis and retinopathy of prematurity compared with infants who receive milk substitutes. The decrease in necrotizing enterocolitis appears to outweigh any short-term increase in growth achieved with preterm formula feeding.

Evidence of improved feeding tolerance, earlier full enteral feeds, and decreased risk of atopic diseases has been inconsistent to date. A meta-analysis of 20 studies concluded that breastfeeding is associated with long-term cognitive advantages and that preterm infants derive more benefit than full-term infants. Other long-term health benefits from human milk feeding in the preterm infant include decreased risk of metabolic syndrome and hypertension, decreased insulin and leptin resistance, and lower low-density lipoprotein levels.

Preterm infants who are provided human milk in the neonatal intensive care unit (NICU) have lower rates of rehospitalization. Human milk also has been associated with enhanced retinal development and visual acuity in preterm infants. However, protein fortification may be necessary for smaller or more fragile preterm infants.

Studies have shown that preterm infants show greater cardiac and respiratory stability when breastfeeding rather than bottle-feeding. Therefore, initiating breastfeeding in preterm infants does not require the demonstrated ability to bottle-feed. In addition to promoting physiologic stability in premature infants, skin-to-skin contact (i.e., “kangaroo care”) increases maternal milk supply and breastfeeding rates.

Mothers of preterm infants should be presented with information about the benefits of breastfeeding and human milk for the premature infant. A woman who is hesitant to make a long-term commitment to breastfeeding can be encouraged to nurse or express colostrum and milk for her infant until hospital discharge. The mother of a preterm infant faces many challenges, such as infant illness; maternal-infant separation; infant feeding difficulties at the breast; the possibility of prolonged pumping; and the emotional and physical stress of juggling personal care with other commitments to her family, job, and newborn. When family physicians work as part of a medical team of neonatologists, nurses, social workers, dietitians, and lactation consultants, they can be effective in supporting the successful initiation and continuation of breastfeeding the preterm infant.

Breastfeeding the Late Preterm Infant

Newborns born at 35 to 37 weeks of gestation have special nutritional needs and require extra lactation support compared with newborns who are full term. These babies tend to be sleepy and are at high risk of not feeding effectively enough at the breast to support sufficient growth. This increases their risk of hypoglycemia and dehydration. Because of their relative immaturity, they are also at risk of delayed hepatic bilirubin excretion leading to jaundice. These babies require monitoring of adequate breast milk intake and often need supplementation of expressed colostrum or mother’s milk until they are sufficiently vigorous at the breast to maintain proper growth.

Donor Milk

There are 17 nonprofit human milk banks in the United States and Canada that are members of the Human Milk Banking Association of North America, with four additional banks in the developing stage (www.hmbana.org). Each milk bank carefully screens donors and then pasteurizes and distributes human milk from donors to a variety of infant and child populations in need. Banked pasteurized human milk from donors has been found to be safe and nutritionally sound for babies who do not have access to their own mother’s milk. Certain premature infants, such as those weighing less than 1,500 g (3 lb, 4 oz), generally need the protein fortification of banked donor milk to achieve optimal growth.

In recent years, a new trend of casual milk sharing has emerged among some mothers, in which unpasteurized milk is shared with or sold to other mothers, without benefit of medical screening. One study found that milk purchased anonymously over the Internet frequently was contaminated, though these results may not be generalizable to situations in which donor and recipient mothers are acquainted and shipping is not necessary. Mothers accepting milk from unscreened donors should be warned of the potential dangers, including possible transmission of HIV, hepatitis, and other infectious diseases; unknown hygiene of collection and storage.
techniques; and unknown medication history of the donor mother. Age and health status of the recipient baby should also be considered, and mothers should make a fully informed decision in their particular situation, weighing the risks of unscreened and unpasteurized human milk from a donor versus risks of artificial infant formula.

Breastfeeding Multiples

Mothers of twins and higher order multiples should be encouraged to breastfeed. In highly motivated mothers and those with good support, breastfeeding initiation rates in twins can be as high as 70% to 90%. Mothers of multiples will need additional support for breastfeeding. Most mothers can fully breastfeed twins. Success with breastfeeding triplets and even quadruplets has been reported. A consistent concern about breastfeeding multiples is whether there will be enough supply. One study showed adequate supply, with mothers of twins producing twice the volume of milk with adequate nutrient composition compared with mothers of singletons, and mothers of triplets capable of producing more than three liters per day. Wet nurses in France in the 17th century were reported to breastfeed three to six infants, often of different ages and requirements. Encouraging simultaneous feedings may be helpful to the breastfeeding mother of multiples, and attendance at support groups also can be beneficial.

Physicians need to recognize that, while breastfeeding multiples is a challenge, with support, it can be successful. They must be prepared to counsel prior to delivery and support breastfeeding with reassurance of adequate supply, along with the usual recommendations of proper rest, nutritious diet, and the need for intensive support and help. Physicians should be familiar with techniques for increasing milk supply and recognize that even partial breastfeeding is beneficial.

Adoptive Breastfeeding

Family physicians often care for adoptive parents. The physician should discuss with the adoptive mother the option to breastfeed her child.

A knowledgeable physician or lactation consultant may help the mother develop a milk supply before or after an adoption. The family physician who is supporting lactation induction or relactation should begin as early as possible in the adoptive process. The physician should facilitate placing the newborn to the breast as soon as possible after the birth of the adopted child. Many adoptive mothers are physiologically capable of producing milk, to a greater or lesser extent. A multiparous woman will likely produce significantly more milk than a nulliparous mother. Although the adoptive mother may not develop a full milk supply, with induced lactation techniques and the use of galactagogues, it is often possible to provide a significant amount of mother’s milk. It is also important to be knowledgeable about the informal milk-sharing resources in communities and on the Internet and to counsel adoptive mothers about the potential risks of such arrangements. Suckling at the breast has developmental advantages for babies. In many cases, the opportunity to emotionally bond during nursing is the primary benefit of breastfeeding for adoptive mothers and babies.

Nursing Beyond Infancy

As recommended by the World Health Organization, breastfeeding ideally should continue beyond infancy, but this is not the cultural norm in the United States and requires ongoing support and encouragement. It has been estimated that a natural weaning age for humans is between two and seven years. Family physicians should be knowledgeable regarding the ongoing benefits to the child of extended breastfeeding, including continued immune protection, better social adjustment, and availability of a sustainable food source in times of emergency. The longer women breastfeed, the greater the decrease in their risk of breast cancer. Mothers who have immigrated from cultures in which breastfeeding beyond infancy is routine should be encouraged to continue this tradition. There is no evidence that extended breastfeeding is harmful to mother or child. Emerging research on nutrient content of human milk into the second year of lactation suggests that breast milk continues to offer significant nutritional and immunological benefits. Breastfeeding during a subsequent pregnancy is not
unusual. If the pregnancy is normal and the mother is healthy, breastfeeding during pregnancy is the woman’s personal decision. If the child is younger than two years, the child is at increased risk of illness if weaned.

Breastfeeding the nursing child during pregnancy and after delivery of the next child (tandem nursing) may help provide a smooth transition psychologically for the older child.5

**Weaning**

Weaning has nutritional, behavioral, and psychosocial components. From a strictly nutritional perspective, weaning is the gradual process of transitioning infants from mother’s milk to complementary foods and, ultimately, to an older child’s diet. In this sense, weaning begins with the introduction of solids around the middle of the first year. Complete weaning, or complete cessation of breastfeeding, ideally should be a gradual process accomplished over a long period. There is no evidence that a specific age of weaning is necessary or mandated. Like other developmental milestones, weaning takes place when a child is ready, physically and psychologically. Anthropological data suggest a wide range of normal self-weaning ages, from 2.5 to 7 years of age.92 As mother’s milk decreases in nutritional importance in the growing child’s diet and complementary foods are added for additional needed protein, minerals, and other nutrients, behavioral and psychosocial factors become more important in the bonding and comforting aspects of nursing.

The role of the family physician involves knowledge of the physiologic norm for weaning and the provision of culturally sensitive anticipatory guidance and counseling to mothers and families during the process. It is important to recognize and counsel mothers about the difference between weaning and a nursing strike because mothers may misinterpret an abrupt breast refusal—especially in an infant younger than one year of age—as a sign that the baby is ready to wean. It is also important to avoid inappropriate recommendations for premature weaning for noncontraindications.

If the mother chooses to wean, she can be supported to go about it gradually to lessen the risk of engorgement, plugged ducts, galactoceles, mastitis, and breast abscess for herself; emotional trauma for herself and the child; and the risk of infectious illnesses, dehydration, and malnutrition in the child.

Medications to decrease or stop milk production are not necessary and should be avoided. If the mother is interested, she can be encouraged to try a partial, rather than complete, weaning. In rare cases in which abrupt weaning is necessary, the advice of a lactation consultant should be sought to minimize the risks. Regardless of the reasons for weaning, whether premature and abrupt or gradual and mother- or child-led, many mothers feel a sense of grief or loss as breastfeeding ends.97 The family physician can provide anticipatory guidance and support for the mother and the family during this phase.

**Father’s Role in Breastfeeding Support**

In the United States, the role of the father has been shown to be one of the most powerful influences on a mother’s decision to breastfeed.98–100 To support and increase breastfeeding initiation and continuation, the father’s opinion, attitude, and knowledge about breastfeeding and his relationship to his baby and the baby’s mother must be considered.101

Approval and support of breastfeeding by the father is associated strongly with the decision to breastfeed.100 Mothers who perceive their partners to prefer formula or to be ambivalent about the feeding method are significantly more likely to discontinue breastfeeding before discharge compared with those who perceive their partners as being supportive.102 If the mother thinks that the father has a negative attitude toward breastfeeding—even if that perception is incorrect—she is more likely to bottle-feed.103

Much of the focus on breastfeeding support is on the maternal-infant dyad. This focus may lead some fathers to feel excluded and resentful of breastfeeding.104 The father’s negative perceptions of breastfeeding’s potential negative effects on sexual relations or breast appearance also can lead the mother to bottle-feed.104, 105

In general, fathers whose children are bottle-fed have poor knowledge about breastfeeding. Fathers who had previous breastfed children, had attended breastfeeding classes, and had received information about breastfeeding from medical personnel had a significantly higher chance of having a better knowledge about
Providing postpartum advice and educational materials to fathers is associated with higher incidence of exclusive breastfeeding or receiving maternal milk within the first three months. If the decision by the mother to breastfeed is made after she becomes pregnant and not before, she is more likely to discontinue breastfeeding before discharge, so it is important for the couple to begin discussing breastfeeding before pregnancy.

For fathers who have no breastfeeding role models, who have not discussed breastfeeding with their partner, or who have not attended a breastfeeding class, their first exposure to breastfeeding may be at the time of delivery. Family physicians must encourage pre-pregnancy and prenatal participation by fathers to promote breastfeeding. Family physicians who provide maternity care should include fathers in the prenatal visits and invite their questions or concerns about breastfeeding.

Five main attributes of father support in relationship to successful breastfeeding have been identified: (1) knowledge about breastfeeding; (2) positive attitude toward breastfeeding; (3) involvement in the decision-making process; (4) practical support; and (5) emotional support. Family physicians must be prepared to help support these paternal attributes, to educate fathers on the benefits of breastfeeding for mother and baby, and to dispel any myths and misperceptions fathers may have. They need to understand that what they may perceive as problems, such as soreness, physiologic infant weight loss, jaundice, baby fussiness, and frequency of feedings, especially at night, do not necessitate a switch to formula.

**Adolescents and Breastfeeding**

Although teenage mothers share issues with their adult peers, they also face many unique pressures. The family physician is well positioned to assist the pregnant and breastfeeding teenager and her family. All adolescent mothers should be encouraged to breastfeed. Many adults in the United States may have a negative attitude toward the pregnant teenager. It is essential for the family physician to be aware of these negative attitudes, including his or her own feelings. The family physician can help pregnant teenagers cope with these issues and encourage breastfeeding. Enlisting and educating the teenager’s support system is important; including her own mother and other female relatives, peers, friends, and the baby’s father, may make the difference. Since teenage mothers living with their own mothers may be at especially high risk of early weaning, maternal grandmothers should be included with the adolescent mother in all counseling sessions on breastfeeding. Peer counseling by other breastfeeding teenagers can be powerful. Adolescents usually are interested in learning about the practical issues of breastfeeding and learn quickly. However, they often may have an incorrect understanding, and dispelling myths is key.

Pregnant and breastfeeding adolescents often have significant concerns about body image. These concerns can be addressed by providing positive images of discreet breastfeeding and educating teens about changes that will occur during pregnancy and breastfeeding. Often, teenagers are disinclined to bring up such concerns, but, if asked, they are willing to discuss body image concerns, as well as issues such as sexuality and contraception. Because teenagers worry about their changing bodies, it is important to share information about proper nutrition, diet, exercise, and weight loss proactively with the mother and those in her support system.

Continued support of the adolescent mother will help her maintain breastfeeding. It is also important to help create environments suitable for her success in breastfeeding. The physician may need to advocate on the mother’s behalf at school or work to provide time for breastfeeding and pumping. In addition, anticipatory guidance about her baby’s growth and development, as well as ongoing parenting education, will help the mother and her family to maintain breastfeeding as part of her lifestyle.

**Breastfeeding in Underserved Populations**

Since the enactment of the Patient Protection and Affordable Care Act (ACA) in 2010, an estimated 19 million women have become covered by the breastfeeding provisions. ACA protections for expressing breast milk in the workplace will serve to equalize opportunities for breastfeeding across lines of socioeconomic status. Employment and breastfeeding will be more compatible for those who historically have faced the greatest challenges combining these activities.
Women in a relatively weak position in the labor market, including those who are poor, young, do not hold a college diploma, or are African American, also historically have had low rates of breastfeeding. These women most often are covered by ACA workplace breastfeeding protections. This first estimate of coverage is based on an analysis of the 2009 Annual Social Economic Supplement to the Current Population Survey. The ACA provisions therefore appropriately target mothers who are most likely to benefit from the provisions.

Slightly more than 25,000 mothers living in poverty do not breastfeed their infants through six months of age because of stringent work requirements under the Temporary Assistance to Needy Families program. Conservative estimates suggest that an overlapping group of 16,500 mothers living in poverty will likely breastfeed as a result of the ACA provisions, partly redressing some of the effects of welfare reform.

Unfortunately, the ACA’s requirement of coverage of “breastfeeding support, supplies, and counseling” applies only to private health care plans. It does not apply to Medicaid; rather, coverage decisions for Medicaid are managed at the state level. In 2012, the Centers for Medicare & Medicaid Services published an issue brief on Medicaid coverage of lactation services. The United States Breastfeeding Committee encourages states to go beyond current requirements to include lactation services as separately reimbursed pregnancy-related services and provides examples of current state practices.

Issues of Ethnicity and Culture

Ethnic subgroups within U.S. society also face significant obstacles to breastfeeding, even when economics is not a factor. First-generation immigrants from countries where breastfeeding is the norm are more likely to breastfeed than are second- and later-generation women. This may be because of convenience, belief in modern food technology, and attempts to acculturate into a society where bottle-feeding is perceived to be the norm. Thus, breastfeeding role models are lost with successive generations. Additionally, accurate breastfeeding information is less available in languages of smaller ethnic minorities. Few lactation consultants or other health care professionals are equipped to help women who speak languages other than English or Spanish. Some ethnic and cultural groups are underrepresented in the lactation consultant field. Many cultures also have unique beliefs about lactation, including rituals regarding milk production, concerns about colostrum, sexual taboos, and beliefs about wet-nursing. These beliefs need to be taken into account when counseling patients about the lactation process.

Family physicians can promote lactation among their patients of various ethnicities and socioeconomic levels in a number of ways, including:

- Learning about the family structure of their patients. Support from key family members may assist greatly in the promotion of breastfeeding. This often will include the baby’s father and maternal grandmother, but could also include a key family decision maker, such as the patriarch or the paternal grandmother.
- Ensuring that parents from diverse cultures understand the importance of breastfeeding to their children’s growth and development.
- Respecting cultural traditions and taboos associated with lactation and adapting cultural beliefs to facilitate optimal breastfeeding, while sensitively educating about traditions that may be detrimental to breastfeeding.
- Encouraging exclusive lactation in the hospital in a culturally sensitive manner.
- Providing all information and instruction, whenever possible, in the mother’s native language in a culturally relevant manner and assessing for literacy level when appropriate.
- Understanding the specific financial, work, and time obstacles to breastfeeding, working with families to overcome them, and providing specific means to address the obstacles.
- Being aware of the role of the physician’s own personal cultural attitudes when interacting with patients.

Military Issues

Military mothers have many issues in common with other employed mothers but also face some unique challenges. There is not a comprehensive Department of Defense policy about breastfeeding, but most branches of the service do have some kind of instruction regarding active-duty women and breastfeeding. The military environment provides unique challenges to breastfeeding servicewomen. In general, active-duty mothers may return to work six weeks after delivery, and mothers are deployable four months postpartum. In partnership with their family physician, servicewomen may request medical extensions when medically indicated. Another challenge is the variety of resources, support, time, and environmental factors that vary from command...
to command. In the military environment, the attitudes of leaders, such as personnel commanders, are important to the success of any breastfeeding program. Family physicians should be aware of the unique challenges these families face and be actively involved in working with the military to educate commanders, supervisors, and peers about the benefits of breastfeeding and how to support maintenance of breastfeeding.

Family Physicians and Breastfeeding Advocacy

Family physicians have many opportunities to advocate for and support breastfeeding because they care for all members of the family, and often the extended family, and practice in a variety of community settings. Family physicians who provide maternity care can advocate for and support breastfeeding before conception, during the pregnancy, and after the delivery; no other specialty has that unique opportunity. Family physicians can serve as breastfeeding advocates in physician offices, hospitals, residency education, medical schools, birthing centers, workplaces, legislatures, and insurance companies.

The AAFP endorses the “Ten Steps to Successful Breastfeeding” for making hospitals and staff more breastfeeding friendly (see Appendix 6). These 10 steps are the core of the Baby Friendly Hospital Initiative (BFHI). While BFHI-designated facilities have been shown to increase breastfeeding rates, successful breastfeeding requires prenatal and post-delivery education and support. Family physicians can play an important role in helping their hospital or birthing facility implement the provisions of the 10 steps and eventually seek BFHI “Baby-Friendly” designation.

Studies have shown that a physician’s recommendation to breastfeed increases breastfeeding initiation and duration rates. Eliminating formula company literature, advertising, and distribution of samples encourages breastfeeding as normal infant feeding. Family physicians need to ensure that office and hospital policies support breastfeeding patients. Family physicians can advocate for breastfeeding in their offices by making their office and staff “breastfeeding friendly.” The Academy of Breastfeeding Medicine’s (ABM) Clinical Protocol #14: Breastfeeding-Friendly Physician’s Office: Optimizing Care for Infants and Children offers guidelines for establishing a breastfeeding-friendly office.

Family physicians should support and advocate for public health policies and research that would increase breastfeeding rates. Recent legislative efforts of states have ensured protection for lactating mothers. Family physicians should promote legislation actively and provide testimony that encourages the ease, safety, and security of breastfeeding on demand. Although an individual family physician is not likely to be involved in all areas of advocacy for breastfeeding, family physicians working together as a group or through their state academies can become effective advocates for breastfeeding patients. Family physicians should advocate for and become involved with breastfeeding-related research aimed at increasing innovative educational models in training programs.

In advocacy for breastfeeding issues related to insurance coverage and workplace changes, the economic benefits of breastfeeding are essential points. Several studies have shown a substantial increase in cost to families, communities, health care systems, and employers when babies are not breastfed. Physicians must be aware of these data to be effective advocates in promoting change in policies regarding breastfeeding.

Family physicians have assumed many administrative roles in hospitals, managed care plans, insurance companies, and large physician organizations. In these roles, family physicians are in a position to promote breastfeeding and ensure appropriate payment for lactation services provided by physicians or lactation consultants. Family physicians should advocate for improved access to lactation services by encouraging increased availability of lactation consultants.

Family physicians are active and influential in their communities. By projecting a positive attitude toward breastfeeding in the office and the community, they can strongly affect a patient’s decision to breastfeed. The U.S. Preventive Services Task Force recommends structured breastfeeding education and counseling to improve breastfeeding rates. Family physicians provide a wealth of patient education in their offices. As a part of their health education and promotion activities in schools, family physicians should incorporate breastfeeding into their education for boys and girls. Making breastfeeding education available to all family and community members will make breastfeeding the community norm.
References


77. ABM clinical protocol #10: breastfeeding the late preterm infant (34(0/7) to 36(6/7) weeks gestation) (first revision June 2011). Breastfeed Med, 2011. 6(3): 151-156.


Appendix 3: Education of Medical Students and Family Medicine Residents

**Medical Students**

In the preclinical years, courses in anatomy, physiology, and biochemistry, among others, should include aspects pertinent to lactation. These include anatomy of a lactating breast and how this relates to baby’s latch-on, physiology of milk production and the milk ejection reflex, and biochemistry of human milk and the vast differences in artificial substitutes. Aspects of lactation relevant to particular disciplines could be integrated into the existing curriculum. For example, the basics of the passage of medications into human milk could be incorporated into the pharmacology course. In the introductory clinical course, students should be taught how to take a breastfeeding history (when appropriate) and how to examine lactating breasts. In the clinical years, patient care experience in family medicine, obstetrics, and pediatrics should include instruction in care for normal breastfeeding mothers and babies and in common breastfeeding problems.

**Family Medicine Residency**

The family medicine residency curriculum should reinforce the concept that breastfeeding is the physiologic norm for mothers and children. All aspects of normal breastfeeding and management of common problems should be covered and integrated longitudinally in the three-year residency curriculum. The American Academy of Pediatrics has developed a residency curriculum that is easily modified for use in family medicine residencies. This curriculum, which includes advocacy, community outreach, coordination of care, anatomy and physiology, basic skills, peripartum support, ambulatory management, and cultural competency, has been shown to improve breastfeeding outcomes for patients cared for by family medicine residents, pediatric residents, and OB-GYN residents.

Specific elective experiences in breastfeeding medicine should be made available for residents who want more intensive education. Multidisciplinary breastfeeding education has proven beneficial to interns across primary care. Residency practices should model support of their breastfeeding patients. Specific support also should be
provided for medical students and residents (and other staff members) who are breastfeeding. Evidence shows that physicians tend to base their breastfeeding advice on their personal experiences.5

All family physicians should be trained to understand and practice according to the United States Breastfeeding Committee (USBC) Core Competencies.

Core Competencies in Breastfeeding Care and Services for All Health Professionals

(Endorsed by the American Academy of Family Physicians)

Revised Edition

About USBC

The United States Breastfeeding Committee (USBC) is an independent nonprofit coalition of more than 40 nationally influential professional, educational, and governmental organizations. Representing over half a million concerned professionals and the families they serve, USBC and its member organizations share a common mission to improve the Nation’s health by working collaboratively to protect, promote, and support breastfeeding. For more information, visit www.usbreastfeeding.org.

Background

Breastfeeding is a basic and cost-effective measure that has a significant positive impact on short- and long-term health outcomes for individuals and populations.6 The greatest health impact is found with early initiation, exclusive breastfeeding for the first six months of life, and continued breastfeeding with appropriate complementary foods for the first year of life and beyond.7 Lack of breastfeeding is a significant risk to the public health of our nation and increases health care spending.8

In order to establish and maintain breastfeeding, women need education and support from a knowledgeable health care community.9 Evidence-based knowledge, skills, and attitudes are lacking among health professionals in many disciplines.10 The volume of new information, advances in treatments and technologies, and health care system challenges, combined with the relative paucity of professional training in human lactation and breastfeeding, leave many providers without satisfactory answers for their patients.11, 12

Purpose

These core competencies in breastfeeding care and services were developed to provide health professionals with a guideline and framework to integrate evidence-based breastfeeding knowledge, skills, and attitudes into their standard health care delivery practices. The United States Breastfeeding Committee recommends that all health professionals possess the core competencies identified in this document in order to integrate breastfeeding care effectively and responsibly into current practice and thus provide effective and comprehensive services to mothers, children, and families.

Effecting Change

Educators are in a unique position to lead the way by incorporating these core competencies into the undergraduate, graduate, and post-graduate curricula of health professionals.2, 13-15 These core competencies provide a structure for educators to respond to the emerging necessity of educating all health care providers regarding breastfeeding and human lactation in the context of findings from the World Health Organization (WHO)16 and the Agency for Healthcare Research and Quality (AHRQ).17

Maternal and child health (MCH) education and practice is based upon a life cycle framework that recognizes that there are pivotal periods in human development that present both risks and opportunities for improving health outcomes for individuals and populations.18 In particular, USBC calls upon MCH leaders to emphasize the synergistic value of these breastfeeding core competences to the health of women, children, and families.
Breastfeeding Core Competencies

Competence in the following areas represents the minimal knowledge, skills, and attitudes necessary for health professionals from all disciplines to provide patient care that protects, promotes, and supports breastfeeding. At a minimum, every health professional should understand the role of lactation, human milk, and breastfeeding in:

- The optimal feeding of infants and young children\(^8\), \(^19\)
- Enhancing health and reducing:
  - long-term morbidities in infants and young children\(^7\), \(^19\)
  - morbidities in women\(^19\), \(^20\)

All health professionals should be able to facilitate the breastfeeding care process by:

- Preparing families for realistic expectations
- Communicating pertinent information to the lactation care team\(^21\)
- Following up with the family, when appropriate, in a culturally competent manner after breastfeeding care and services have been provided\(^22\)

USBC proposes to accomplish this by recommending that health professional organizations:

- Understand and act upon the importance of protecting, promoting, and supporting breastfeeding as a public health priority\(^7\), \(^8\), \(^20\), \(^23\), \(^24\)
- Educate their practitioners to:
  - appreciate the limitations of their breastfeeding care expertise\(^21\), \(^25\)
  - know when and how to make a referral to a lactation care professional\(^21\), \(^25\)

Regularly examine the care practices of their practitioners and establish core competencies related to breastfeeding care and services\(^24\), \(^26\)

Knowledge

All health professionals should understand the:

1.1 basic anatomy and physiology of the breast\(^13\), \(^27\)
1.2 role of breastfeeding and human milk in maintaining health and preventing disease\(^7\), \(^19\)
1.3 importance of exclusive breastfeeding, and its correlation with optimal health outcomes\(^19\), \(^28\)
1.4 impact of pregnancy, birth, and other health care practices on breastfeeding outcomes\(^23\), \(^29\)
1.5 role of behavioral, cultural, social, and environmental factors in infant feeding decisions and practices\(^30\), \(^31\)
1.6 potentially adverse outcomes for infants and mothers who do not breastfeed\(^32\)
1.7 potential problems associated with the use of human milk substitutes\(^33\)
1.8 few evidence-based contraindications to breastfeeding\(^34\), \(^35\)
1.9 indications for referral to lactation services\(^21\)
1.10 resources available to assist mothers seeking breastfeeding and lactation information or services\(^34\), \(^36\)
1.11 effects of marketing of human milk substitutes on the decision to breastfeed and the duration of breastfeeding\(^6\), \(^37\), \(^38\)

Skills

All health professionals should be able to:

2.1 practice in a manner that protects, promotes, and supports breastfeeding\(^7\), \(^8\), \(^20\), \(^26\)
2.2 gather breastfeeding history information sufficient to identify mothers and families who would benefit
from specific breastfeeding support services
2.3 seek assistance from and refer to appropriate lactation specialists
2.4 safeguard privacy and confidentiality
2.5 effectively use new information technologies to obtain current evidence-based information about breastfeeding and human lactation

Attitudes

All health professionals should:

3.1 value breastfeeding as an important health promotion and disease prevention strategy
3.2 recognize and respect philosophical, cultural, and ethical perspectives influencing the use and delivery of breastfeeding care and services
3.3 respect the confidential nature of the provision of breastfeeding care and services
3.4 recognize the importance of delivering breastfeeding care and services that are free of commercial conflict of interest or personal bias
3.5 understand the importance of tailoring information and services to the family's culture, knowledge, and language level
3.6 seek coordination and collaboration with interdisciplinary teams of health professionals
3.7 recognize the limitations of their own lactation knowledge and breastfeeding expertise
3.8 recognize when personal values and biases may affect or interfere with breastfeeding care and services provided to families
3.9 encourage workplace support for breastfeeding
3.10 support breastfeeding colleagues
3.11 support family-centered policies at federal, state, and local levels

All health professionals do not need to have the level of competence expected of those practitioners who care for childbearing women, infants, and young children. Health professionals who care for childbearing women, infants, and young children can be further divided into two groups:

1. Those that provide primary care are front-line practitioners who care for women of childbearing age and/or infants and young children.
2. Those that provide secondary care may be front-line practitioners or practitioners with enhanced knowledge and skills specifically referable to the use of human milk and breastfeeding.

Those health professionals who provide primary and secondary care for childbearing women, infants, and young children should be able to:

4.1 understand the evidence-based Ten Steps to Successful Breastfeeding
4.2 obtain an appropriate breastfeeding history
4.3 provide mothers with evidence-based breastfeeding information
4.4 use effective counseling skills
4.5 offer strategies to address problems and concerns in order to maintain breastfeeding
4.6 know how and when to integrate technology and equipment to support breastfeeding
4.7 collaborate and/or refer for complex breastfeeding situations
4.8 provide and encourage use of culturally appropriate education materials
4.9 share evidence-based knowledge and clinical skills with other health professionals
4.10 preserve breastfeeding under adverse conditions

In addition, those health professionals who provide secondary or more direct “hands-on” care for childbearing women, infants, and young children should also be able to:

5.1 assist in early initiation of breastfeeding
5.2 assess the lactating breast
5.3 perform an infant feeding observation\textsuperscript{41, 55}
5.4 recognize normal and abnormal infant feeding patterns\textsuperscript{55, 56}
5.5 develop and appropriately communicate a breastfeeding care plan\textsuperscript{55, 56}

References


Appendix 4: AAFP Policies Related to Breastfeeding

AAFP Policy Statement on Breastfeeding

AAFP Policy Statement on Hospital Use of Infant Formula in Breastfeeding Infants

AAFP Policy Statement on Breastfeeding Accommodations for Trainees

Appendix 5: Resources for Family Physicians and Other Health Care Professionals

The following is a limited list of references and resources to assist family physicians in their efforts to support recommendations of the American Academy of Family Physicians (AAFP) position paper on breastfeeding.

Government Support Services

Centers for Disease Control and Prevention (CDC) (www.cdc.gov)

www.cdc.gov/breastfeeding (www.cdc.gov)

The CDC is committed to increasing breastfeeding rates throughout the United States and to promoting optimal breastfeeding practices as a means of improving the public’s health.

Resources:

- Maternity Practices in Infant Nutrition and Care (mPINC) is a national survey of maternity care practices and policies that is conducted by the CDC. The survey is administered to all hospitals and birth centers with registered maternity beds in the United States and U.S. territories.
- CDC Guide to Strategies to Support Breastfeeding Mothers and Babies.
- Breastfeeding Report Card, by State

The National Women’s Health Information Center

www.womenshealth.gov/breastfeeding (www.womenshealth.gov)

A project of the U.S. Department of Health and Human Services (HHS) Office on Women’s Health

Resources:

- HHS Blueprint for Action on Breastfeeding
- The Business Case for Breastfeeding
- Breastfeeding: Best for Baby, Best for Mom

State Departments of Public Health

Many states have comprehensive programs that support breastfeeding and breastfeeding education.

State Universities

Many state universities or extension services offer information, training materials, and educational opportunities for physicians and other health care professionals.

National Library of Medicine Drug and Lactation Database (toxnet.nlm.nih.gov)
Resources:

- LactMed is a user-friendly source for information on the use of drugs and other chemicals to which breastfeeding mothers may be exposed.

Surgeon General
(www.surgeongeneral.gov)


Resources:

- The Surgeon General’s Call to Action to Support Breastfeeding – 2011

Print and Internet Resources

Breastfeeding: A Guide for the Medical Profession
Ruth A. Lawrence, Robert M. Lawrence 7th ed. (2011)
Mosby, Inc.

Breastfeeding Handbook for Physicians
American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG) 2nd ed. (2014)
www.aap.org/bookstore(www.aap.org)

Breastfeeding and Human Lactation
Jan Riordan
Jones and Bartlett Publishers

Gerald G. Briggs; Roger K. Freeman; Sumner J. Yaffe
9th ed. (2011)
Lippincott, Williams & Wilkins

Medications and Mothers’ Milk 2012
Thomas W. Hale, PhD
Hale Publishing

Nonprescription Drugs for the Breastfeeding Mother
Frank J. Nice RPh, DPA, CPHP
2nd ed. (2011)
Hale Publishing

Textbook of Human Lactation
Thomas W. Hale, PhD; Peter Hartmann, PhD
2007
Hale Publishing

Lactation Management: Strategies for Working with African-American Moms
Katherine Barber
2013
Hale Publishing L.P.

Organizations and Educational Resources for Physicians
American Academy of Family Physicians
www.aafp.org
A national organization representing more than 115,000 members who provide comprehensive, coordinated, and continuing care to all members of the family and serve as the patient’s advocate in the changing health care system. Breastfeeding support materials and continuing medical education (CME) training are available.

Resources:
- AAFP Policy Statement on Breastfeeding
- The AAFP Commission on Health of the Public and Science coordinates breastfeeding-related clinical information and policy.
- Additional courses with AAFP Prescribed credit are listed in the AAFP CME database.

American Academy of Pediatrics
www.aap.org
Resources
- Policy Statement, Section on Breastfeeding – Breastfeeding and the Use of Human Milk
- Breastfeeding Promotion in Physicians’ Office Practices Program (BPPOP III) provides support for pediatric, obstetric, and family medicine residents; practicing physicians; and other health care professionals in effective breastfeeding promotion and management (www2.aap.org/breastfeeding/curriculum/index.html).

Academy of Breastfeeding Medicine
www.bfmed.org
A worldwide organization of physicians dedicated to the promotion, protection, and support of breastfeeding and human lactation. Membership is open to all physicians.

Resources:
- Fellowship (FABM) recognizes physicians with additional training, experience, and knowledge in the clinical, research, academic, or public policy areas of breastfeeding medicine
- Breastfeeding Medicine: A peer-reviewed physician journal
- Academy of Breastfeeding Medicine Annual International Meeting: Offers the “What Every Physician Needs to Know about Breastfeeding” pre-conference course and a health team meeting for nonphysician health professionals

Breastfeeding Basics
www.breastfeedingbasics.org
Resources:
An online short course on the fundamentals of breastfeeding; geared primarily for the medical professional.

Wellstart International
www.wellstart.org
A nonprofit organization that promotes maternal and child health, specializing in the area of breastfeeding. Wellstart provides educational opportunities for perinatal health care professionals, focusing on the scientific basis and management of human lactation.

Resources:
- Lactation Management Curriculum – A Faculty Guide for Schools of Medicine, Nursing, and Nutrition
- Lactation Management Self-Study Modules, Level 1

American Congress of Obstetricians and Gynecologists
www.acog.org/breastfeeding
Resources:
- “Breastfeeding in Underserved Women: Increasing Initiation and Continuation of Breastfeeding.” Committee Opinion #570
- “Breastfeeding: Maternal and Infant Aspects.” Committee Opinion #361: Provides a brief introduction to concepts detailed in a special report from the American Congress of Obstetricians and Gynecologists of the

La Leche League International  
[www.llli.org](www.llli.org)  
Their mission is to help mothers worldwide to breastfeed through mother-to-mother support, encouragement, information, and education, and to promote a better understanding of breastfeeding as an important element in the healthy development of the baby and the mother.  

**Resources:**  
- *The Womanly Art of Breastfeeding*, 8th revised ed. (July 2010)  
- Numerous resources on breastfeeding, the law, and education  
- International Board of Lactation Consultant Examiners  
  [www.iblce.org](www.iblce.org)  
The internationally recognized certifying agency for lactation consultants.

International Lactation Consultants Association  
[www.ilca.org](www.ilca.org)  
The professional association for International Board Certified Lactation Consultants (IBCLCs) and other health care professionals who care for breastfeeding families.  

**Resources:**  
- *Journal of Human Lactation*

The Joint Commission  
[www.jointcommission.org/perinatal_care](www.jointcommission.org/perinatal_care)  
An independent, not-for-profit organization that accredits and certifies more than 20,500 health care organizations and programs in the United States.  

**Resources:**  
- *Speak Up: What you need to know about breastfeeding*  
- Perinatal Care Core Measure: Includes a performance measurement for “exclusive breastfeeding.”  
  Mandatory for all hospitals with >1,100 births per year, effective January 1, 2014.

United States Breastfeeding Committee  
[www.usbreastfeeding.org](www.usbreastfeeding.org)  
Composed of representatives from health care professional associations, relevant government departments, and nongovernmental organizations organized for coordination of breastfeeding activities in the United States.  

World Alliance for Breastfeeding Action  
[www.waba.org.my](www.waba.org.my)  
A global network of individuals and organizations concerned with the protection, promotion, and support of breastfeeding worldwide.

Appendix 6: National and International Breastfeeding Initiatives  

The Baby-Friendly Hospital Initiative  
[www.babyfriendlyusa.org](www.babyfriendlyusa.org)  

The Baby-Friendly Hospital Initiative (BFHI) is a worldwide project of UNICEF and the World Health Organization (WHO). The goal of the initiative is to recognize hospitals and birth centers that take special steps to provide an optimal environment for breastfeeding and implement the “Ten Steps to Successful Breastfeeding.” Baby-Friendly USA (BFUSA), Inc., is the accrediting body for the BFHI in the United States. In the United States, hospitals and birth centers may take a first step toward receiving “Baby-Friendly” designation through the Certificate of Intent program.

Baby-Friendly facility designation is awarded after a comprehensive process of self-assessment, policy development, staff training, data collection, quality improvement, and BFUSA on-site assessment. The process is guided by the BFHI Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation. Baby-Friendly designation requires successful implementation of the “Ten Steps to Successful Breastfeeding” and the
Ten Steps to Successful Breastfeeding

(Endorsed by the American Academy of Family Physicians)

1. Develop a written breastfeeding policy and routinely communicate it to all health care staff.
2. Train all health care staff in skills necessary to implement the policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within half an hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming-in: Allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

The WHO/UNICEF Code of Marketing of Breast-milk Substitutes

(www.who.int)

www.who.int/nutrition/publications/code_english.pdf

In 1981, the World Health Assembly adopted the International Code of Marketing of Breast-milk Substitutes as a tool to protect breastfeeding. Formula marketing targets women. New mothers are given free samples of formula, babies are given bottles in hospitals, coupons or food samples arrive in the mail, and booklets and videotapes are distributed on breastfeeding and weaning. The Code prohibits marketing of these products in these ways. It covers formula, other milk products, cereals, teas, and juices, as well as bottles and teats.

The Code has significant provisions that require the following:

1. No advertising of any of these products to the public
2. No free samples to mothers
3. No promotion of products in health care facilities, including the distribution of free or low-cost supplies
4. No company sales representatives to advise mothers
5. No gifts or personal samples to health care professionals
6. No words or pictures idealizing artificial feeding or pictures of infants on labels of infant milk containers
7. Information to health care professionals should be scientific and factual
8. ALL information on artificial infant feeding, including that on labels, should explain the benefits of breastfeeding and the costs and hazards associated with artificial feeding
9. Unsuitable products, such as sweetened condensed milk, should not be promoted for infants
10. Manufacturers and distributors should comply with the Code’s provisions, even if countries have not adopted laws or other measures

Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding

(www.unicef-irc.org)


The Innocenti Declaration was produced and adopted by participants at the WHO/UNICEF policymakers’ meeting on “Breastfeeding in the 1990s: A Global Initiative,” co-sponsored by the U.S. Agency for International Development (AID) and the Swedish International Development Authority (SIDA). In 2005, the Innocenti Declaration updated operational targets for action (full text available online at www.unicef-irc.org/publications/pdf/declaration_eng_v.pdf).

The Global Strategy for Infant and Young Child Feeding: Operational Targets (updated 2005):

• Four operational targets from the 1990 Innocenti Declaration:
1. Appoint a national breastfeeding coordinator with appropriate authority, and establish a multisectoral national breastfeeding committee composed of representatives from relevant government departments, nongovernmental organizations, and health care professional associations.

2. Ensure that every facility providing maternity services fully practices the “Ten Steps to Successful Breastfeeding” set out in the WHO/UNICEF statement on breastfeeding and maternity services.


4. Enact imaginative legislation protecting the breastfeeding rights of working women and establish means for its enforcement.

• Five additional operational targets:

5. Develop, implement, monitor, and evaluate a comprehensive policy on infant and young child feeding, in the context of national policies and programs for nutrition, child and reproductive health, and poverty reduction.

6. Ensure that the health and other relevant sectors protect, promote, and support exclusive breastfeeding for six months and continued breastfeeding up to two years of age or beyond, while providing women access to the support they require—in the family, community, and workplace—to achieve this goal.

7. Promote timely, adequate, safe, and appropriate complementary feeding with continued breastfeeding.

8. Provide guidance on feeding infants and young children in exceptionally difficult circumstances and on the related support required by mothers, families, and other caregivers.

9. Consider what new legislation or other suitable measures may be required, as part of a comprehensive policy on infant and young child feeding, to give effect to the principles and aim of the International Code of Marketing of Breast-milk Substitutes and to subsequent relevant Health Assembly resolutions.

Healthy People 2020
(www.healthypeople.gov)

www.healthypeople.gov (www.healthypeople.gov)
Department of Health and Human Services

MICH - Maternal, Infant, Child Health - Breastfeeding Objectives and Targets:

MICH-21.1 Increase the proportion of infants who are ever breastfed: 81.9%
MICH-21.2 Increase the proportion of infants who are breastfed at six months: 60.6%
MICH-21.3 Increase the proportion of infants who are breastfed at one year: 34.1%
MICH-21.4 Increase the proportion of infants who are breastfed exclusively through three months: 46.2%
MICH-21.5 Increase the proportion of infants who are breastfed exclusively through six months: 25.5%
MICH-22 Increase the proportion of employers that have worksite lactation support programs: 38%
MICH-23 Reduce the proportion of breastfed newborns who receive formula supplementation within the first two days of life: 14.2%
MICH-24 Increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies: 8.1%

U.S. Preventive Services Task Force
(www.uspreventiveservicestaskforce.org)

www.uspreventiveservicestaskforce.org/uspstf/uspsbrfd.htm (www.uspreventiveservicestaskforce.org)
An independent, volunteer panel of national experts in prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications.

Recommendation Statement:
The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding. Grade: B recommendation. Date: October 2008

World Health Organization
(www.cdc.gov)

www.cdc.gov/growthcharts/who_charts.htm (www.cdc.gov)
The WHO standards establish growth of the breastfed infant as the norm for growth. Breastfeeding is the
recommended standard for infant feeding. The WHO charts reflect growth patterns among children who were predominantly breastfed for at least four months and were still breastfeeding at 12 months.

Resources:

Business Principles, Undergraduate Medical Education

The American Academy of Family Physicians (AAFP) promote the importance of learning the fundamentals of health policy and health system management early in medical training and supports inclusion of curriculum on health policy and health system management in undergraduate medical education. Furthermore, the AAFP believes this education should include evolving payment models and the range of sustainable practice opportunities available in primary care. (2012 COD) (2017 February Board Chair)
The American Academy Family Physicians supports the Institute of Medicine’s 2013 report, “Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis,” and its recognition of the need for an integrated workforce to address the needs of cancer patients. The role of the family physician should be at all stages of cancer care: cancer diagnosis, referral for specialty care, co-management with specialty care, survivorship management and palliative care before the last six months of life and including hospice care. The following elements of quality care should be accessible for each individual with cancer:

Cancer Diagnosis: Patients should have healthcare access to ensure evidence-based screening and early identification of cancer.

Referral for Specialty Care: Patients should have affordable and accessible options for care. Accurate staging and prognosis should be completed and communicated in language that patients can understand. Treatment options should be presented with a clear explanation of benefit and expected side effects. There should be written communication back to the referring family physician.

Co-management with Specialty Care: The cancer-care workforce should include family physicians and other physicians who can work as part of the care-team for the cancer team. There should be transparent communication between members of the health-care team. An enhanced information system may be able to facilitate this. Co-management should recognize complexity and cost of care and work toward adherence to cost-effective, evidence-based treatment algorithms.

Survivorship Management: Patients should have access to appropriate surveillance and screening tests specific to the cancer they have had, and the anticipated long-term side effects of treatments they have received. The physician workforce, including family physicians, should be educated about the protocols for survivorship management. When possible a transition of care document could be issued to clarify who will be conducting the ongoing surveillance and recommended testing.

Palliative Care: Patients should have access to palliative care before the last six months of life, concurrent with active treatment as well as conventional hospice care. Patients should be engaged and informed of their choices. Patients should be given accurate information about their prognosis and this should be included in documents which are shared with other team-members.

(May 2016 BOD) (2016 COD)
Capitation, Primary Care

See also

- Payment for Non-Face-to-Face Physician Services
- Payment, Physician
- Primary Care

Capitation is a payment arrangement for health care service providers such as physicians. Under capitation, a physician or group of physicians receives a risk adjusted set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care. Primary care capitation, in turn, refers to capitated payments for primary care clinical services only. It does not include payments for other professional, facility, or ancillary services. With regards to primary care capitation for family physicians, it is the position of the AAFP that:

1. The capitation rate should be differentiated based on common risk adjustment factors such as age, sex, health status, prior health care utilization (inpatient, outpatient, pharmacy, home health, durable medical equipment, etc.), socioeconomic status, localized geographic area, insurance status prior to enrollment, and institutional status within the family physician's patient population. Risk-adjustment should take into account factors that can significantly increase utilization to ensure the capitated payment is enough for the necessary primary care services.
2. Any contract which includes capitated payments for primary care services should identify, by Current Procedural Terminology (CPT) code, the services included in the capitation rate which should, in turn, reflect the scope of services included in the rate (e.g., if the scope increases, so should the capitation rate).
3. Health plans should recognize that family physicians have varying scopes of practice, and accordingly, specific services provided by a family physician that are not included in the capitation rate, should be listed by CPT code, and paid for separately.
4. Under full capitation, the rate should explicitly acknowledge and include the family physician's care delivery, management, and coordination functions (i.e., the physician work and practice expense associated with the elements specified in the AAFP's policy on "Care Management Fees" and should increase the overall current investment in primary care.
5. The capitation rate should also cover the cost of any additional practice expenses (e.g., non-physician staff, equipment, information technology, etc.) required to meet the health plan's requirements (e.g., quality assurance, precertification, referral management, credentialing, costs of providing quality improvement/utilization review, outcome data, etc.).
6. Health plans, including those that capitate their physicians, should provide incentives to patients and physicians that encourage care in the most appropriate setting (e.g., lower co-pay for office versus emergency room visit, additional payment for extended office hours, using telehealth/telemedicine, etc.).
7. The delivery and quality of care should not be affected by the method of payment; that is, physicians should not discriminate among patients based on the method of payment.

Care Management Fees

See also

- Primary Care
- Physician Payment

During the past few decades, family physicians increasingly have been challenged to transform the way they deliver care to their patients while still participating in a traditional fee-for-service (FFS) payment environment. However, substantial transformations in health care delivery systems can only be effective if accompanied by the adoption of innovative payment models.

One innovation that is growing in popularity is the blended payment model. In this model, a practice functioning as a patient-centered medical home (PCMH) is paid a combination (i.e., a “blend”) of enhanced FFS payment, incentives for quality performance, and a per member per month (PMPM) care management fee to cover care that falls outside of the traditional office visit.

The term “care management” refers to activities performed by health care professionals with a goal of facilitating appropriate patient care across the health care system. In order to increase patient satisfaction and improve outcomes (e.g., greater adherence to treatment recommendations; more effective self-management; improved health and wellness), care management programs provide services that typically are not reimbursed under traditional, FFS payment models. These services include patient education; medication management and adherence support; risk stratification; population management; and coordination of care transitions; and care planning.

The PMPM care management fee is not intended to defray start-up costs associated with implementing a care management program, nor to provide payment to practices for improved outcomes and/or savings that result from their care management efforts. Such additional payments are an important part of a blended payment model; however, they are distinct from reimbursement for care management services. The American Academy of Family Physicians (AAFP) considers the following eight elements to be core activities covered by a PMPM care management fee within the context of a PCMH.

ELEMENT 1: Nonphysician staff time dedicated to care management

Nonphysician staff can range from a full-time care manager who oversees all care management activities in the practice to part-time staff members who provide one-on-one care management and support to an assigned panel of patients. Patient support can be provided on site or remotely (e.g., via telephone or videoconferencing). Staff members who dedicate time to care management may not necessarily be employees of the practice or work at the practice location. Although many advocates emphasize the need for highly educated care management staff—preferably registered nurses or nurse practitioners—the optimal level of education and prior experience for a care manager is still undefined.

ELEMENT 2: Patient education

Health care professionals provide patient education to promote health literacy (i.e., the ability to understand health-related information and use it to make appropriate decisions about one’s health). Regularly scheduled learning sessions and group visits are examples of innovative approaches that care management programs use to engage patients, broaden patients’ knowledge base, encourage behavior change, and teach self-management skills.

ELEMENT 3: Use of advanced technology to support care management

Technology enables practices to provide care management for their patients outside of the traditional face-to-face office visit. Advanced communication tools (e.g., secure email, audio, video, web portals) enable more frequent and timely exchange of information between the patient and the care management team. Patients use in-home electronic devices (e.g., blood glucose meters, weight scales, blood pressure monitors) to collect real-time clinical information that is relevant to managing their care. Telemonitoring devices and services enable patients to transmit information about their vital signs, symptoms, and
behaviors (e.g., blood pressure levels, blood glucose levels, exercise logs, medication schedules) directly to their care management team.

**ELEMENT 4: Physician time dedicated to care management**
Many physicians already spend a substantial amount of time engaged in non-face-to-face care management (e.g., communicating with other health care professionals who provide care for their patients). In addition, physicians often lead or supervise care management services provided by other staff members on the care management team.

**ELEMENT 5: Medication management**
Each patient participating in a care management program should have an individual medication plan. One aspect of a care manager’s role is to provide education and support to ensure that each patient is capable of adhering to his or her medication plan.

**ELEMENT 6: Population risk stratification and management**
Care management programs use risk-stratification tools to predict patients’ health care needs and recommend appropriate preventive services and/or chronic care management. These tools take into account information such as a patient’s self-identified health risks, clinical diagnoses, and utilization data from payers (if available). Electronic health records and disease registries allow practices to monitor the provision of recommended care for each patient on an ongoing basis.

**ELEMENT 7: Integrated, coordinated care across the health care system**
Integrating other elements of health care (e.g., subspecialty care, home health care, inpatient and outpatient hospital care, behavioral health services) with primary care services is essential for the success of a care management program. A care management program provides the foundation for effective communication, coordinated treatment, and well-managed care transitions across the “medical neighborhood” to optimize the quality of patient care and reduce unnecessary utilization. These efforts are facilitated by electronic health information exchanges, clinical registries, telehealth and/or telementicine, and direct communication among health care professionals.

**ELEMENT 8: Care Planning**
Care management involves establishing, implementing, revising, and monitoring a comprehensive plan of care addressing all aspects of a patient’s health. This care plan should be patient-centered, reflecting the patient’s choices and values, and it should be based on a physical, mental, cognitive, psychosocial, functional, and environmental assessment of the patient as well as an inventory of resources available to the patient.

The AAFP believes that a PMPM care management fee needs to cover the costs to family medicine practices of dedicating staff time, physician time, and advanced technology to provide ongoing patient education, risk stratification, population management, medication management and adherence support, and coordination of care transitions, and care planning. Although additional research is required to determine the most effective and efficient way to implement each care management element in a PCMH, the AAFP believes that a successful care management program incorporates these essential elements. As blended payment models continue to evolve, additional core elements may be identified. (2004) (2016 COD)
Certificates of Added Qualification (CAQ)

See also

- Adolescent Health Care, Role of the Family Physician
- Aging
- Certification/Maintenance of Certification, Definitions
- Fellowship, Definition
- Residency Training Leading to Dual Board Certification
- Sports Medicine, Health and Fitness

The AAFP recognizes that the primary benefit of CAQs is to strengthen the development of academic and administrative family physicians. CAQs should not be required for credentialing of family physicians who apply for privileges within the scope of their training. (August Board 2001) (2016 COD)
Certification/ Maintenance of Certification, Definitions

See also

- Residency Training Leading to Dual Board Certification
- Licensure
- Professional Competence Evaluation
- Hospital Medical Staff, Board Certification for Membership
- Licensure/Relicensure, Definitions
- Licensure, Restricting Physician Licensure

To avoid possible confusion which could result from the use of these terms, the AAFP adopted the following definitions to clarify the distinctions when the terms certification/Maintenance of Certification are used in reference to physicians. (1990) (2008)

Certification

Certification is the mechanism whereby nongovernmental bodies recognize a certain level of achievement by those engaged in the practice of medicine. Generally, such achievement is evidenced by completion of an accredited training program and successful performance on an examination administered by the professional organization representative of that field of medicine. Inasmuch as certification is not a function of government, it does not carry with it inherent legal rights and privileges such as licensure does. (1990) (2002)

Maintenance of Certification

The ABMS Maintenance of Certification (MOC) program is a process designed to document that physicians maintain the necessary competencies to provide quality patient care in the specialties in which they have been certified. It is an ongoing process and will require the assessment and improvement of practice performance by physician specialists. The American Board of Family Medicine (ABFM) utilizes the MOC to continually assess ABFM Diplomates.

ABFM MC-FP, the Maintenance of Certification for Family Physicians by ABFM has four basic components:

Part I - Professionalism

Evidence of professional standing, such as an unrestricted license, a license that has no limitations on the practice of medicine and surgery in that jurisdiction;

Part II - Self-Assessment and Lifelong Learning

Evidence of a commitment to lifelong learning and involvement in a periodic self-assessment process to guide continuing learning;

Part III - Cognitive Expertise

Evidence of cognitive expertise based on performance on an examination. That exam should be secure, reliable and valid. It must contain questions on fundamental knowledge, up-to-date practice-related knowledge, and other issues such as ethics and professionalism;

Part IV - Performance in Practice
Evidence of evaluation of performance in practice, including the medical care provided for common/major health problems (e.g., asthma, diabetes, heart disease, hernia, hip surgery) and physician behaviors, such as communication and professionalism, as they relate to patient care. (1976) (2013 COD)
Cesarean Delivery in Family Medicine (Position Paper)

Overview and Purpose

Obstetric care is an integral part of many family physicians’ scope of practice and an important component of family medicine residency training. A substantial percentage of perinatal care in the United States is provided by family physicians, especially in rural and underserved communities, in which family physicians provide a disproportionate amount of perinatal care. An American Academy of Family Physicians (AAFP)/American College of Obstetricians and Gynecologists (ACOG) joint statement asserts that access to high-quality maternity care is an important public health concern in the United States. A cooperative relationship among family physicians, obstetrics subspecialists, and nurse midwives is essential in order to provide pregnant women with consistent, comprehensive care. The most important objective must be the highest standard of obstetric care, regardless of specialty.

In 2004, a report of the Future of Family Medicine project outlined the broad spectrum of services that family physicians must provide to renew the specialty and meet the needs of patients and society. The report stated that family medicine education should continue to include training in maternity care. Provision of comprehensive, accessible care is a characteristic of the patient-centered medical home (PCMH) model promoted by the AAFP and other organizations. Operative delivery and other advanced perinatal services are ideally suited for this model of care, which includes extended and advanced services.

Cesarean delivery is one of the most common surgical procedures in the United States. According to the National Center for Health Statistics (NCHS), approximately 1.3 million cesarean deliveries are performed in the United States annually. In 2013, 32.7% of U.S. births were cesarean deliveries. Previous cesarean delivery, labor dystocia, abnormal or indeterminate fetal heart rate tracing, fetal malpresentation, multiple gestation, and suspected fetal macrosomia are some of the most common indications for cesarean delivery. Despite the use of risk-assessment systems and protocols, the need for cesarean delivery can arise suddenly and unpredictably during the course of labor. An essential component of modern perinatal care is the prompt availability of surgical intervention that does not require transporting the patient.

Provision of cesarean delivery by well-trained family physicians augments maternity care services available to women or, in some cases, provides a service that would not otherwise be available. Quality patient care requires that all physicians—regardless of specialty—practice within their ability, as determined by training, experience, and current competence. Given that many family physicians currently perform cesarean delivery, and many are being trained to provide this service, it is important to have shared common standards of perinatal care, as well as a common understanding of the place of cesarean delivery within a family physician’s scope of practice and within the health care delivery system.

This document should serve as a resource for family physicians who are training to perform cesarean delivery and planning to include this service in their practices. It also will help hospital and health plan credentialing committee members and administrators, obstetrics subspecialists, nurse midwives, and clinical staff understand the role of family physicians in providing cesarean delivery.

Section II - Scope of Practice for Family Physicians

Family medicine is a specialty based on comprehensive care that encompasses a wide range of medical services. Family physicians practice among diverse populations and in geographically varied settings, including rural communities. They choose a personal scope of practice based on factors that include their training experiences, their practice interests, and the needs of their patient populations. Broadly speaking, the following indicate the extent to which cesarean delivery is within the current scope of family medicine:

- A joint AAFP/ACOG statement on cooperative practice and hospital privileges affirms that surgical delivery is within the scope of family medicine.
- The AAFP’s recommended curriculum guidelines for family medicine residents describe training in both core obstetric skills and advanced obstetric skills, which include performance of cesarean delivery.
- In the United States, there are approximately 32 family medicine fellowships in obstetrics, many of which seek to train family physicians to perform cesarean delivery independently. Many graduates of these programs practice in rural and/or underserved areas and have cesarean delivery privileges.

There are limited data on outcomes of cesarean deliveries performed by family physicians, and much of the literature is dated. However, studies have shown that the maternal and infant outcomes of cesarean deliveries performed by family physicians in active practice or in training can meet or exceed national standards. A small 2013 study showed that patients who had a

cesarean delivery performed by a family physician did not face increased overall risk. In addition, there is some evidence that women who receive perinatal care from family physicians have lower cesarean delivery rates than patients cared for by obstetricians and obstetrician-gynecologists. This is important for social and financial reasons, and because surgical delivery carries a significantly increased risk of maternal morbidity and mortality compared with vaginal delivery.

Section III - Training Methods

Cesarean delivery is a major abdominal surgical procedure that typically is learned during residency, extended residency, or fellowship training. The AAFP’s recommended curriculum guidelines indicate that family medicine residents who seek cesarean delivery training because of their planned practice sites should be able to acquire this advanced skill during the course of a three-year residency.22 Data indicate that many family physicians have achieved proficiency in operative delivery during residency, preparing them to perform cesarean delivery in various practice settings.23,24,25,26 In 2009, a Society of Teachers of Family Medicine (STFM) task force published a consensus document affirming that cesarean delivery proficiency can be achieved in traditional family medicine residencies.27

In approximately 32 U.S. family medicine fellowships in obstetrics, cesarean delivery is identified as a key skill and training is provided. Another training model involves a four-year family medicine residency curriculum that includes an enhanced obstetrics track. A 2005 review of the first six years of one residency program’s enhanced obstetrics track found that residents who completed it had cesarean and high-risk delivery numbers comparable to those of residents completing an obstetrics/gynecology residency.29 Although the curriculum for fellowships and advanced training programs is not standardized by the Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee, a 2008 survey of 165 graduates of family medicine fellowships in obstetrics throughout the United States found that 66% of graduates had obtained cesarean delivery privileges.30 Another possible route to the acquisition of cesarean delivery skills is preceptorship by a family physician, an obstetrician-gynecologist, or a general surgeon who already has these privileges. Because cesarean delivery is a major surgical procedure, it would be unusual to acquire cesarean delivery skills in brief (e.g., weekend or weeklong) courses.

As with many other procedures, the number of cesarean deliveries a physician must perform during training to gain competence has not been extensively studied. The literature documents high variability in the training numbers necessary for mastery of procedural skills.31,32 A 2006 study of the cesarean delivery training curriculum in one three-year family medicine residency program found an average of 60 cesarean deliveries performed per resident.33 In a survey of family medicine maternity care fellowships, the estimated mean number of cesarean deliveries performed annually by fellows was 108.6 (SD=48.2), with a range of 60 to 190 performed.34 A study of cesarean deliveries performed by three family physicians in a rural hospital found that the physicians had performed 37 to 50 primary cesarean deliveries and assisted on 75 to 110 cesarean deliveries before they were credentialed at the hospital.35 One of these physicians was trained in a residency program with a strong rural focus, one was trained in a fourth-year rural obstetrics fellowship program, and the third was trained while employed in the National Health Service Corps. The variability of training numbers for cesarean delivery emphasizes the need for careful supervision and review of trainees, and the need for progressive proctoring in training and assessment of competence that is not heavily based on training numbers.

Acquisition of the psychomotor skills needed for cesarean delivery should be coupled with the development of cognitive skills required to know when to perform the procedure and how to manage medical and surgical complications, such as those listed in Table A1. Family physicians should be able to recognize and manage complications of cesarean delivery, or obtain necessary consultation. Another important topic that should be part of cesarean delivery training is identification and understanding of preoperative risk factors that should prompt consultation, referral, or transfer of patients before surgery (Table A2). In addition, because cesarean delivery is an abdominal surgery, experience with other abdominal procedures is helpful for skill development.

Section IV - Testing, Demonstrated Proficiency, and Documentation

The AAFP recommends an approach that gives family physicians who perform procedures three methods to demonstrate competence:

1) Perform the procedure in high enough volume that any quality trends are detectable
2) Have references attesting to competence
3) Have a proctor attest to competence

Regarding the first method, the volume threshold should be evidence based. If the literature does not support a specific volume threshold, one should be established by the consensus of a multidisciplinary group of physicians that includes family physicians.

Testing and demonstration of proficiency in major surgical procedures such as cesarean delivery is usually done by direct observation during training or during a period of proctorship under another physician who is significantly more experienced. The literature describes several processes for supervising physicians to determine whether physicians completing training are proficient in cesarean delivery.36,37,38

The volume of cesarean deliveries needed to maintain proficiency has not been extensively studied. In a 15-year retrospective
study that showed that maternal and infant outcomes of cesarean deliveries performed by family physicians met or exceeded national standards, the number of cesarean deliveries performed by study participants ranged from five to 22 procedures per physician per year.\textsuperscript{39} A 2008 survey of graduates of U.S. family medicine fellowships in obstetrics found an overall average of 28.9 cesarean deliveries per year; only 22.5% of respondents averaged more than 30 procedures per year.\textsuperscript{40}

Family physicians seeking to document their experience may do so in a variety of ways. These include keeping a file of operative reports and discharge summaries for patients on whom they have operated, or assembling a case database that includes details such as those suggested in Table A3.

In 2009, the American Board of Physician Specialties began offering certification in family medicine obstetrics to recognize “the advanced level of training and experience that some [family physicians] gain through recognized fellowship programs or their historical equivalent.”\textsuperscript{41} For eligible applicants, the process of certification for family medicine obstetrics involves satisfactory completion of a written examination and an oral examination, and confirmation of surgical competence by peer observers. This certification should not be a requirement for privileges in routine obstetric care and should not be mandatory for certification in advanced maternity care skills, such as high-risk obstetrics and cesarean delivery. It is merely one of several mechanisms for verification of training and competence in this area.

Section V - Credentialing and Privileges

For hospitals and medical staff, the policies of respected national organizations are the best source of guidance on the credentialing of appropriately trained, competent family physicians who seek hospital privileges. In their joint statement on cooperative practice and hospital privileges, the AAFP and ACOG state the following:\textsuperscript{42}

“Everything of hospital privileges is a local responsibility, and privileges should be granted on the basis of training, experience, and demonstrated current competence. All physicians should be held to the same standards for granting of privileges, regardless of specialty, in order to [ensure] the provision of high-quality patient care. Prearranged, collaborative relationships should be established to ensure ongoing consultations, as well as consultations needed for emergencies.

The standard of training should allow any physician who receives training in a cognitive or surgical skill to meet the criteria for privileges in that area of practice. Provisional privileges in primary care, obstetric care, and cesarean delivery should be granted regardless of specialty as long as training criteria and experience are documented. All physicians should be subject to a proctorship period to allow demonstration of ability and current competence. These principles should apply to all health care systems.”

According to these guidelines, it would be improper to base the granting of privileges on the specialty of a physician’s residency training.

The American Medical Association’s (AMA’s) policy on staff privileges states the following: “Decisions regarding hospital privileges should be based upon the training, experience, and demonstrated competence of candidates, taking into consideration the availability of facilities and the overall medical needs of the community, the hospital, and especially patients.”\textsuperscript{43}

The Joint Commission’s hospital accreditation standards state the following: “The credentialing and privileging process involves a series of activities designed to collect, verify, and evaluate data relevant to a practitioner's professional performance. These activities serve as the foundation for objective, evidence-based decisions regarding appointment to membership on the medical staff, and recommendations to grant or deny initial and renewed privileges. In the course of the credentialing and privileging process, an overview of each applicant’s licensure, education, training, current competence, and physical ability to discharge patient care responsibilities is established.”\textsuperscript{44}

Current hospital and health care organization policies and procedures for credentialing family physicians in cesarean delivery vary markedly from site to site. In hospitals that have a department of family medicine, the department may credential its own members. In hospitals that have no experience with family physicians performing cesarean delivery, there may be no mechanism for credentialing in this procedure. If a hospital has coexisting departments of family medicine and obstetrics, the departments may or may not have a cooperative credentialing arrangement.

Family physicians moving to a new practice site would benefit from extensively researching the policies and procedures of their chosen site regarding privileges for cesarean delivery and other procedures, and obtaining these privileges before actually moving to the new practice site, if possible. This approach is particularly advisable if a family physician is the first to request cesarean delivery privileges in an environment in which obstetrics subspecialists alone hold such privileges.

The number of procedures performed in training is often used as a criterion for credentialing; however, numbers alone do not demonstrate quality of outcomes. Family physicians seeking cesarean delivery privileges should have extensive documentation of their experience, including the following:\textsuperscript{45}
Lack of community need may be cited as a reason to withhold cesarean delivery privileges from family physicians who practice in environments shared with obstetrics subspecialists. However, this approach is not consistent with Joint Commission, AMA, or joint AAFP/ACOG credentialing guidelines. Services provided by family physicians, obstetrics subspecialists, and nurse midwives are different and offer patients options for care. Obstetric services are provided by family physicians in the context of whole-person family care, often in a PCMH, and usually with subsequent neonatal care. Furthermore, “turf battle” situations could lead to legal action on the basis of discrimination and restraint of trade (i.e., antitrust).

At some institutions, ability to manage complications of cesarean delivery may be a requirement for obtaining privileges. For example, the ability to perform a cesarean hysterectomy for persistent hemorrhage may be required, in spite of the fact that cesarean hysterectomy is a rare procedure that a family physician would not typically need to perform. All physicians, regardless of specialty, would be expected to seek consultation for a rare condition, and numerous effective temporizing techniques are available to manage severe blood loss during cesarean delivery while consultation is being arranged. In addition, a significant percentage of patients who are at high risk of severe hemorrhage and subsequent cesarean hysterectomy—most notably those who have a history of previous cesarean delivery or placenta previa—can be identified before surgery. Although no risk-assessment system can predict the outcomes of all cesarean deliveries, preoperative risk factors (Table A2) for complications of cesarean delivery that are outside of the family physician’s scope of practice can be identified to prompt consultation, referral, or transfer of patients before surgery, as necessary.

A family physician who performs cesarean delivery should have an established system for consulting with partners, other family physicians, general surgeons, and obstetrics subspecialists, as appropriate. In addition, resources (e.g., laminated protocol cards, an electronic database) should be available in the delivery suite for immediate reference if assistance is needed. Assistance via video conferencing might be especially useful for family physicians who practice in rural communities.

Section VI - Miscellaneous Issues

Quality Programs
Family physicians who perform cesarean delivery should establish ongoing case-review programs to monitor their delivery and surgical outcomes. Table A3 provides a suggested model for collection of data on maternal and infant outcomes that can be compared with standard outcomes.

Public Health and Community Implications
High-quality surgical care is important for good perinatal outcomes. Because family physicians are the most widely available physicians, particularly in rural and underserved areas, expanding and improving cesarean delivery skills could improve access to modern perinatal care for many patient populations. There is extensive literature that documents better birth outcomes when local maternity care services are available. The survival of small rural hospitals often depends on their ability to continue providing perinatal care. Therefore, rural hospitals need physicians who can perform normal deliveries and operative deliveries. Collaborative efforts by physicians of several specialties in Canada can serve as models of training and support that equip family physicians to provide cesarean delivery in rural communities that lack access to obstetric services.

Research Agenda
The research agenda related to cesarean delivery by family physicians should focus on four major areas:

1. Documenting the ongoing outcomes of cesarean delivery by family physicians
2. Investigating differences between family physicians and obstetrics subspecialists in the management of labor and cesarean delivery rates
3. Evaluating training methods (including cognitive and procedural aspects of training); identifying the points at which proficiency in cesarean delivery and other procedures is reached; and determining what learner qualities predict earlier mastery
4. Identifying conditions under which a trial of labor after cesarean (TOLAC) is acceptable and evaluating the effect of policies regarding vaginal birth after cesarean (VBAC) on access to care for women in rural communities

This area of research should include investigating whether tools such as videos, multimedia programs, and simulators can be developed to prepare physicians to manage rare complications.

See the AAFP’s clinical practice guideline Planning for Labor and Vaginal Birth After Cesarean for additional information.

Relationship With Other Organizations
The AAFP and ACOG should maintain a dialogue on the issue of cesarean delivery by family physicians. The AAFP/ACOG Joint
Statement on Cooperative Practice and Hospital Privileges and the AAFP’s recommended maternity care curriculum guidelines for family medicine residents should be periodically reaffirmed and revised. Cooperation between family physicians and obstetrics subspecialists for the common goal of improving access to quality maternity care and availability of such care (as modeled by the collaborative efforts seen elsewhere) should be encouraged. (B1997) (2010 COD)

Section VII - References


Appendix

Table A1: Complications of Cesarean Delivery

<table>
<thead>
<tr>
<th>Injury to maternal bladder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury to maternal bowel</td>
</tr>
<tr>
<td>Extension of uterine incision into uterine arteries</td>
</tr>
<tr>
<td>Extension of uterine incision into the cervix or vagina</td>
</tr>
<tr>
<td>Uterine atony</td>
</tr>
<tr>
<td>Dense adhesions from previous surgery</td>
</tr>
<tr>
<td>Hemorrhage from placental implantation site</td>
</tr>
<tr>
<td>Uterine rupture</td>
</tr>
<tr>
<td>Wound hematoma</td>
</tr>
<tr>
<td>Endomyometritis</td>
</tr>
<tr>
<td>Wound infection</td>
</tr>
</tbody>
</table>

Table A2: Preoperative Risk Factors for Complications of Cesarean Delivery

<table>
<thead>
<tr>
<th>Preterm pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple gestations</td>
</tr>
<tr>
<td>Grand multiparity</td>
</tr>
<tr>
<td>Placenta previa</td>
</tr>
<tr>
<td>Placenta accreta</td>
</tr>
<tr>
<td>Morbid obesity</td>
</tr>
<tr>
<td>Fetal anomalies</td>
</tr>
<tr>
<td>Transverse fetal lie</td>
</tr>
<tr>
<td>Maternal coagulopathy</td>
</tr>
<tr>
<td>Large uterine fibroids</td>
</tr>
<tr>
<td>Repeat cesarean delivery in a patient with extensive adhesions</td>
</tr>
<tr>
<td>Medical problems that would make maternal anesthesia hazardous</td>
</tr>
</tbody>
</table>

Table A3: Suggested Data List for Documentation of Cesarean Delivery Experience

<table>
<thead>
<tr>
<th>Patient identification or code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of procedure</td>
</tr>
<tr>
<td>Name of hospital</td>
</tr>
<tr>
<td>Patient’s age</td>
</tr>
<tr>
<td>Patient’s number of previous pregnancies</td>
</tr>
<tr>
<td>Medical problems during pregnancy</td>
</tr>
<tr>
<td>Clinical reason(s) for cesarean delivery</td>
</tr>
<tr>
<td>Physician’s role in surgery; (i.e. primary surgeon, first assistant or second assistant)</td>
</tr>
<tr>
<td>Supervising surgeon</td>
</tr>
<tr>
<td>Occurrence of postoperative infection</td>
</tr>
<tr>
<td>Surgical complications and treatment</td>
</tr>
<tr>
<td>Infant Apgar score and weight</td>
</tr>
<tr>
<td>Admission to neonatal intensive care unit</td>
</tr>
</tbody>
</table>
Chelation Therapy

The AAFP endorses the 1983 AMA Diagnostic and Therapeutic Assessment of Chelation Therapy which reads as follows.

Chelation therapy with ethylenediaminetetraacetic acid or its sodium salt is not an established treatment for atherosclerotic vascular disease. (B1984) (2013 COD)

These policies are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient’s family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These policies are only one element in the complex process of improving the health of America. To be effective, this policy must be implemented.
Child Abuse

See also

- Medical Necessity for the Hospitalization of the Abused and Neglected Child
- Children's Health
- Adolescents, Protecting: Ensuring Access to Care and Reporting Sexual Activity and Abuse (Positions Paper)
- Hate Crimes
- Treatment of Survivors of Sexual Assault
- Violence as a Public Health Concern
- Female Genital Mutilation
- Intimate Partner Violence
- Violence in the Media and Entertainment (Position Paper)
- Violence, Harrassment and School Bullying
- Human Trafficking

Child abuse is a multifaceted problem that includes physical, sexual, and emotional abuse. Neglect, or not providing for a child's needs, is also a form of abuse. The American Academy of Family Physicians recognizes that child abuse is a very complex issue and addressing child abuse requires a multidisciplinary approach, including recognition, treatment, and education.

Therefore, the AAFP will cooperate in recognition, treatment, and education efforts with other groups in organized medicine, nationally-recognized centers for the prevention and treatment of child abuse, responsible government agencies, and appropriate lay organizations.

The AAFP will provide child abuse educational information to members about:

- the incidence, prevalence and complexities of all forms of child abuse,
- information about the reporting of child abuse,
- prevention of child abuse,
- early recognition of child abuse; and
- the diagnosis and appropriate treatment of child abuse.

In the treatment of child abuse, the AAFP endorses the treatment of the child involved and that child's whole family. The AAFP also endorses rehabilitation of the abusers or potential abusers using all modalities, including the penal/correctional system, along with medical and psychological treatments.

The AAFP endorses family preservation when possible, always keeping the safety and well being of the children as primary objectives. (1987) (2013 COD)
The AAFP establishes policy and is supportive of legislation which promotes a safe and nurturing environment, including psychological and legal security for all children, including those of adoptive or foster parents, regardless of the parents’ sexual orientation. (2002) (2012 COD)
Chronic Pain Management and Opioid Misuse: A Public Health Concern (Position Paper)

See Also

- Drugs, Prescribing
- Drugs, Opposition to Mandatory Education for Drug Prescribing
- Substance Abuse and Addiction
- Pain Management and Opioid Abuse
- AAFP Chronic Pain Management Toolkit

Executive Summary

The intertwined public health issues of chronic pain management and the risks of opioid use and misuse continue to receive national attention. Family physicians find themselves at the crux of the issue, balancing care of people who have chronic pain with the challenges of managing opioid misuse and abuse. Pain is one of the oldest challenges for medicine. Despite advances in evidence and understanding of its pathophysiology, chronic pain continues to burden patients in a medical system that is not designed to care for them effectively. Opioids have been used in the treatment of pain for centuries, despite limited evidence and knowledge about their long-term benefits, but there is a growing body of clear evidence regarding their risks. As a result of limited science, external pressures, physician behavior, and pharmacologic development, we have seen the significant consequences of opioid overprescribing, misuse, diversion, and dependence.

In the face of this growing crisis, family physicians have a unique opportunity to be part of the solution. Both pain management and dependence therapy require patient-centered, compassionate care as the foundation of treatment. These are attributes that family physicians readily bring to their relationships with patients. While our currently fragmented health care system is not well-prepared to address these interrelated issues, the specialty of family medicine is suited for this task. The American Academy of Family Physicians (AAFP) is actively engaged in the national discussion on pain management and opioid misuse. Committed to ensuring that our specialty remains part of the solution to these public health crises, the AAFP challenges itself and its members at the physician, practice, community, education, and advocacy levels to address the needs of a population struggling with chronic pain and/or opioid dependence.

Call to Action

The AAFP is committed to addressing the dual public health crises of undertreated pain and opioid misuse/abuse at both the national and grassroots levels. To this end, the AAFP has formed a cross-commission advisory committee to address the multiple issues involved. Through its efforts with other physician and medical organizations, as well as governmental entities, the AAFP is committed to being a leader in promoting the advancement of safe pain management and opioid prescribing, and in addressing the growing burden of opioid dependence. The AAFP therefore challenges itself and its members to action in the following areas:

Physician Level

- Deliver patient-centered, compassionate care to patients struggling with chronic pain and/or opioid dependence
- Collaborate with other health care professionals to deliver the multidisciplinary care that patients struggling with chronic pain and/or opioid dependence need
- Critically appraise currently available evidence and guidelines on the treatment of chronic pain and opioid dependence
- Acknowledge risk factors for opioid overdose and misuse in patients who have chronic pain and in patients currently being treated with opioids, and appropriately use prescription drug monitoring programs (PDMPs), periodic drug screens, treatment agreements, and related tools to combat misuse
- Consider obtaining a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver to deliver office-based opioid treatment (OBOT)
- Provide access to and information about appropriate antidotes (e.g. naloxone) for patients who are at highest risk of an intentional or unintentional overdose
Practice Level

- Create a nonjudgmental and culturally proficient environment for patients struggling with chronic pain and/or opioid dependence
- Review current practice patterns and protocols, considering the Federation of State Medical Boards (FSMB) and Centers for Disease Control and Prevention (CDC) guidelines for the treatment of chronic pain
- Identify key partners and community resources for collaboration in the treatment of chronic pain and opioid dependence
- Encourage and enable physicians to use protocols for medication-assisted treatment (MAT) to address opioid dependence within the clinic population
- Work with local, regional, and/or national practice-based research networks to develop science that will best inform the care of patients who have chronic pain and the appropriate management of opioid use, especially in vulnerable populations

Community Level

- Develop partners within the medical neighborhood to ensure successful multidisciplinary delivery of care for patients struggling with chronic pain and/or opioid dependence
- Work with local organizations and patient advocacy groups to develop community-based solutions to chronic pain and opioid dependence, with the goal of destigmatizing the issues surrounding both
- Inform, educate, and facilitate development of overdose education and naloxone distribution (OEND) programs in the community
- Increase collaboration among community behavioral health services, nurse care management services, other psychosocial support services, and primary care in order to support community providers of MAT
- Expand cross-coverage opportunities for solo, waivered family physicians working in rural and underserved areas, including the possible short-term use of nonwaivered physicians to provide coverage

Education Level

- Align residency program training to deliver evidence-based information on best practices in the management of chronic pain and opioid dependence
- Expand current continuing medical education (CME) offerings to deliver evidence-based information on best practices in the management of chronic pain and opioid dependence, including the appropriate use of naloxone
- Expand the opportunities for DATA 2000 waiver training during residency. For mentoring and training purposes, this will ideally include faculty members at each residency site who are trained in MAT. Sites where waivered family medicine faculty members are not available should utilize collaborative teaching and mentoring arrangements with other providers.
- Expand the availability of waivered training courses at national, state, and regional CME meetings, as well as the availability of online and other alternative models of waiver training
- Develop a list of DATA 2000-waivered family physicians across the United States who are willing to provide mentorship for newly waivered family physicians and residents, ideally with some form of reimbursement for their mentorship activities

Advocacy Level

- Work for adjustments in payment models to enable physicians to provide patient-centered, compassionate care in the treatment of chronic pain and opioid dependence and to appropriately compensate them for providing such care
- Expand governmental and private insurance coverage of MAT in the primary care setting, with adequate reimbursement for the increased time, staff, and regulatory commitments associated with MAT
- Expand the role of advanced practice nurses (APNs) and physician assistants (PAs) in providing MAT as part of a team supervised by a DATA 2000-waivered primary care physician
- In states that lack appropriate laws, advocate for better access to naloxone, and appropriate Good Samaritan protections for prescribers and lay rescuers
- Work with state and federal licensing boards, the Drug Enforcement Administration (DEA), and the Substance Abuse and Mental Health Services Administration (SAMHSA) to destigmatize MAT, particularly in the setting of the community provider
- Work with state and national partners to improve the functionality, utility, and interoperability of PDMPs, and develop best practices for their use and implementation
- Expand governmental and private support of research into the management of chronic pain, as well as methods to better identify and manage opioid misuse. Particular attention should be paid to vulnerable populations who are at higher risk for undertreatment of pain and/or for opioid misuse.
Introduction

Chronic pain and opioid misuse are significant and interrelated health care issues that are important to our patients, the medical community, and society as a whole. A core tenet of the practice of medicine is to relieve suffering, yet the undertreatment of pain has been deemed a public health crisis by the National Academy of Medicine (NAM). The physician community struggles with uncertainties when managing a patient’s chronic pain in the face of an epidemic of opioid misuse, as well as the morbidity and mortality associated with overdose. When a family physician sits down with a patient who is seeking help, the fundamental goals of relieving suffering and avoiding harm can come into clear opposition.

Sadly, our current health care system is poorly equipped to address the needs of a patient who has chronic pain and/or opioid dependence. Patients can feel abandoned in their care, such as when they are marked with the stigma of addiction, labeled as “drug seekers” by health care providers, or “fired” from medical practices for opioid misuse. No one disputes that chronic pain should be managed with a multidisciplinary approach, yet family physicians often do not have the resources or personnel to provide that approach. They must work within a fragmented health care system in which patients can obtain prescriptions from multiple sources and multiple physicians. Since family physicians treat the whole patient and not just a subset of diseases, they face the challenge of working with patients who have multiple comorbidities, which complicates both managing chronic pain and balancing competing priorities during the office visit. Furthermore, the payment structure for the system at large (and for medications in particular) often rewards a fast-track approach instead of the comprehensive and time-consuming processes required to deliver the most appropriate care to patients struggling with chronic pain and/or opioid dependence and opioid use disorder.

Despite these challenges, family physicians must understand the history of managing chronic pain and opioid dependence, as well as the current science. They must also be prepared to be a key part of the solution. This position paper provides family physicians with critical information and calls them to action to address chronic pain and opioid dependence and opioid use disorder.

Pain and Opioids: How Did We Get Here?

Pain is one of the oldest medical problems, with a long history in medicine, religion, and social science. Recent history demonstrates that we still do not have a full understanding of chronic pain, leading us to ineffective and counterproductive pain management strategies. Opioid use for pain dates back to the 1800s. The use of opioids increased due to the need to treat devastating injuries sustained in warfare; opioid use was also affected by advancements in pain physiology, the discovery of endogenous endorphins and opioid receptors, and the development of synthetic opioids. Opioid pain relievers can effectively reduce pain, as demonstrated by multiple randomized trials. Unfortunately, almost all of these studies have lasted less than 16 weeks, and there are few data regarding the longer term effectiveness of opioids for chronic pain.

Chronic pain is common, with approximately 11% of the U.S. population reporting daily pain. In addition, pain is often more severe and more frequently undertreated in vulnerable subpopulations, including the elderly, racial/ethnic minorities, women, and socioeconomically challenged groups. Efforts to address the significant morbidity of chronic pain led to an increased emphasis on the recognition and treatment of chronic pain. These efforts—which were highlighted by actions of the U.S. Congress, the National Academy of Medicine (NAM), and multiple professional organizations—focused on improving care, increasing research into pain and its management, and improving training of physicians who manage pain.

Current Issues with Opioid Misuse and Abuse

Regular opioid use, including use in an appropriate therapeutic context, is associated with both tolerance and dependence. The presence of tolerance or dependence does not necessarily mean that an individual has an opioid use disorder. Tolerance is present when an individual needs to use more of a substance in order to achieve the same desired therapeutic effect. Dependence is characterized by specific signs or symptoms when a drug is stopped. “Opioid misuse” is a broad term that covers any situation in which opioid use is outside of prescribed parameters; this can range from a simple misunderstanding of instructions, to self-medication for other symptoms, to compulsive use driven by an opioid use disorder. “Abuse” is also a nonspecific term that refers to use of a drug without a prescription, for a reason other than that prescribed, or to elicit certain sensory responses.
While cause and effect is unclear, the fact that rates of opioid use increased at the same time that physicians were being criticized for their undertreatment of pain is probably not a coincidence. Efforts to improve pain control led to pain becoming the “fifth vital sign,” and physicians were encouraged to address pain aggressively. In 2012, the number of opioid prescriptions written (259 million) equaled the adult population of the United States.14 Despite the increase in opioid prescribing, similar increases have not been observed with other analgesics, including nonsteroidal anti-inflammatory drugs (NSAIDs), acetaminophen, or other adjunctive nonopioid therapies, nor have we seen a concomitant change in the amount of pain that Americans report.15, 16

Increasing rates of opioid misuse and abuse have become a prominent topic in medical, public health, and mainstream media. The reality is that this growing trend is largely related to misuse of prescription medications. Prescription opioids are second only to marijuana as the first illicit substance people try, with approximately 1.9 million new initiates per year.14 Sales of prescriptions opioids quadrupled between 1999 and 2014.17 Not surprisingly, the prescribing practices of physicians have come under scrutiny. It is estimated that one out of five patients who have noncancer pain is prescribed opioids.15 Family physicians have played a role in this rising trend; primary care providers are responsible for about half of the opioid pain relievers dispensed.15

These increased prescribing practices have clearly contributed to the growing opioid epidemic. In 2014, almost 2 million Americans abused or were dependent on prescription opioids.18 In primary care settings, one in four people who receive prescription opioids chronically for noncancer pain struggles with opioid dependence.19 Every day, more than 1,000 people are treated in emergency departments for misusing prescription opioids.20 Concurrently, some of the challenges associated with obtaining prescription opioids, as well as cost issues, have led to a rise in heroin use.21, 22

Probably the most concerning consequence is the rise in intentional and unintentional opioid overdoses, which lead to substantial morbidity and mortality. While most people who abuse opioids get them for free from a friend or relative, those at highest risk of overdose (defined as individuals who use prescription opioids nonmedically for 200 or more days a year) obtain opioids using their own prescriptions (27%), get them from friends or relatives for free (26%), buy them from friends or relatives (23%), or buy them from a drug dealer (15%).23 The ultimate source remains prescribed medications. At least half of all U.S. opioid overdose deaths involve a prescription opioid.24 Based on data from 1999 to 2014, risk factors for death from prescription opioid overdose included being between ages 25 and 54, being a non-Hispanic white, and being male.24 Other risk factors include concomitant use of multiple prescribed and illicit substances (especially benzodiazepines),25, 26 nicotine use, higher prescribed dosages, inappropriate prescribing procedures, methadone use, and having a history of substance abuse.27

**Opioids and the Management of Pain**

There are key differences between acute and chronic pain. Acute pain is a warning symptom that has a functional role in the immune system and resolves with tissue recovery. It is mediated by intact neural pathways and it can be, when needed, controlled with opioids.28 Chronic pain arises from a complex web of heterogeneous illnesses and injuries, and affects a patient physically, psychologically, and emotionally. Frequently, it is associated with undue social and functional consequences, leading to lost productivity, reduced quality of life, and social stigma. Not surprisingly, addressing chronic pain requires a comprehensive approach, with an emphasis on safe and compassionate patient-centered care; chronic pain usually cannot be managed by prescription therapy alone.1, 29

Recognizing this complexity, family physicians need guidance on how to best provide patient-centered, compassionate care. While guidelines and policy statements provide some assistance, the evidence available to support such recommendations and guidance is very limited. Previous guidelines have encouraged physicians to access and use specific resources, such as opioid risk assessment screeners,30 urine drug screening, standardized pain scales, and prescription drug monitoring databases.31, 32 Using these resources often adds time to already busy patient visits, so it is not surprising that many are not routinely used by physicians prescribing opioids for chronic pain.33 It is also worth noting that a report from the 2014 National Institutes of Health (NIH) Pathways to Prevention Workshop on the role of opioids in treatment of chronic pain stated that “evidence is insufficient for every clinical decision that a provider needs to make about the use of opioids for chronic pain.”8

The Federation of State Medical Boards (FSMB) developed a model policy to help state medical boards ensure the practice of both appropriate pain management and safe, appropriate opioid prescribing. This policy addresses key areas for medical boards, physicians, and patients with respect to the following: understanding of pain; patient evaluation and risk stratification; development of a treatment plan and goals; informed consent and treatment.
agreement; initiation of an opioid trial; ongoing monitoring and adaptation of the treatment plan; periodic drug testing; consultation and referral; discontinuation of opioid therapy; medical records; and compliance with controlled substance laws and regulations. Many states either have a medical board policy that is reflective of the FSMB’s model policy or are currently amending their medical board policy to reflect the model policy.

In 2016, the Centers for Disease Control and Prevention (CDC) published the CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016, which addresses many of the elements of the FSMB’s model policy. This CDC guideline was based on an evidence review that found no studies that evaluated the effectiveness of long-term (one year or greater) opioid therapy versus placebo or nonuse with regard to pain, function, and quality of life. Instead, the CDC based most of its recommendations on a review of contextual evidence using inconsistent inclusion and exclusion criteria for different pain management therapies. Because of these inconsistencies in methodology, and because strong recommendations were made on the basis of low-quality or insufficient evidence, the American Academy of Family Physicians (AAFP) did not endorse the guideline. However, the guideline does provide some useful information for family physicians; therefore, it was categorized as Affirmation of Value.

While guidelines and policies are available to physicians, there is a substantial deficit in the peer-reviewed research necessary to form a reliable evidence base. In order to fill this gap, it is imperative that family physicians actively advocate for and engage in research opportunities on appropriate pain management strategies.

Role of Family Medicine in Care of Patients with Opioid Use Disorders

Screening for Opioid Abuse and Misuse

Most guidelines recommend screening patients to determine risks of drug misuse and abuse and to mitigate those risks as much as possible. Screening is typically based on risk factors that can be identified through a thorough patient history, the use of prescription drug monitoring programs (PDMPs), and, on occasion, drug screening. Unfortunately, there are no risk assessment tools that have been validated in multiple settings and populations. Furthermore, cited risk factors, such as sociodemographic factors, psychological comorbidity, family history, and alcohol and substance use disorders, may lead to discriminatory practices that affect care for vulnerable populations. As a member of the American Medical Association (AMA) Task Force to Reduce Prescription Opioid Abuse, the American Academy of Family Physicians (AAFP) encourages physicians to use their state PDMP. These electronic databases are used to track prescribing and dispensing of controlled prescription drugs; they can be used to obtain information on suspected abuse or diversion and to help identify patients at risk so they can benefit from early intervention.

Naloxone

Family physicians should be aware of the utility of naloxone in a harm-reduction strategy for combating opioid overdose. The use of naloxone as a reversal agent for opioid overdose is standard therapy for advanced emergency medical service (EMS) providers and in emergency departments. Increasingly over the last two decades, naloxone has been provided to lay people for use in an opioid overdose. While little high-quality data is available, naloxone consistently shows benefit in the studies that are available, whether used by nonmedical first responders or lay people. The Centers for Disease Control and Prevention (CDC) reports more than 26,000 opioid reversals by lay people from 1996 to 2014. Often, these opioid reversals are part of an overdose education and naloxone distribution (OEND) program. The Substance Abuse and Mental Health Services Administration (SAMSHA) and the AMA Task Force to Reduce Prescription Opioid Abuse are encouraging physicians to identify patients at higher risk of overdose (e.g., use of higher opioid doses, concomitant benzodiazepine use, respiratory disease) and to provide them with naloxone. Most, but not all, states provide for increased layperson access to naloxone, and many have Good Samaritan provisions for prescribers and lay people.

Medication-Assisted Treatment

Medication-assisted treatment (MAT) of opioid and heroin dependence has existed for more than five decades and involves some form of opioid substitution treatment. Originally, only methadone (an opioid agonist) was available, but now clinicians have buprenorphine (a partial agonist used alone or in combination with naloxone) and naltrexone (an opioid antagonist with both oral and extended-release injectable formulations) as pharmacologic options for MAT. In addition, adjunctive medications such as clonidine, nonsteroidal anti-inflammatory medications (NSAIDs), and others are used in the treatment of specific opioid withdrawal symptoms. Prior to the Drug Addiction

With the increase in opioid misuse and the passage and implementation of DATA 2000, various federal and state authorities and professional organizations have produced guidelines to help providers treat opioid use disorders. Since 2001, SAMHSA has provided the Federal Guidelines for Opioid Treatment Programs, which outlines specific recommendations for the administrative and organizational structure and function of an OTP. SAMHSA also published Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction, which outlines the elements of office-based opioid treatment (OBOT) utilizing buprenorphine. The American Society of Addiction Medicine (ASAM) guideline for treatment of opioid use disorders describes a comprehensive strategy for management that encompasses elements of OTPs and OBOT. Similar to the SAMHSA guidelines, it details the initial assessment and evaluation of the patient who has opioid use disorder, offers recommendations for managing opioid withdrawal, and describes and contrasts all of the available pharmacologic options for treatment of opioid use disorder. It concludes with a discussion of psychosocial therapy to be used in conjunction with pharmacologic treatments, and provides guidance in the management of various special populations (e.g., pregnant women and adolescents).

Under the DATA 2000 legislation, qualified physicians—including primary care physicians—can apply to SAMHSA for a waiver that allows them to treat patients who have opioid use disorder with buprenorphine in the office setting. To get such a waiver, a physician needs to meet specific criteria (Table 1).

Table 1. Criteria For Physicians to Obtain DATA 2000 Waiver to Provide OBOT
- Be licensed to practice in the state in which the prescriber will be working
- Have an active Drug Enforcement Agency (DEA) registration to prescribe Schedule III, IV, or V medications
- Have completed an eight-hour training course in the treatment and management of patients who have opioid use disorder (available in live and online/webinar formats)
- Supply documentation of successful completion of required training to SAMHSA

The waiver process allows a resident in training to get a waiver as long as the resident holds an unrestricted medical license and the appropriate DEA registration. Once SAMHSA verifies that the information submitted by the candidate is complete and valid, the DEA issues a special identification number that must be included along with the regular DEA number on all buprenorphine prescriptions for opioid treatment. In the first year after successful completion of waiver certification, the physician can manage up to 30 patients with buprenorphine. After the first year, the physician can submit a request to treat up to 100 patients per year. Under a proposal submitted by President Barack Obama in March 2016, the maximum number of patients that a qualified buprenorphine provider can treat would increase to 200 per year.

As of the most recent statistics, only about 2% of all U.S. physicians (4% of primary care physicians) have a valid DATA 2000 waiver, with even fewer actively prescribing MAT. Even if all of the waivered physicians prescribed MAT to the fullest extent possible, the workforce would only be able to treat 1.4 million of the patients who have a diagnosis of opioid dependence. Table 2 lists some barriers to obtaining and utilizing the waiver and providing OBOT.

Table 2. Barriers to Providing OBOT
- Lack of adequate funding; neither governmental nor private insurers adequately reimburse providers for all the costs associated with MAT in the office setting.
- Lack of institutional support for prescribing MAT
- Lack of cross-covering providers in the group or community setting when the MAT provider needs to take leave
- Lack of psychosocial support services in the community
- Concerns about the possibility of office auditing visits by the DEA
• Confidentiality rules that limit the integration of care for patients with substance use disorders into primary care
• Perceived increased scrutiny that providers face when prescribing MAT
• Increased care coordination and patient management requirements associated with MAT
• Lack of MAT training opportunities in residency
• Lack of MAT mentors and subspecialty backup

Despite these barriers, OBOT represents a critical opportunity for family physicians to address the opioid abuse epidemic. By working to reduce these barriers, the AAFP encourages family physicians to obtain a waiver and incorporate MAT into their practice.

AAFP Efforts to Tackle the Opioid Abuse Epidemic

Policies

The American Academy of Family Physicians (AAFP) recognizes the vital role that family physicians and other primary care clinicians play in the appropriate management of pain. To this end, the AAFP has developed policies, programs, and partnerships to advocate for and educate family physicians and the community. The AAFP’s policy on substance abuse outlines the organization’s support for training family physicians on the proper assessment, referral, and treatment of chronic pain. The AAFP also supports continued research into evidence-based guidelines for treatment of chronic pain. The AAFP supports implementation and use of prescription drug monitoring programs (PDMPs) and greater physician input into pain management regulation and legislation. In conjunction with the Association of Departments of Family Medicine (ADFMRD), the Association of Family Medicine Residency Directors (AFMRD), and the Society of Teachers of Family Medicine (STFM), the AAFP supports appropriate training for pain management and has developed guidance for teaching residents how to care for patients who have chronic pain.

Through its maintenance of certification process, the American Board of Family Medicine (ABFM) offers a self-assessment module (SAM) in pain management, as well as a certificate of added qualifications (CAQ) in pain medicine and hospice and palliative medicine.

Education and REMS

Since its inception in 1947, the AAFP has been committed to promoting and maintaining high standards in family medicine, and promoting the improvement of the health of the public. This is demonstrated by the dual role the AAFP plays in the continuing medical education (CME) community as an accredited CME provider, the first of three national standard-setting, credit-granting systems. While the AAFP opposes mandatory CME for physicians on opioid prescribing, it strongly supports educating its members on effective and evidence-based pain management through CME and non-CME activities. The AAFP has offered several courses in risk evaluation and mitigation strategies (REMS). Additionally, the AAFP develops and provides multiple certified CME activities to address the topic of pain for its members. These CME activities are available in live, online, and enduring formats, which allows for increased access by members. The AAFP will continue to support family physicians to enhance their knowledge, competence, and performance when treating patients who have pain; it will also continue to provide CME to address the abuse, misuse, and safety of opioid prescribing.

Resources and Commitment

The AAFP collaborates with numerous external organizations on issues pertaining to opioids; these organizations include the American Medical Association (AMA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the State Pain Policy Advocacy Network (SPPAN), and the American Academy of Pain Medicine (AAPM). The AAFP has a prominent role on the steering committee of the Providers’ Clinical Support System (PCSS), which is sponsored by the American Academy of Addiction Psychiatry (AAAP). The PCSS provides training modules on pain management and medication-assisted treatment (MAT). Additionally, the AAFP joined 26 other medical associations in the AMA Task Force to Reduce Prescription Opioid Abuse. This task force was formed in 2014 to identify best practices for combating opioid abuse and to implement these practices across the country. The goals of the task force are to increase registration and use of PDMPs by physicians; enhance education on effective, evidence-based prescribing of opioids; reduce the stigma of pain and substance use disorder; enhance comprehensive assessment and treatment of pain; increase access to treatment for substance use disorder; and expand access to naloxone in communities. With other members of the AMA Task Force and a number of other public- and private-sector partners, the AAFP joined the White House and President Obama to address the nation’s epidemic of opioid abuse and heroin use by increasing education on opioid prescribing.
The U.S. Department of Health and Human Services (DHHS) has updated its National Pain Strategy, which makes recommendations for improving pain management in the United States by addressing six key areas: population research; prevention and care; disparities; service delivery and payment; professional education and training; and public education and communication. The report also highlights opportunities to reduce the overreliance on opioid prescribing. Importantly, the strategy calls for better evidence and more research on pain management. The AAFP supports the National Pain Strategy, which outlines the essential elements of a nationwide strategy and is in line with the AAFP’s own position.

The AAFP provides its members with tools and resources for education, advocacy, and patient care. These resources include a chronic pain management toolkit, continuing medical education, office-based tools, and resources for community engagement, advocacy, and science and education. The AAFP also has formed a member advisory panel that comprises commission members and subject matter experts. This panel will provide input on and support for the AAFP’s goals and initiatives related to opioids and pain management.

Summary

Effective pain management and care of patients with substance use disorders require patient centeredness and compassion, which are hallmarks of family medicine. The AAFP is committed to ensuring that the specialty of family medicine is a central component of the solutions to ongoing issues with the health care system and the growing public health crisis. The recommendations and resources outlined in this paper are provided to encourage family physicians to take action on all levels to address the needs of a population struggling with chronic pain and/or opioid dependence, and to facilitate family physicians’ efforts.

References


(July 2012 BOD) (2016 COD)
Civil Marriage for Same-Gender Couples

See Also

- Equality for Same-Gender Families

The American Academy of Family Physicians (AAFP) supports civil marriage for same-gender couples to contribute to overall health and longevity, improved family stability, and to benefit children of Lesbian, Gay, Bisexual, Transgender (LGBT) families. (2012 COD) (2016 December BOD)
Climate Change and Air Pollution

In recognition of the numerous and serious adverse health consequences resulting from pollution, climate change and ozone layer depletion, the AAFP recommends strong action on all public and private levels to limit and correct the pollution of our land, atmosphere and water. (1969) (2015 COD)

See also

- Professional Medical Liability
- Professional Medical Liability, Lawsuits
- Physician Expert Witness in Medical Liability Suits

In recent years the health care literature has been replete with studies documenting the all too frequent occurrence of clinical errors in hospital and office based medical practice. While it was common practice in the past to cover up such mistakes, today it is widely accepted that patients should be informed when errors occur. Standards promulgated by the Joint Commission make this an explicit requirement in the hospital setting. The question physicians must ask today is not whether to disclose a clinical mistake, but how to share the information. Many physicians are not familiar with the results of coordinated efforts by some health care organizations to institutionalize the disclosure of medical mistakes. By and large, these efforts have been quite positive in helping patients come to grips with the clinical consequences of a clinical error, aiding physicians who may be plagued by guilt following the occurrence of a clinical 'mishap', and in ameliorating liability costs. While many doctors fear that such disclosures will result in ruinous lawsuits, a number of the studies listed below suggest otherwise. A number of organizations, such as Sorry Works! (described below) have been created to assist physicians to communicate effectively with patients under the emotionally laden circumstances of a clinical error.

The Bibliography and Resource List which follows is meant to provide the busy clinician a reference point for learning more about approaches to disclosing medical mistakes. The articles and resources below are best explored before an unfortunate circumstance makes the need compelling. However, they will also be useful for those reaching out for ‘just-in-time’ knowledge. This resource listing is meant to be a useful, but not an exhaustive, guide to the literature on this subject and there is little doubt that additional resources will constantly be appearing.

RESOURCES

Organizations:

Sorry Works: The Sorry Works! Coalition is a nationwide organization of doctors, lawyers, insurers, and patient advocates dedicated to promoting full-disclosure and apologies for medical errors as a “middle ground solution” to the medical liability crisis. It has published white papers and protocols for addressing medical errors and it is a major sponsor of legislation at the state level. It has an informative web site at www.sorryworks.net.

Articles and Publications:


Cherry RA, Marcus L, Dorn B. Reporting adverse events to patients: a step-by-step approach, Physician Exec J. 2010;36(3):4-6, 8-9. net.acpe.org/MembersOnly/pejournal/2010/MayJune/Cherry.pdf


**Helpful Books:**

**Medical Errors and Medical Narcissism** by Banja JD, Sudbury, MA: Jones and Bartlett Publishers; 2004

**ISBN:** 0763783617

**SYNOPSIS**

In a book "dedicated to all healthcare professionals who did the right thing, when the right thing was very, very difficult," clinical ethicist Banja (rehabilitation medicine, Emory U., Atlanta) presents the concept of "medical narcissism" to explain failure to disclose medical errors. The author offers insights into how professionals' self-esteem issues may subvert patient’s rights and advice on communicating about errors based on an emphatic model. He believes that ethical practice can be taught. Appendices discuss a neurologically-based model of rationalization, and the nature of pathological narcissism from a psychoanalytic perspective. Annotation ©2004 Book News, Inc., Portland, OR
"This jewel of a book reveals the many facets of the seemingly simple act of apology.... Drawing on a vast array of literary and real-life examples, from Agamemnon to George Patton to Arnold Schwarzenegger, from the current pope to the machinist who approached him after a lecture, Lazare lucidly dissects the process of apology.... Everybody on earth could benefit from this small but essential book."--Publishers Weekly (starred review)


Complications: A Surgeon’s Notes on an Imperfect Science. Gawande A. New York: Metropolitan Books; 2002. For a brief description see the Amazon.com editorial review at:
www.amazon.com(www.amazon.com)
(March Board 2006) (2012 COD)
Clinical Practice Guidelines

See Also

- Clinical Recommendations

The American Academy of Family Physicians supports the use of evidence-based and explicitly stated clinical practice guidelines utilizing the following principles:

Clinical practice guidelines should be developed using rigorous evidence-based methodology with the strength of evidence for each guideline explicitly stated.

- Clinical practice guidelines should be feasible, measurable and achievable.
- Clinical practice guidelines, from which quality performance measures will be developed, should be reviewed by representatives of the physicians they will impact.
- Clinical performance measures may be developed from clinical practice guidelines and used in quality improvement initiatives. When these performance measures are incorporated into public reporting, accountability or pay for performance programs, the strength of evidence and magnitude of benefit should be sufficient to justify the burden of implementation.
- In the clinical setting, implementation of clinical practice guidelines should be prioritized to those that have the strongest supporting evidence and the most impact on patient population morbidity and mortality.
- Research should be conducted on how to effectively implement clinical practice guidelines and the impact of their use as quality measures.
- Clinical practice guidelines, from which quality performance measures have been developed, should be updated as new evidence is available, and the producers of the performance measures should be notified of the work in progress.

(1994) (April BOD 2013)
Clinical Proctoring

See also
- Privileges
- Privileges, Family Medicine Departments and Procedural Skills, Preceptor/Proctor Readiness Course
- Peer Review
- Peer Review, Confidentiality

AAFP Position

Clinical proctoring is an important peer review tool for physicians seeking privileges in hospitals and healthcare organizations. The American Academy of Family Physicians (AAFP) supports the development of proctoring programs, with appropriate medical staff bylaws provisions, to evaluate the clinical competence of new medical staff members seeking privileges and existing medical staff members requesting new or expanded privileges. Proctoring requirements should apply equally to all medical staff members, regardless of specialty. The AAFP supports family physicians proctoring family physicians, whenever possible.

Definitions of Clinical Proctoring

Proctoring is an objective evaluation of a physician's clinical competence by a proctor who represents, and is responsible to, the medical staff. New medical staff members seeking privileges or existing medical staff members requesting new or expanded privileges are proctored while providing the services or performing the procedure for which privileges are requested. In most instances, a proctor acts only as a monitor to evaluate the technical and cognitive skills of another physician. A proctor does not directly provide patient care, has no physician-patient relationship with the patient being treated, and does not receive a fee from the patient.

The terms proctorship and preceptorship are sometimes used interchangeably. However, a preceptorship is different in that it is an educational program in which a preceptor teaches another physician new skills and the preceptor has primary responsibility for the patient's care.

There are three types of proctoring: prospective, concurrent, and retrospective. In prospective proctoring, prior to treatment, the proctor either reviews the patient personally or reviews the patient's chart. This type of proctoring may be used if the indications for a particular procedure are difficult to determine or if the procedure is particularly risky. In concurrent proctoring, the proctor observes the applicant's work in person. This type of proctoring usually is used for invasive procedures so that the proctor can give the medical staff a firsthand account to assure them of the applicant's competence. Retrospective proctoring involves a retrospective review of patient charts by the proctor. Retrospective review is usually adequate for proctoring of noninvasive procedures.

Proctoring Guidelines for Bylaws Provisions

(1) If evidence of sufficient experience is lacking, new medical staff members and all existing medical staff members requesting new or expanded privileges should be subject to a period of proctoring, regardless of specialty.

(2) In departmentalized hospitals, each department should proctor its own new medical staff members or existing medical staff members who are requesting new or expanded privileges. For example, the family medicine department should recommend privileges for its members directly to the credentials committee without obtaining the approval of other departments, and the department also should perform the proctoring for those privileges. If there is no suitable proctor within the department, the department should
select a proctor from the medical staff or recommend that the hospital obtain a particular proctor from
another institution or training program. The length of the proctoring period, and/or the number of cases to
be proctored or objectives to be met during proctoring, should be established by the department.

(3) In non-departmentalized hospitals, proctoring responsibilities should be assigned by the medical
executive committee. The proctor should have similar qualifications to the applicant and be in the same
specialty.

(4) The proctor should be impartial and have documented training and/or experience, demonstrated
abilities, and current competence in the service or procedure that is the subject of the proctoring. The
proctor also should be a member of the hospital's medical staff, unless no suitable proctor is available on
the medical staff (as may occur in rural hospitals). Occasional service as a proctor should be required for all
medical staff members by the medical staff bylaws. In the event that no suitable proctor is available on
the medical staff, the hospital should obtain a proctor from another institution or training program. The hospital
should pay the expenses incurred in obtaining that proctor.

(5) The proctor's duty is to observe and evaluate the applicant and report to the department chair or
medical executive committee. In the event that a proctor finds it necessary to intervene in a case, the
hospital should agree in writing to indemnify the proctored physician for any damages that might result
from following the proctor's orders. The medical executive committee should get written confirmation of this
indemnification from the hospital's insurance carrier. The hospital also should agree to indemnify a proctor
for any damages resulting from a claim of battery.

(6) The proctor should prepare a written report describing the cases proctored and evaluating the
applicant's performance. The report should be submitted by the department chair to the medical executive
committee. In addition to the report, the department chair should recommend on of the following to the
medical executive committee: (1) the applicant should be granted the clinical privileges for which he or she
applied; (2) the applicant should be required to extend the proctoring period, or (3) the applicant should
have privileges restricted or terminated in accordance with the bylaws. The decision of the department
should be based on the applicant's performance during the proctoring period.

(7) The proctoring report should remain confidential and should be handled in the same manner as other
medical staff peer review information. Through the Board of Trustees, the medical staff should determine
the following: the location in which report files will be kept; access rights (i.e., who can access the reports,
when, and in what format); the procedure for an applicant to appeal a report or question the proctor who
wrote it; and the policy on retention of proctoring reports.

Guidelines for Proctors

Privileges for procedures and services should be based on a physician's documented training and/or
experience and demonstrated current competence. Competence is determined and verified on the basis of
evaluation of performance under clinical conditions (i.e., proctoring) rather than by the performance of an
arbitrary number of procedures. Direct observation by a trained and experienced proctor is the best method
for determining if a physician has the necessary knowledge and skills to perform a procedure or provide a
service safely and appropriately. Concurrent proctoring should be used for invasive procedures, while
retrospective proctoring may be adequate for noninvasive procedures.

Knowledge and Skills: Knowledge components of procedural skills are complex and procedure-specific;
however, some general rules govern the development of proficiency in performing most procedures. The
general areas of knowledge that should be mastered before one can be deemed competent are clinical,
 procedural, and equipment. The proctor should assess the following areas.¹

1. Clinical Knowledge
   1. General background information
   2. Indications and contraindications
   3. Physiology and pathophysiology

4. Anatomy
5. Limitations of the practitioner
6. Economics

2. Knowledge of the Equipment
   1. Technical aspects of the equipment
   2. Specific details of the equipment
   3. Operating details of the equipment
   4. Safety aspects of the equipment

3. Knowledge of the Procedure
   1. Physical characteristics of the procedure
   2. Technique of the procedure
   3. Preparation of the patient
   4. Precautions and potential complications
   5. Limitations of the procedure
   6. Special techniques
   7. Advanced techniques

Resources

(1) Miller M D. Education, training, and proficiency of procedural skills Primary Care 1997; 24:231-241
Clinical Recommendations

See Also

- Clinical Practice Guidelines
- Immunizations

AAFP's Clinical Recommendations
Clinical Skills Assessment Exam for Medical Students

The AAFP recognizes the importance of medical school graduate competency in the performance of patient evaluation that includes a medical history and physician examination. The AAFP also supports the comprehensive assessment of clinical skills through the use of standardized patient encounter simulations. If medical schools cannot consistently provide an objective assessment of clinical skills, then other resources should be used to assure graduate competence.

The US Medical Licensing Examination (USMLE) Clinical Skills Assessment Examination should be both affordable and conveniently accessible to all medical students. Performance standards and consistent reproducibility of USMLE Clinical Skills Assessment Examination results should be publicly available, and regularly updated, along with outcomes data confirming the effectiveness of the examination’s capacity to document competence. (2010 COD) (2015 COD)
CME Credit, AAFP/ AMA Equivalency Agreement

See also

- CME Credit, AAFP/CFPC Reciprocal Agreement
- CME Credit Eligibility Requirements

The American Medical Association (AMA) accepts the American Academy of Family Physicians (AAFP) Prescribed credit as equivalent to AMA PRA Category 1™ Credit for the AMA Physician's Recognition Award (PRA). When applying for the AMA PRA, AAFP Prescribed credit earned must be reported as Prescribed credit, not as AMA PRA Category 1 Credit™.

The AAFP accepts AMA PRA Category 1 Credit™ as equivalent to AAFP Elective credit. When reporting to the AAFP, AMA PRA Category 1 Credit™ earned must be reported as AMA PRA Category 1 Credit™, not as AAFP Prescribed credit. (1995) (2015 COD)
CME Credit, AAFP/ CFPC Reciprocal Agreement

See also

- CME Credit, AAFP/AMA Equivalency Agreement
- CME Credit Eligibility Requirements

The AAFP and the CFPC have a bilateral reciprocal certification agreement whereby: CME/CPD activities held across the Canada - U.S. border are certified according to the nationality of the primary target audiences regardless of where the providers are located. The activities will be reviewed according to the criteria of the certifying organization.

A CME/CPD activity is to be certified by the CFPC if the primary target audience is Canadian. If it is to be held in Canada by a U.S. provider, this is done through the appropriate CFPC Chapter office. If it is to be held in the United States, it is done through the CFPC national office. The CFPC will inform the AAFP of all such activities.

**AAFP Member - CME Credit Conversion**

AAFP members who complete any CME/CPD activity certified by the CFPC for Mainpro+ Certified credit can claim the equivalent number of AAFP Prescribed credits.

**CFPC Member - CME Credit Conversion**

CFPC members who complete any CME/CPD activity certified by the AAFP for Prescribed credit can claim the equivalent number of Mainpro+ Certified credits.

CFPC members who complete any CME/CPD activity certified by the AAFP for elective credit can claim the equivalent number of Mainpro+ Non-Certified credits.

Organizers of such activities who would like to promote their activities to CFPC members or AAFP members can remind them of the reciprocal agreement.

Upon written confirmation from the AAFP or CFPC that an activity has been certified, the following statements can be used in activity materials but must be presented exactly as indicated:

**AAFP-CERTIFIED CME ACTIVITIES:**

Members of the College of Family Physicians of Canada are eligible to receive MAINPRO+ Certified or Non-Certified credits for participation in this activity due to reciprocal agreement with the American Academy of Family Physicians.

**CFPC-CERTIFIED CME ACTIVITIES:**

Members of the American Academy of Family Physicians are eligible to receive Prescribed credits for participation in this activity due to reciprocal agreement with the College of Family Physicians of Canada (B1999) (2016 COD)
CME Mandatory for Relicensure

See also

- Continuing Medical Education (CME), Definition
- Continuing Medical Education (CME), Mission Statement
- CME, Physician Remediation
- CME Credit Eligibility Requirements
- Integrative Medicine, Credit for CME Activities

The AAFP requests that each constituent chapter undertake a program which will encourage at least one representative of its chapter be elected or appointed to any board or accreditation committee which mandates continuing medical education as a requisite for medical licensure or relicensure.

Maintenance of Licensure

The Federation of State Medical Boards (FSMB) Maintenance of Licensure (MOL) continues to evolve its framework, which has implications for the AAFP in its support of lifelong learning for family physicians. State licensure is currently mandatory, meets minimal standards, and aligns state board missions with public protection and safety.

Maintenance of Licensure Guiding Principles include:

- Reflective self-assessment - Maintenance of Certification (MOC)/Osteopathic Continuous Certification (OCC) and CME in practice area assist to meet this requirement
- Assessment of knowledge and skills - Practice-relevant Multiple Choice Question exams, standardized patients, computer-based case simulations, patient/peer surveys, procedural hospital privileging, and observation of procedures are suggested tools to meet this requirement
- Performance in practice - Performance improvement CME/projects, MOC/OCC, American Osteopathic Association Bureau of Osteopathic Specialists Clinical Assessment Programs, 360 evaluations, patient reviews, analysis of practice data, and CMS measures are additional recommended tools

(1977) (2013 COD)
CME Mission Statement

See also

- Continuing Medical Education (CME), Definition
- CME Mandatory for Relicensure
- CME, Physician Remediation
- Integrative Medicine, Credit of CME Activities
- CME, AAFP Activities and Industry Funding

The American Academy of Family Physicians (AAFP) seeks to provide family physicians and other health care professionals with continuing medical education activities that are based on the principles of adult learning. These activities are high-quality, unbiased, evidence-based, up-to-date, learner-driven, and produced in a variety of formats. The expected outcome of the AAFP CME program is to increase the number of learners who plan and/or demonstrate implementation of a meaningful change in their practices. (2010 COD) (May 2016 BOD)
CME, Physician Remediation

See also

- Integrative Medicine
- Integrative Medicine, Credit for CME Activities
- Definition of Continuing Medical Education
- CME Mandatory for Relicensure
- Continuing Medical Education (CME), Mission Statement
- Education, Physician Retraining

The AAFP recognizes physicians with gaps in educational and clinical skills are being identified by various means. To address these gaps, the AAFP believes that a prescriptive, corrective educational program based upon a comprehensive, individualized assessment is essential, as is documentation of achievement of competence at completion of the program. (COCPD) (1996) (2013 COD)
Coding and Payment

See also

- Payment, Physician
- Pre-payments and Post-payment Audits
- Payment for Non Face-to-Face Physician Services
- Payment, Non-Physician Providers

The introduction to the American Medical Association's *Current Procedural Terminology* states, in part:

*Current Procedural Terminology*, (CPT®), Fourth Edition, is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals, or entities.

Inclusion of a descriptor and its associated five-digit code number in the CPT Category I code set is based on whether the procedure or service is consistent with contemporary medical practice and is performed by many practitioners in clinical practice in multiple locations.

The American Academy of Family Physicians (AAFP) supports this position. The AAFP agrees that CPT describes the services that physicians provide and that inclusion of a service in CPT reflects contemporary medical practice.

The AAFP is not alone in its support for CPT and the coding principles it contains. The U.S. Department of Health and Human Services has adopted CPT, in combination with the Healthcare Common Procedure Coding System, as the standard medical data code set for physician services under the *Health Insurance Portability and Accountability Act*. Thus, CPT has both medical and regulatory recognition.

Given this recognition, the AAFP believes that it is important for both physicians and health plans to abide by the principles of CPT. For physicians, this means selecting the code that accurately identifies the service performed and documented. It also means that when a single code accurately describes multiple services provided by the physician, the physician should report that code rather than codes for each of the individual services provided.

For health plans, abiding by the principles of CPT means that payment for covered services should be based on the codes documented and billed by the physician. It also means that health plans should only bundle codes for payment consistent with CPT guidelines. Automatic, unilateral downcoding of physician reported CPT codes and bundling of codes contrary to CPT is not acceptable. It is also not acceptable for health plans to threaten to or actually restrict, terminate, or exclude a family physician from plan participation based on his or her coding pattern if the family physician provides medically necessary services and conscientiously abides by the principles and rules of CPT coding. The AAFP expects health plans to abide by CPT rules and is concerned about any variance from those rules.

Collective Negotiation

SEE ALSO

- Direct Contracting with Businesses by Family Physicians (Discussion Paper)
- Physician Payment
- Professional Medical Liability

To improve the quality of care in the American health care system, improve access to the system, and to reduce the cost of care, primary care physicians should be granted a limited exemption from federal and state antitrust legislation, so they can effectively negotiate with health insurance companies and become stronger patient advocates.

The McCarran-Ferguson Act (15 USC §§ 1011-1015), which exempts health insurance companies from federal anti-trust legislation that applies to most businesses, has:

- led to the consolidation of health insurance companies and thus limited competition among them, thereby giving them superior negotiating leverage with primary care physicians, and
- given health plans extraordinary control over benefit design, coverage exclusion, patient co-pay and deductible design, and formulary design, which adversely affects patients’ welfare.

Specifically, the AAFP recommends that:

1. America’s primary care physicians be given the same exemption from federal anti-trust legislation that is enjoyed by health insurance companies under the McCarran-Ferguson Act;
2. Any exemption for primary care physicians from federal anti-trust legislation, as is enjoyed by health insurance companies under the McCarran-Ferguson Act, be extended to state anti-trust legislation;
3. That primary care physicians be permitted to collectively negotiate with health insurers on matters including, but not limited to:
   - Fees for providing primary care services, including those for ancillary services they provide in their offices,
   - Monthly retainers, stipends, or capitations intended to cover care management and other non-face-to-face care, such as population management, quality improvement, etc.;
   - Utilization management (including, but not limited to, therapeutic and diagnostic denials and preauthorization processes); and
   - Any other matter that affects the quality of care received by patients.

(2011 COD) (2016 COD)
Colonoscopy (Position Paper)

See also

- Colonoscopy Privileging
- Rural Practice: Graduate Medical Education for (Position Paper)

Colonoscopy is an indispensable part of modern medical practice and one of the most commonly used invasive medical procedures. Like other endoscopic procedures, it has become “despecialized” in recent years and is now performed by physicians in many specialties, including family physicians. Colonoscopy is essential in diagnosing a variety of conditions, but it is most commonly used in the prevention and detection of colon cancer.

Family physicians have demonstrated the ability to learn colonoscopy and to perform the procedure safely and effectively. Because family physicians practice in all areas, including rural and underserved areas, their ability to offer colonoscopy improves access to care for many needy populations. Making this service readily available also helps reduce the inconvenience to patients who might otherwise have to wait weeks or travel long distances to see a specialist for the procedure.

The performance of colonoscopy is within the scope of family medicine, as evidenced by the following:

- In 2011, 2.6% of family physicians across the United States reported performing colonoscopy in their hospital practices, and an additional 5.1% said they perform colonoscopy with consultation only, demonstrating that in many locations mechanisms exist for family physicians to be privileged in this procedure.

- In rural areas, an average of 6.7% of family physicians perform colonoscopy. One geographic area in Texas reported a rate as high as 42% among physicians who graduated from family medicine residencies since 1990.

- Results of the 2009 American Academy of Family Physicians (AAFP) Practice Profile II Survey indicate that 5.7% of family physicians reported performing colonoscopy in their offices.

- According to a 2004 study, 48% of family medicine residency program offered training in colonoscopy, and 18% reported actually training one or more residents in the procedure.

Colonoscopy can be a natural extension of the total care provided by a well-trained family physician. Patients with gastrointestinal disorders are commonly seen by family physicians, and such complaints are often first reported to a family physician. Family physicians are trained to diagnose, treat, manage and appropriately refer patients with gastrointestinal disorders. Thus, part of a family physician’s role is to know when patients require endoscopy.

Studies indicate that family physicians who perform colonoscopy compare favorably with gastroenterologists and general surgeons when observable factors such as the cecal intubation rate, the time required to complete the procedure, and the rate of complications are used to determine technical competency in colonoscopy.

Benefits to the patient of having his or her family physician perform the colonoscopy include less fragmentation of care, patients’ comfort in having colonoscopy done by a physician they know and trust, decreased travel time, decreased cost to the patient, fewer (often redundant) lab tests, and high patient satisfaction. Rural patients particularly benefit from these factors because of their distance from urban referral centers.

The provision of colonoscopy by family physicians also has community implications. Endoscopic procedures constitute a major portion of the clinical care provided by many hospitals. Rural hospitals, in order to
continue providing this care, need physicians who can perform colonoscopy. The survival of small hospitals may hinge on the presence of family physicians who can provide modern endoscopic care, among other issues.

**Table 1**
Circumstances in Which Diagnostic Colonoscopy is Generally Not Indicated

- Chronic, stable irritable bowel syndrome
- Chronic abdominal pain
- Acute diarrhea
- Routine follow-up of inflammatory bowel disease (except dysplasia/cancer surveillance in chronic ulcerative colitis)
- Upper gastrointestinal tract bleeding or melena with a demonstrated upper gastrointestinal tract source
- Metastatic adenocarcinoma or unknown primary site in the absence of colonic signs or symptoms when it will not influence management

**Table 2**
Conditions Increasing the Risk of Colonoscopy

- Fulminant colitis
- Known or suspected perforation
- History of radiation therapy for abdominal or pelvic cancer
- History of abdominal or pelvic malignancy
- Extensive adhesions from prior abdominal surgery
- Bleeding dyscrasias
- Anticoagulant therapy
- History of complications with anesthesia or intravenous conscious sedation
- Known history of diverticulosis/diverticulitis
- Unstable cardiorespiratory condition
- Early post-colectomy period
- Uncooperative patient

**Table 3**
Possible Complications of Colonoscopy

- Bleeding
- Perforation
- Respiratory depression
- Bradycardia
- Hypoxia
- Hypotension
- Cardiac arrhythmias or ischemia
- Transient bacteremia
- Postpolypectomy syndrome
- Drug reaction
- Nausea/vomiting
- Ileus

Family physicians most often acquire skills for performing colonoscopy during their three years of family medicine residency training. Another possible route to acquiring the needed skills is through preceptorship by another physician who already has such training and privileges. Established experience in flexible sigmoidoscopy examination is helpful in developing colonoscopy skills. For those family physicians already skilled at flexible sigmoidoscopy, there are courses, seminars, and other extended opportunities to learn colonoscopy. These courses usually include the use of models, patients, and extensive didactic instruction, including slide and/or video programs.
The acquisition of the psychomotor skill involved in performing colonoscopy should be coupled with development of the cognitive skills involved in knowing when to perform the procedure and how to properly interpret findings and pathology reports. Any program that includes endoscopy training should provide both. It is equally important to teach the recognition of the contraindications to colonoscopy, the possible complications, and their proper management as laid out in tables 1 through 3 above.\textsuperscript{16,17}

Advanced Cardiac Life Support (ACLS) training and certification may be required for hospital privileges because of the use of intravenous (IV) conscious sedation. Even if ACLS certification is not required, it is recommended, so that the physician performing colonoscopy is prepared for an anesthetic or cardiopulmonary complication.

Although the number of procedures performed in training is sometimes recommended as a criterion for credentialing, numbers alone do not demonstrate quality of outcomes. There is no scientific data correlating the volume of colonoscopies performed with the acquisition of competence.\textsuperscript{18} The American Society for Gastrointestinal Endoscopy (ASGE) recommends that physicians perform a minimum of 140 diagnostic colonoscopies and 30 snare polypectomies before competency can be assessed, but the organization does acknowledge the importance of using "objective criteria of skill, rather than an arbitrary number of procedures performed" in the granting of endoscopic privileges.\textsuperscript{19}

Based upon recent studies, the AAFP has determined that the standard of fifty (50) cases as the primary operator be used as a basis for determination of basic competency.\textsuperscript{20-22}

Family physicians seeking colonoscopy privileges would do well to document their training and experience. This should include keeping a record of patients' operative reports (including the items listed in Table 4), a record of experience and training (including items listed in Table 5), and a competence-based evaluation or recommendation from their residency program or faculty instructors.

**Table 4**
Content of Procedure Notes

- Patient identification or code
- Date of procedure
- Name of hospital/location of procedure
- Patient's age
- Patient's history of prior colonoscopy, including any problems associated with previous procedures
- Clinical indication for colonoscopy
- Description of procedure
- Complications

**Table 5**
Suggested Documentation of Colonoscopy Experience

- Number of procedures performed during training and practice
- Outcome data, including complication rate
- Letters from instructors, preceptors, and proctors documenting training, experience, demonstrated abilities, and current competence
- Letters from previous hospitals documenting experience and outcomes
- Documentation that potential complications from the procedure and medications have been discussed with the patients, that alternative diagnostic tests and their advantages and disadvantages compared with endoscopy were discussed, and that informed consent has been obtained.\textsuperscript{7}

The amount of continuing colonoscopy experience needed to maintain proficiency has not been extensively studied. As mentioned above, however, researchers have reported that family physicians performing endoscopic procedures have outcomes comparable to, or exceeding, those of other specialists.\textsuperscript{9-14}

Current policies and procedures for credentialing family physicians in colonoscopy vary markedly from site
to site. In hospitals with departments of family medicine where other family physicians perform colonoscopy, the department should privilege its own members. In hospitals where it is not usual for family physicians to perform colonoscopy, there may be no mechanism for family medicine credentialing in this or other invasive procedures. In these institutions, completion of a residency in gastroenterology may be stated as a prerequisite for obtaining colonoscopy privileges. Such requirements run counter to the positions of the AAFP, the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), and the American Medical Association (AMA) credentialing criteria.

It is the position of the American Academy of Family Physicians (AAFP) that clinical privileges should be based on the individual physician's documented training and/or experience, demonstrated abilities and current competence, and not on the physician's specialty.²³

The JCAHO requires this, as it makes clear in its Hospital Accreditation Standards 2013:

The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process. ...

The hospital, based upon recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a practitioner’s ability to provide patient care, treatment, and services within the scope of privilege(s) requested. Evaluation of all of the following are included in the criteria:

- Current licensure and/or certification, as appropriate, verified with the primary source
- The applicant’s specific relevant training, verified with the primary source
- Evidence of physical ability to perform the requested privilege
- Data from professional practice review by an organization(s) that currently privileges the applicant (if available)
- Peer and/or faculty recommendation
- When renewing privileges, review of the practitioner’s performance within the organization

All of the criteria used are consistently evaluated for all practitioners holding that privilege. (MS.06.01.05)²⁴

The AMA holds a similar position. Regarding staff privileges, AMA Policy E-4.07 says this:

The mutual objective of both the governing board and the medical staff is to improve the quality and efficiency of patient care in the hospital. Decisions regarding hospital privileges should be based upon the training, experience, and demonstrated competence of candidates, taking into consideration the availability of facilities and the overall medical needs of the community, the hospital, and especially patients. Privileges should not be based on numbers of patients admitted to the facility or the economic or insurance status of the patient. Personal friendships, antagonisms, jurisdictional disputes, or fear of competition should not play a role in making these decisions. Physicians who are involved in the granting, denying, or termination of hospital privileges have an ethical responsibility to be guided primarily by concern for the welfare and best interests of patients in discharging this responsibility.²⁵

In addition, AMA policy H-230.998 on Hospital Privileges says, “Our AMA believes that clinical departments of family practice should be established where appropriate with duties comparable to any other specialty department of the medical staff.”²⁶

“Community need” is often cited as a reason to withhold colonoscopy privileges from family physicians practicing in environments shared with subspecialists. In such environments, gastroenterologists may not perceive a community need for family physicians to provide this service. This approach is not consistent with Joint Commission or AMA credentialing guidelines either, however.

Family physicians moving to new practice sites who plan on performing colonoscopy would do well to extensively research the site’s policies and procedures regarding privileges for colonoscopy. They should obtain these privileges before moving to the new practice site. This approach would be particularly helpful if
the family physician is to be the first to request these privileges in an environment where gastroenterologists alone hold such privileges.

The following is a list of items to consider when applying for hospital privileges to perform colonoscopy:

1. Carefully study the language of the hospital privileges policy, and make sure you understand the process by which the privileges are granted.
2. Prepare a brief resume describing your educational background including college, medical school, and board certification/recertification. Include dates of hospital affiliations, state and national medical societies, professional honors, awards, and elected offices or committee chair positions. Describe any prior hands-on proctorship experiences.
3. Describe the years of practice and your record in providing high-quality health care for a variety of cases. This should include the number of colonoscopies performed, your cecal intubation rate, and your complication rate.
4. List all accredited CME courses you have taken that pertain to colonoscopy. Also include any self-study of gastrointestinal disease, such as atlases, articles, etc.
5. Include a summary letter from your residency or state chapter of the American Academy of Family Physicians that supports these privileges as being within the scope of family practice.
6. Cite pertinent AAFP policies, including these:
   B. The AAFP believes that adequate training [in colonoscopy] can consist of documented education in an ACGME-approved residency program which prepares residents to practice colonoscopy; continuing medical education courses which provide didactic and procedural training; and/or precepted experience focused on colonoscopy.
   D. Endoscopic competence should be demonstrated by any physician seeking privileges for the procedure.
   E. Privileges should be granted for each specific procedure for which training has been documented and competence verified. The ability to perform any one endoscopic procedure does not guarantee competency to perform others
   F. Endoscopic privileges should be defined by the institution granting privileges and reviewed periodically with due consideration for performance and continuing education.
7. Indicate that the AAFP strongly believes that all medical staff members should realize that there is overlap between specialties and that no one department has exclusive “rights” to privileges.
9. Highlight JCAHO Standard MS.06.01.05, ("The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s), is an objective, evidence-based process,")
10. Identify to the appropriate hospital committee a physician on staff who has colonoscopy privileges and is willing to proctor you.
11. Provide evidence of your ability to obtain malpractice insurance coverage. If your malpractice coverage includes surgical assisting, or if you are doing obstetrics, you should not have to increase your “insurance class.”
12. Describe your plan for quality assurance. This should mean tracking your cases, and providing the data to your department chair after a period of six to 12 months.
13. Establish a plan for continuing medical education, such as attendance at gastrointestinal conferences or board reviews, the annual meetings of the American College of Gastroenterology or the American Gastroenterology Association, or Digestive Disease Week.
14. Express your willingness to work with the hospital to provide any information it believes is missing or incomplete.
15. If necessary, indicate that legal opinion and precedent have determined liability regarding the granting
and/or failure to grant privileges for procedures based on factors other than the experience and
competency of the physician in question. A legal opinion on privileges for endoscopy submitted to the
AAFP in 1993 stated the following:
   A. Hospitals and peer review participants risk liability under state law if they base credentialing
decisions solely on whether or not a physician has obtained specialty certification.
   B. The Council on Ethical and Judicial Affairs of the AMA has issued the opinion that competitive
factors must be disregarded in making decisions about credentials and privileges.
   C. There is no evidence that only board-certified gastroenterologists are “qualified” to perform
endoscopic procedures.
   D. Hospitals violate the “Medicare Conditions for Participation” if they base credentialing decisions
solely on specialty board certification.
   E. Hospitals and peer review participants risk loss of federal and state immunity from liability by
basing credentialing decisions solely on whether or not a physician has obtained specialty
certification.\(^29\)

Some family physicians may find office colonoscopy to be considered a safe and cost-effective alternative
to in-hospital colonoscopy.\(^5\,7\) Because of the equipment expense, however, this may be too costly an
option, especially for solo practitioners. Practices that offer office colonoscopy, need to maintain monitoring
equipment and emergency supplies. These should include a pulse oximeter, a blood pressure cuff
(preferably automated), an electrocardiogram monitor, oxygen, and a “crash cart,” with both naloxone
(Narcan) and flumazenil (Romazicon) to reverse narcotic and benzodiazepine effects, if necessary.
Consideration should also be given to meeting JCAHO or other accreditation inspection and licensing
standards for this equipment.

Since some health insurance companies now require that colonoscopy be performed in a hospital or
licensed outpatient facility, family physicians should determine whether their practices are in compliance

The research agenda relating to colonoscopy by family physicians should focus on these major areas:

- **Quality assurance.** Initiate ongoing case review programs/studies to monitor the endoscopic
  outcomes of family physicians performing colonoscopy, and compare these outcomes with those of
  other specialties.
- **Training methods, including cognitive and procedural aspects.** Address questions concerning
  the learning curve. For continuing quality improvement purposes, research is needed to determine the
  relationship significance, if any, between the number of procedures performed and demonstrated
  proficiency and maintenance of skills.

In an ideal world, the specialty societies would work together to improve patient care by disseminating
technology and educating all physicians. Unfortunately, other groups have in the past been unwilling to
work cooperatively with the AAFP on endoscopy issues. In such situations, the AAFP has had no choice but
to develop its own educational programs. In situations where other specialty organizations are willing to
partner with the AAFP, the AAFP welcomes the chance to work toward improved patient care by increasing
the education of its members.

1. American Academy of Family Physicians. Provision of selected services and procedures in hospital
practices of family physicians (as of April 2011). In Facts About Family Medicine. Kansas City, MO: American
2. Carr KW, Worthington JM, Rodney WM, et al. Advancing from flexible sigmoidoscopy to colonoscopy in
4. Young RA, Byrd AN. Practice patterns of rural Texas physicians trained in a full-service family practice


27. Rodney WM. How to apply for GI endoscopy privileges. Memorandum to the American Academy of Family Physicians Commission on Continuing Medical Education. 6th draft. June 29, 1994.


(B2000) (2013 COD)
Colonoscopy Privileging

See also

- Colonoscopy (Position Paper)
- Privileges
- Family Medicine Departments and Privileges

National screening guidelines for colon cancer have expanded in recent years to include a number of options. Although no single procedure has emerged as the screening of choice, colonoscopy is increasing in frequency because of greater likelihood of detecting early lesions and for patient comfort. To meet this important public health challenge, communities must have adequate numbers of physicians capable of performing colonoscopy. Increasing numbers of family physicians are trained to perform colonoscopy, with nearly 2,000 practicing this procedure in communities throughout the United States.

Hospital governing boards, with the input of their medical staffs, must determine who should be granted colonoscopy privileges at their institutions. The basis for such decisions is a review of the education, training, experience and current competence of the practitioner applying for the privilege. Where family physicians meet the institution’s privileging criteria for colonoscopy, they should be granted this privilege. This decision should be based solely on the candidate’s ability to meet established criteria, and not be improperly blocked or derailed by the opposition of other specialists or competitors on the medical staff.

The American Academy of Family Physicians (AAFP) believes that adequate training can consist of documented education in an ACGME-approved residency program which prepares residents to practice colonoscopy; continuing medical education courses which provide didactic and procedural training; and/or precepted experience focused on colonoscopy.

The amount of experience that should be required to hold privileges in colonoscopy is often a matter of contention. There is no scientific data correlating the volume of colonoscopies performed with the acquisition of competence. It is clear that individual practitioners have varying levels of manual dexterity and prior experience with flexible sigmoidoscopy and acquire skills at different rates. Studies indicate that family physicians who perform colonoscopy compare favorably with gastroenterologists and general surgeons when observable factors (such as the “reach-the-cecum” rate, the time required to complete the procedure, and the rate of complications) are used to determine technical competency in colonoscopy.¹

The AAFP has performed a national survey of its members who have been granted colonoscopy privileges in US hospitals. The data from this survey indicate that hospitals have granted privileges to family physicians whose experience ranges from five colonoscopies to more than 150. Of those surveyed, 61 percent had received hospital privileges having performed less than 55 colonoscopies. A review of the literature and available data provide no basis for believing individuals at the low end of this experience range should not hold colonoscopy privileges. Nevertheless, specialty societies have sometimes promulgated “privileging guidelines” putting forth high number requirements for experience which are arbitrary and self-serving.

Once a hospital determines the experience it will require to qualify for a privilege, it must confirm current competency. The AAFP believes this can be efficiently and fairly achieved through a requirement for references. The reference should have first-hand knowledge of the applicant’s ability to perform colonoscopy competently. The reference’s attestation to competency affirms that the applicant’s training and experience have actually been adequate for the particular individual under review. If after reviewing references, the hospital still has questions about an individual’s competence, a period of proctoring to observe performance may be appropriate.

The process just described protects patients and, when uniformly applied, provides a fair mechanism for a hospital to grant a particular privilege such as colonoscopy. Hospital credentialing committees, medical executive committees, and governing boards should resist pressure to create artificial and arbitrarily high experience requirements as barriers to the privileging of family doctors to perform colonoscopy. (2003)
Colposcopy (Position Paper)

See also
- AAFP/ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Rural Practice: Family Medicine Graduate Medical Education Training for Rural Practice (Position Paper)
- Privileges

Overview and Justification

Worldwide, it is estimated that there are 528,000 new cases of cervical cancer each year and that 266,000 women die from the disease.\(^1\) In the United States, the National Cancer Institute (NCI) estimates that 1,200 new cases of cervical cancer will be diagnosed in 2015, and that 4,100 women will die from the disease.\(^2\) Currently, the five-year survival rate for localized cervical cancer is 91.5%; the overall (i.e., all stages combined) five-year survival rate is approximately 67.8%.\(^3\) Cervical cancer was once one of the most common causes of cancer death among U.S. women, but since the 1980s, the cervical cancer death rate in the United States has decreased by more than 50%.\(^4\)

Studies show that access to health care is an important predictor of cancer screening. In the United States, pap tests are ordered or provided in approximately 29.4 million physician office visits each year, and it is estimated that more than 3 million women get unclear or abnormal results.\(^5,6\)

Colposcopy is the diagnostic test indicated for evaluating patients with abnormal Pap test results.\(^7\) During the procedure, features of the cervical epithelium are examined under magnified illumination after the application of normal saline, 3% to 5% dilute acetic acid, and Lugol iodine solution in successive steps.\(^7\) A green filter highlights vascular patterns.

Neither cytologic sampling nor colposcopic examination alone provides definitive answers. If abnormal tissue is present, it is the histologic result that provides the basis for treatment or observation.

Section I - Scope of Practice for Family Physicians

Use of colposcopy-directed biopsies to confirm lower genital tract disease has become common practice for many physicians. It is recognized that performance of colposcopy, in both inpatient and outpatient settings, is within the scope of family medicine, and data from a 2014 member census show that 15.6% of American Academy of Family Physicians (AAFP) members perform this procedure in the office setting.\(^8\)

It is the position of the AAFP that clinical privileges should be commensurate with the individual physician’s documented training and/or experience, demonstrated abilities, and current competence.\(^9\) This policy applies to privileges in all areas. The AAFP also maintains the position that all physicians should be paid for performing all clinical services for which they have documented training and/or experience, demonstrated abilities and current competence to perform.\(^10\)

The AAFP also advocates the development of explicit patient-centered clinical practice guidelines that focus on what should be done for patients rather than who should do it.\(^11\) When clinical practice guidelines address the issue of who should provide care, then recommendations for management, consultation, or referral should emphasize appropriate specific competencies, rather than a clinician’s specialty designation.

The American Medical Association’s policy on staff privileges states that “Decisions regarding hospital privileges should be based upon the training, experience, and demonstrated competence of candidates, taking into consideration the availability of facilities and the overall medical needs of the community, the hospital, and especially patients. Privileges should not be based on numbers of patients admitted to the facility or the economic or insurance status of the patient. Personal friendships, antagonisms, jurisdictional disputes, or fear of competition should not play a role in making these decisions. Physicians who are involved in the granting, denying, or termination of hospital privileges have an ethical responsibility to be guided primarily by concern for the welfare and best interests of patients in discharging this responsibility.”\(^12\)

The Joint Commission requires hospitals or credentialing entities to establish a process that provides fair and equal treatment to all applicants. The “credentialing and privileging process involves a series of activities designed to collect, verify, and evaluate data relevant to a practitioner’s professional performance. These activities serve as the foundation
for an objective, evidence-based decisions regarding appointment to membership on the medical staff. And recommendations to grant or deny initial and renewed privileges. In the course of the credentialing and privileging process, an overview of each applicant’s licensure, education, training, current competence, and physical ability to discharge patient care responsibilities is established.”

Section II - Clinical Indications for Colposcopy

The following, however, are generally considered to be the most specific indications for colposcopy:

- Abnormal Pap test result (the primary indication for colposcopy).
- Abnormal-appearing tissue in the vagina, on the cervix or vulva, perineum, perianal area, or male genitalia.
- Abnormal-appearing cervix, even if cervical cytology is normal.
- Intrauterine exposure to diethylstilbestrol.
- Child abuse and rape cases.
- Patient history indicates high risk for cervical cancer, such as a male partner who has had previous or current sex partners who developed cervical cancer.
- Follow-up examinations after treatment for high grade squamous intraepithelial lesion (HGSIL) or lower genital tract cancer.
- Follow-up examination after and positive human papillomavirus (HPV) test result when the Pap test is normal.

Section III - Training Methodology

The AAFP’s recommended curriculum guidelines for family medicine residents are intended to help family medicine residency directors develop curricula and to help residents identify areas of needed training. The curriculum guideline on women’s health and gynecologic care lists colposcopy as a skill that family medicine residents should demonstrate the ability to independently perform or appropriately refer. A curriculum in colposcopy must impart cognitive and psychomotor skills.

Ideally, the family physician will continue a lifelong learning program that incorporates participation in intermediate and advanced colposcopy courses, which are offered by the American Society of Colposcopy and Cervical Pathology (ASCCP) and other organizations and institutions. Membership in societies that are actively involved in developing evidence-based practice guidelines and standards for colposcopy may also be beneficial.

Section IV - Testing, Demonstrated Proficiency and Documentation

The AAFP recommends that family physicians document all significant training and experience so that it is recorded and can be reported in an organized fashion. Such documentation should include at a minimum all procedural skills, intensive/critical care experiences, treatment of major illnesses, and other significant training and experiences. Further, procedural skills and professional competency can be effectively evaluated. Clinical proctoring is an important peer review tool for physicians seeking privileges in hospitals and health care organizations including colposcopy. Please see the Academy’s position paper on Clinical Proctoring for additional information.

Section V - Credentialing and Privileges

As is already established, the AAFP holds that all physicians on the medical staff should have the opportunity to practice medicine in their health care organizations, and should be granted clinical privileges commensurate with their documented training and/or experience, demonstrated abilities, and current competence. The AAFP believes that any hospital departmentalized by specialty should establish a department of family medicine that has the right to recommend privileges that fall within the scope of family medicine directly to the appropriate committee. Please see the AAFP’s policy on Family Medicine Departments and Privileges for additional information.

The process for credentialing and delineation of family medicine privileges varies among organizations. Before applying for colposcopy privileges, the applicant should do the following:

- Ensure that the documentation of his or her documentation of training, experience, and current competence is in order. It is also advisable to maintain ongoing documentation of relevant clinical experience.
- Review the eligibility criteria for each privileges requested, and review his or her training and experience for any gaps or areas that may need to be addressed before applying for privileges.
- Review the hospital’s privileging process and bylaws, including procedures in the event of a denial. If the applicant is denied privileges, he or she should ask for the reason in writing.
Collect letters of recommendation from past instructors, preceptors, those who have monitored your clinical performance, and colleagues who have worked with you throughout the years.

Assemble case reports including data about the number and types of cases, treatment outcomes, etc.

Assemble documentation records maintained during your family medicine residency.

The applicant should include complete documentation, case reports, and letters of recommendation with the application for colposcopy privileges. To avoid losing original documents in the course of the review, he or she should submit copies, not originals.

Some problems with privileges arise because other specialists do not understand the scope of family medicine. Family physicians on the medical staff—or within the hospital's family medicine department, if there is one—should provide general information about family medicine to other specialists. They should also communicate the following points:

1. Clinical privileges should be considered on the basis of each individual physician's documented training or experience, demonstrated abilities, and current competence.
2. Overlap occurs among many specialties.
3. No clinical privileges are the exclusive province of one department.
4. Determining when to consult and when to refer patients is a vital part of a family physician's training.
5. Continuity of care is a primary objective of family medicine, and this objective is consistent with quality patient care.
6. Family physicians are supported by the AAFP in their efforts to obtain privileges for which they are qualified.

Section VI - Miscellaneous Issues

It is important for family physicians to receive high-quality didactic and procedural training in colposcopy.

Primary prevention through risk-factor identification and patient education is as important in reducing the prevalence of cervical cancer as secondary prevention by identification of dysplastic lesions at the time of colposcopy.

Whether the performance of colposcopy by family physicians saves money and resources at the societal level is unknown, although it would seem to have several favorable results:

1. Identification of disease at earlier stages
2. Improved compliance with follow-up regimens that can be expected with the increased continuity of care
3. An increased knowledge of and attention to risk factors
4. Increased patient satisfaction

Productive areas for educational research on colposcopy privileging include improved definition of the competency-based measures required for performance of colposcopy and analysis of outcomes in family medicine compared with other specialties.

Section VII - Data Sources

8. American Academy of Family Physicians. Family medicine facts. Table 12: Clinical procedures performed by physicians at their practice (as of June 30, 2014). http://www.aafp.org/about/the-aafp/family-medicine-facts/table-


(B1998) (2015 COD)
Commission Meetings, Officer Attendance At

See also

- Commissions, Orientation Manual (100 page PDF)

The number of officers attending cluster meetings is limited to three per cluster, with the president, president-elect and Board chair having first priority. (B1986) (2016 December BOD)
Community and Migrant Health Centers

See also

- Migrant Health Care
- Diversity, Assuring Sensitivity to Diversity in AAFP Education Activities
- Diversity in the Workforce
- Culturally Sensitive Interpretive Services - AAFP Legislative
- Criminalization of Medical Practice
- Criminalization of the Provision of Medical Care to Undocumented Individuals
- Reporting on Residency Status of Patients
- Medically Underserved
- Essential Community Provider
- Homelessness
- National Minority Health Month
- Neonatal Circumcision

The American Academy of Family Physicians recognizes the important contribution of the Community and Migrant Health Center Programs in improving access to health care services in underserved communities. The Academy is committed to working with community and migrant health centers to improve the availability of family physicians for practice in underserved communities. (1992 COD) (2015 COD)
The American Academy of Family Physicians supports the concept of access to essential health care to all peoples regardless of social and economic status. The AAFP supports efforts to identify appropriate funding of these essential medical services, and the AAFP continues to support its basic concepts and long-term goals of access to comprehensive and continuing medical care for all. (CGA) (1981) (2013 COD)
Comprehensive Care, Definition of

See also

- Comprehensive Care, Access to
- Health Care for All
- Family Medicine, Scope and Philosophical Statement
- Patient Care, Concurrent

The practice of continuing comprehensive care is the concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment. (CGA) (1980) (2013 COD)
Confidentiality, Patient/Physician

See also

- Adolescent Health Care, Confidentiality
- Infringement on Patient Physician Relationship
- Patient Responsibility for Follow-Up of Diagnosis and Treatment
- Physician and Payment Relationships, Professional Responsibility
- Physician Expert Witness in Medical Liability Suits

A confidential relationship between physician and patient is essential for the free flow of information necessary for sound medical care. Only in a setting of trust can a patient share the private feelings and personal history that enable the physician to comprehend fully, to diagnose logically, and to treat properly. The American Academy of Family Physicians (AAFP) supports full access by physicians to all electronic health information within the context of the medical home.

The AAFP believes that patient confidentiality must be protected. Historically, the privileged nature of communications between physician and patient has been a safeguard for the patient’s personal privacy and constitutional rights. Though not absolute, the privilege is protected by legislative action and case law. NOTE: Nothing herein or below shall be construed as contravening the standards for health information contained in Health Insurance Portability and Accountability Act (HIPAA) relating to privacy, confidentiality, or security of personal health information.

Data sharing is difficult, particularly across state lines given differing state patient privacy/confidentiality requirements. The AAFP believes that state and federal legislators and jurists should seek a greater degree of standardization by recognizing the following principles regarding the privacy of medical information:

A. The right to privacy is personal and fundamental.

B. Medical information maintained by physicians is privileged and should remain confidential.

C. The patient should have a right of access to his/her medical records and be allowed to provide identifiable additional comments or corrections. The right of access is not absolute. For example, in rare cases where full and direct disclosure to the patient might harm the patient’s mental and/or physical well-being, access may be extended to his/her designated representative, preferably a physician.

D. The privacy of adolescent minors should be respected. Parents should not, in some circumstances, have unrestricted access to the adolescent’s medical records. Confidentiality must be maintained particularly in areas where the adolescent has the legal right to give consent.

E. Medical information may have legitimate purposes outside of the physician/patient relationship, such as, billing, quality improvement, quality assurance, population-based care, patient safety, etc. However, patients and physicians must authorize release of any personally identifiable information to other parties. Third party payer and self-insured employer policies and contracts should explicitly describe the patient information that may be released, the purpose of the information release, the party who will receive the information, and the time period limit for release. Policies and contracts should further prohibit secondary information release without specific patient and physician authorization.

F. Any disclosure of medical record information should be limited to information necessary to accomplish the purpose for which disclosure is made. Physicians should be particularly careful to release only necessary and pertinent information when potentially inappropriate requests (e.g., "send photocopies of last five years of records") are received. Sensitive or privileged information may be excluded at the option of the physician unless the patient provides specific authorization for release. Duplication of the medical record by mechanical, digital, or other methods should not be allowed without the specific approval of the physician, taking into consideration applicable law.
G. Disclosure may be made for use in conducting legal medical records audits provided that stringent safeguards to prevent release of individually identifiable information are maintained.

H. Policy exceptions which permit medical records release within applicable law:

1. To another physician who is being consulted in connection with the treatment of the individual by the medical-care provider;
2. In compelling circumstances affecting the health and safety of an individual;
3. Pursuant to a court order or statute that requires the physician to report specific diagnoses to a public health authority; and
4. Pursuant to a court order or statute that requires the release of the medical record to a law enforcement agency or other legal authority.

I. Electronic health information communication systems must be equipped with appropriate safeguards (e.g., encryption; message authentication, user verification, etc.) to protect physician and patient privacy and confidentiality. Individuals with access to electronic systems should be subject to clear, explicit, mandatory policies and procedures regarding the entry, management, storage, transmission and distribution of patient and physician information.

The AAFP supports the use of patient record information for primary care research, biomedical and pharmaceutical research and other health research, provided there is appropriate protection for research subjects, i.e., Institutional Review Board approval.

(1979) (2013 COD)
Consultations and/or Policies on Referrals

See also

- Fees to Physicians for Referrals to Other Health Care Providers
- Consultations, Referrals, and Transfers of Care
- Patient Self-Referral

"The use of consultation serves as a means of maintaining a high standard of professional care. The American Academy of Family Physicians believes that all members of a medical staff should have access to consultation when necessary, and that such consultation, when requested in a timely and appropriate manner, shall not be arbitrarily refused. In those instances in which consultation or backup is required by the medical staff of a hospital, it is the ethical responsibility of the medical staff of that hospital to provide timely consultation or backup." Privileges are granted on the basis of documented training and/or experience, demonstrated abilities and current competence. Therefore, mandatory consultations and/or referrals for groups of physicians based on specialty classification or department membership without reference to individual capabilities are clearly discriminatory. (1986) (2016 September BOD)
Consultations, Referrals, and Transfers of Care

See ALSO

- Consultations and/or Policies on Referrals

Historically, the terms “consultation,” “referral,” and “transfer of care” have sometimes been used interchangeably. That continues to be the case, with understanding of the terms varying among individuals and regions of the country. However, the American Academy of Family Physicians (AAFP) believes there are essential differences among these terms.

A consultation is a request from one physician to another for an advisory opinion. The consultant performs the requested service and makes written recommendations regarding diagnosis and treatment to the requesting physician. The requesting physician utilizes the consultant’s opinion combined with his own professional judgment and other considerations (e.g. patient preferences, other consultations, family concerns, and comorbidities) to provide treatment for the patient.

A referral is a request from one physician to another to assume responsibility for management of one or more of a patient’s specified problems. This may be for a specified period of time, until the problem(s) is resolved, or on an ongoing basis. This represents a temporary or partial transfer of care to another physician for a particular condition. It is the responsibility of the physician accepting the referral to maintain appropriate and timely communication with the referring physician and to seek approval from the referring physician for treating or referring the patient for any other condition that is not part of the original referral.

A transfer of care occurs when one physician turns over responsibility for the comprehensive care of a patient to another physician. The transfer may be initiated by either the patient or by the patient’s physician, and it may be either permanent or for a limited period of time until the patient’s condition improves or resolves, or based on the patient wishes. When initiated by the patient’s physician, the transferring physician should explicitly inform the patient of the transfer, and assist the patient with timely transfer of care consistent with local practice. (2007 COD) (2016 September BOD)
Continuing Medical Education, AAFP Activities and Industry Funding

See also:

- CME Mission Statement

The AAFP affirms that it must maintain responsibility for control over the selection of content, faculty, education methods and materials in all of its continuing medical education (CME) activities, to ensure objectivity, balance, and scientific rigor and independence. "Responsibility" for "control" includes all aspects of topic selection, content development, and speaker selection, which will be conducted by the AAFP.

The AAFP appreciates the financial support provided by proprietary entities for its CME activities. Any funds for this purpose must be in the form of an unrestricted educational grant made payable to the AAFP as the accredited provider of the supported activities. These activities are subject to the AAFP's guidelines for external relationships involving CME.


The AMA "Ethical Guidelines for Gifts to Physicians from Industry" serves as a guide to individual AAFP members, the ACCME "Standards for Commercial Support" serves as a guide for the development of all CME activities by the AAFP; and the CMSS "Code for Interactions with Companies" serves as a guide for the AAFP's relationships with commercial interests.

The AAFP is of the opinion that the AMA guidelines are open to interpretation. The AAFP extends the AMA guidelines to cover relationships with all proprietary health-related entities that might create a conflict of interest rather than limiting the application of the principles to "pharmaceutical, device, and medical equipment industries." The AAFP has the right and responsibility to interpret the guidelines for the organization and its members on an ongoing basis. The AAFP opposes federal or state governmental efforts to enforce these guidelines. The issue of enforcement is the responsibility of physicians and their professional organizations.

In 2013, the Centers for Medicare & Medicaid Services released the "National Physician Payment Transparency Program" (formerly known as the Sunshine Act) which requires manufacturers of pharmaceuticals or medical devices to publicly report payments made to physicians and teaching hospitals thereby creating greater transparency around the financial relationships that occur among them. Indirect payments to faculty are exempted from reporting when the CME activity meets the accreditation requirements and standards of the ACCME and/or the eligibility requirements and standards of the AAFP CME Credit System. (1991) (2014 COD)
Continuing Medical Education (CME), Definition

See also

- Continuing Medical Education (CME), Mission Statement
- CME Credit Eligibility Requirements
- CME Mandatory for Relicensure
- CME, Physician Remediation
- Integrative Medicine, Credit for CME Activities

Continuing medical education is the process by which family physicians and other health professionals engage in activities designed to support their continuing professional development. Activities are derived from multiple instructional domains, are learner centered, and support the ability of those professionals to provide high-quality, comprehensive, and continuous patient care and service to the public and their profession. (COCPD) (1985) (2013 COD)
Continuity of Care, Definition of

See also

- Hospitalists Trained in Family Medicine
- Retail Clinics
- Medical Home
- Long-Term Care Facilities, Continuity and Coordination of Care

Continuity of care is concerned with quality of care over time. It is the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost-effective medical care.

Continuity of care is a hallmark and primary objective of family medicine and is consistent with quality patient care provided through a patient-centered medical home. The continuity of care inherent in family medicine helps family physicians gain their patients’ confidence and enables family physicians to be more effective patient advocates. It also facilitates the family physician's role as a cost-effective coordinator of the patient's health services by making early recognition of problems possible. Continuity of care is rooted in a long-term patient-physician partnership in which the physician knows the patient’s history from experience and can integrate new information and decisions from a whole-person perspective efficiently without extensive investigation or record review.

Continuity of care is facilitated by a physician-led, team-based approach to health care. It reduces fragmentation of care and thus improves patient safety and quality of care. Thus, the American Academy of Family Physicians supports the role of family physicians in providing continuity of care to their patients in all settings, both directly and by coordination of care with other health care professionals.

Contraception Methods for Medicare Patients

See also

- **Over-the-Counter Oral Contraceptives**
- **Coverage, Patient Education, and Counseling for Family Planning, Contraceptive Methods, and Sterilization**
- **Reproductive Decisions**
- **Reproductive Decisions, Training In**
- **Long-Acting Reversible Contraceptives**

The American Academy of Family Physicians support Medicare coverage for all FDA-approved methods of contraception. (2015 COD)
Co-Payments

See also

- First Dollar Coverage for Preventive Care
- Patient-Centered Formularies
- Medical Home

Defined

A co-payment is a fixed fee an insured person is expected to pay each time a particular covered medical service is received and can differ by the place of service.

Practice Setting

The Academy supports the application of differential co-payments by practice setting only to incentivize patients to select/maintain a patient-centered medical home as defined by the AAFP.

Multiple Co-Payments

Multiple co-payments may be assessed for separately identified and delivered services. However, patients should not be required to pay more than a single co-payment for a preventive and an acute service provided during a single office visit.

Waivers

When a co-payment is a barrier to medically necessary care, physicians may on a case-by-case basis forgive or waive the co-payment. Reasons for such may include for financial hardship. Physicians should ensure that forgiving or waiving co-payments is consistent with the terms of their agreements with insurers and any applicable law.

(Board Chair October 2006) (2015 COD)
Corporal Punishment in Schools

The American Academy of Family Physicians is opposed to corporal punishment in schools.

The AAFP defines corporal punishment in schools as the purposeful infliction of bodily pain or discomfort by an official in the educational system upon a student as a penalty for disapproved behavior. Physical force or restraint which is used by a school official to protect someone from physical injury, to disarm a student, or to protect property from damage is not considered corporal punishment.

Evidence indicates that corporal punishment is not as effective as other means of behavior management and may make behavior worse. Positive reinforcement has been shown to be more effective and long-lived than aversive reinforcement. The Academy supports alternative methods of behavior management and modification in the school environment which enhances a student's optimal learning. (1989) (2012 COD)
Coverage, Patient Education, and Counseling for Family Planning, Contraceptive Methods, and Sterilization Procedures

SEE ALSO

- Over-the-Counter Oral Contraceptives
- Contraception Methods for Medicare Patients

The American Academy of Family Physicians (AAFP) supports policies and legislation that would require public and private insurance plans to provide coverage and not impose cost sharing for all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women and men with reproductive capacity including those contraceptive methods for sale over-the-counter.

The AAFP supports the position that intrauterine device and other long-acting reversible contraception be offered as a first-line contraceptive method and encouraged as options for most women with reproductive capacity. The AAFP also supports assuring coverage of Long-Acting Reversible Contraceptives devices and placement prior to hospital discharge, separate from the global fee, for all women who select this method.

The AAFP is concerned about the sexual health of adults and adolescents and believes physicians should provide patient education and counseling to both men and women to decrease the number of unwanted pregnancies. This includes information about abstinence, contraceptive methods, sterilization procedures, and providing emergency contraception. It includes the discussion of all contraceptive methods, where to obtain them, and the reliability of each. In addition, the family physician should explain how the different contraceptive methods do and do not prevent sexually transmitted diseases. If the family physician is uncomfortable providing these services, the patient should be referred to another physician or provider who is willing to provide the education and counseling and/or services.

(2011 COD) (2016 COD)
Criminalization of the Medical Practice

See also

- Criminalization of the Provision of Medical Care to Undocumented Individuals
- Community and Migrant Health Centers
- Medically Underserved
- Health Care for All
- Comprehensive Care, Access to
- Migrant Health Care
- Neonatal Circumcision

The American Academy of Family Physicians take all reasonable and necessary steps to ensure that medical decision-making and treatment, exercised in good faith, does not become a violation of criminal law. (CGA) (2007) (2013 COD)
Criminalization of the Provision of Medical Care to Undocumented Individuals

See Also

- Criminalization of the Medical Practice
- Health Care for All
- Medically Underserved
- Comprehensive Care, Access to
- Community and Migrant Health Centers
- Medical Schools, Service to Minority, Vulnerable and Underserved Populations
- Migrant Health Care
- Neonatal Circumcision

The American Academy of Family Physicians believes that medical care decision-making occurs between the physician and the patient. The AAFP opposes actions that would criminalize the provision of medical care to undocumented foreign-born individuals. (2007) (2012 COD)

See also

- Emergency Department Call for Family Physicians (Position Paper)
- Emergency Medical Care
- Emergency Medicine, Family Physicians in Privileges, Emergency Care Services

Executive Summary

Family physicians are an essential part of the emergency medicine safety net, and without this contribution, large areas of the country would be without adequate emergency medical care. 40% of family physicians provide emergency medical services, and many family physicians have made lifelong careers in emergency medicine. The Future of Family Medicine Project (FFM) envisions a transformation of the United States health care system, in partnership with other organizations, including emergency medicine. One of the critical challenges in equipping family physicians for the 21st century is re-defining our role in providing emergency care.

Historically and internationally, family medicine and emergency medicine have much in common. Both specialties have broad scopes of practice that are unrestricted by age, gender or organ system. In rural areas of the United States, family physicians are uniquely well suited to provide emergency care. Many international programs in emergency medicine are based on a primary care foundation such as family medicine.

Family physicians are trained to provide emergency medical care through residency and post residency education, but have often been viewed by residency trained emergency physicians as competitors, rather than colleagues. The success of emergency medicine as a specialty has perpetuated this bias against family physicians, but several recent events may help to change this. The approval of joint training programs between the American Board of Emergency Medicine (ABEM) and the American Board of Family Medicine (ABFM) may provide areas of cooperation, and the recently released Institute of Medicine (IOM) report on the Future of Emergency Care suggests a model that is compatible with the integrative approach described in the Future of Family Medicine. The integrity of the emergency medical safety net requires family physicians.

Preface

Marcus Welby captured the imaginations of many Americans in the 1970's and popularized the family physician as a compassionate role model. In the same way, recent television programs like 911, ER, and Trauma: Life in the ER reveal that the new medical hero in the public’s eye is the “ER doc”. These programs glamorize the practice of emergency medicine, and project this image across the globe. Although physicians may object too many of the stereotypes that are portrayed in the media, they serve as an example of the evolution of our public image. Emergency medicine is a challenging field with a unique body of knowledge, but it has many similarities with family medicine and it has important historical connections. Although most family physicians do not claim to be “ER docs”, this is still an important part of scope of practice, and in much of the world, emergency medicine and family medicine are educationally and developmentally intertwined.
Introduction

Equipping Family Physicians for Emergency Care in the 21st Century

As family medicine strives to implement the transformative changes that are fundamental to reforming the specialty and the U.S. health care system as a whole, our role in providing emergency care needs to be clarified. The Future of Family Medicine Report\(^2\) calls for a New Model of care that is grounded in timeless values of personalized, patient-centered care coupled with the application of new technologies and systems.\(^4\) This New Model emphasizes our core values and our potential for improving the health care of our nation, but does not specifically address the important role that family physicians have in providing emergency care.

The changes that are recommended in this New Model of family medicine emphasize an integrative, general approach to health care. This core value needs to be applied to the provision of emergency care in the United States, and the implication of this for the future of family medicine needs to be reconsidered. Additionally, the development of international emergency medicine holds specific implications relative to how this integrative and generalist approach should apply to emergency care by family physicians in the United States, particularly in rural areas where workforce issues are problematic.

Background

Family physicians can provide high quality, cost-effective care for all patients in different clinical settings.\(^5,\)\(^6\) Although many family physicians currently provide emergency care in a variety of settings, their abilities have been questioned by some within the emergency medicine professional societies and organizations. This bias against family physicians is ironic, since family and emergency medicine practitioners are the only generalists routinely seeing patients regardless of age, gender, or organ system.\(^7\) Compounding this problem is the fact that many are excluded from certain administrative and clinical appointments\(^9,\)\(^10\) due to American Board of Medical Specialties (ABMS) certification in family medicine rather than in emergency medicine.

History

The Emergency “Room” becomes the Emergency “Department”

The birth of emergency medicine arose partly from the need for better trained physicians who could treat critically ill or multiple trauma patients.\(^12\) In 1979, Emergency Medicine was sanctioned by the American Board of Medical Specialties (ABMS) as the twenty-third medical specialty. Family physicians were among those who championed the cause, and thousands of physicians with family medicine backgrounds accessed the ABMS Emergency Medicine board exam during the 1980s via its “grandfathering” provisions. Initially, family physicians were actively involved in the advancement of emergency medicine. Several charter members of American College of Emergency Physicians (ACEP) were family physicians with a strong interest in moving the specialty forward. American Board of Family Practice (ABFP) members were also involved in the developmental phase of ABEM with the founding ABFP executive director serving on the board of the ABEM for several years.\(^15\)

Family medicine has contributed significantly to the well being of the rural emergency health care system. The majority of after hours and weekend coverage in rural communities has always been provided by family physicians. Residency trained American Board of Emergency Medicine (ABEM) certified physicians do not often settle in these under-served areas\(^13\) or, if they do agree to come, it is difficult to retain them for any length of time.\(^14\)

In 1976, the year that the American Board of Emergency Medicine was first incorporated, dialogue between the leaders of family medicine and emergency medicine “envisioned extensive cooperative efforts in our
training programs, ... post-graduate efforts, ... legislative efforts, and residency preparation, acceptable to both family practice and to emergency medicine, which would allow us to certify that these physicians entering rural practice are indeed well prepared to practice in both of these specialty areas." (17) In 1993, the ABFP explored a combined training program leading to double board certification. This was rejected by ABEM members even though collaborative projects had been developed between ABEM and the American Boards of Pediatrics and Internal Medicine. (16)

After more than 30 years of competition between the specialties of family medicine and emergency medicine in the United States, joint training programs have finally been approved by the ABEM and the ABFM in 2006. (1, 9, 10)

Professional Recognition and Support

Outside the House of Emergency Medicine

The American Academy of Family Physicians (AAFP) has supported its members who practice emergency medicine. In 1995, the AAFP developed a policy that stated, “Family physicians, through their training and experience, are qualified to provide emergency care services. Privileges to practice in the emergency department should be based on the individual physician’s documented training and/or experience, demonstrated abilities, and current competence.” (21) Additionally, the AAFP published a set of core curricular guidelines on acute and emergency care for residents in family medicine residency programs.

In 2006, the AAFP proposed a policy to be addressed by the 2006 Congress of Delegates (22) on emergency medicine that could be the standard of care for credentialing and workforce issues, since it parallels the recommendations from the IOM Report, and provides a foundation for re-defining our role in emergency care in the 21st century.

The Board of Directors approved and 2006 Congress of Delegates adopted the new policy statement on “Emergency Medicine” to read as follows:

Emergency Medicine

The provision of emergency medical care is an essential public service in the United States. Providing comprehensive emergency medical services to a diverse population requires a cooperative relationship among a variety of health professionals.

The most important objective of the physician must be the provision of the highest quality of care. Quality patient care requires that all providers should practice within their degree of ability as determined by training, experience and current competence.

Family physicians are trained in the breadth of medical care, and as such are qualified to provide emergency care in a variety of settings. In rural and remote settings, family physicians are particularly qualified to provide emergency care.

Emergency department credentialing should be based on training, experience and current competence. Combined residency programs in family medicine and emergency medicine, or additional training, such as fellowships in emergency medicine or additional course work, may be of added benefit. (2006)

Certification and Credentialing

Central to the issue of family physicians practicing emergency medicine are fundamental concerns over competency, job security, and certification. Many family physicians have made careers in emergency medicine, and in rural areas family physicians will always be the primary providers of emergency care. At the same time, the criteria for staffing emergency departments have emphasized board certification over actual physician performance. (1, 23, 24) Specialty-neutral credentialing is not the norm in most hospital
organizations. If better standards are not developed for evaluating emergency department practitioner applicants, the practice of emergency medicine by family physicians could be jeopardized.

The recently released Institute of Medicine Report \(^{(25)}\) concludes with recommendations that the “Department of Health and Human Services,... partner with professional organizations (to) develop national standards for core competencies... (in emergency and trauma care) ... using an evidence based, multi-disciplinary process.” If enacted, these changes would be an important expansion from the restrictive credentialing that emergency medicine has previously promoted.

Limited access to the ABEM examination through closure of the “grandfather” practice track created significant controversy in emergency medicine during the first few decades.\(^{(27, 28)}\) The ABEM exam was first offered in 1980.\(^{(29)}\) From 1980 to 1988, there were two ways for physicians to qualify for the examination. One could either complete a residency in emergency medicine, or satisfy the requirements of a “practice track” pathway. The prerequisites of this option were 7,000 hours and 60 months of emergency department practice experience, with a specified number of CME credits in emergency medicine.

In 1988, this alternative pathway was terminated, sparking considerable controversy and dissension. Some felt that this closure was arbitrary and premature. Others felt this action was inevitable, and adequate notification had been provided in the medical literature.

The controversy surrounding certification and competency is linked to the process of how physicians are certified and by which organization. The medical profession has a closely regulated structure for conferring certification to those seeking specialty recognition.\(^{(30, 31)}\) The ABMS has granted specialty status to twenty-four allopathic specialties since 1933. The AOA began in 1897 with the development of Osteopathic Medicine and offers its own specialty exam: the American Osteopathic Board of Emergency Medicine (AOBEM).

The ABMS and its subsidiary boards, which include the ABFM and the ABEM, set the standards for many certification processes and their acceptance by organized medicine and many institutions. In 1994, a committee of the American Board of Medical Specialties developed a proposal to revise the process of board certification. The Committee on Certification, Sub-certification, and Recertification (COCERT) recognized certification as a dynamic process, which “should permit movement of qualified individuals across specialties and sub-specialties”. They recognized that the boards should continue to establish standards and educational and/or practice requirements for admission to the examinations.”\(^{(34)}\) Physicians with knowledge, training, and/or experience in a given area deserve access to the examinations.\(^{(35)}\) In the end, the language from COCERT was viewed by many as too broad in its scope, particularly with regard to “experience” being listed as one factor in determining access to the examination.

COCERT’s failed proposal left in place the certification barriers that still effectually exclude many family physicians from the practice of emergency medicine. This “specialty driven” model of emergency medicine fails to recognize the important role that family physicians have in providing emergency care, and was recently the basis for a national media campaign by the American College of Emergency Physicians (ACEP) promoting ABEM board certification as the only standard for emergency physician quality verification.

The “National Report Card on the State of Emergency Medicine” was released by ACEP in early 2006, and referred to itself as a “wake-up call” for policymakers. Purporting to report each state’s support for their emergency care systems, the Report Card used a series of measuring criteria to rank each state in four areas: access to emergency care, quality/patient safety, public health/safety, and medical liability.\(^{(36)}\)

While the Report Card called for many worthwhile actions and goals, such as liability reforms, increased use of immunizations for the elderly, improved usage rates of seat belts, increasing numbers of trauma centers, etc., it also placed significant emphasis on the number of emergency physicians certified by ABEM in each state. A poor grade was given to any state that had a percentage of ABEM-certified emergency physicians deemed to be below a designated threshold, and importantly for family medicine, it ignored the thousands of career emergency physicians practicing in thousands of emergency departments in this country without the opportunity to have “grandfathered” into the ABEM exam. The family medicine physicians engaged in
the full-time practice of emergency medicine were not mentioned, nor were they entered into any
calculation regarding access to emergency care, quality of emergency care, patient safety, or liability issues.

Credentialing issues have been detrimental to the emergency medicine workforce, since many competent
emergency physicians have been arbitrarily excluded by restrictive policies. Although the success of
emergency medicine as an academic discipline has improved the quality of care, it has led to a “hiring bias”
against family physicians and other primary care trained emergency physicians. Even today, there remains a
demographically determined shortage of board certified emergency medicine physicians, and family physicians
have not been recognized for their role in providing quality emergency department care. Institutional
support for family physicians who practice emergency medicine has gradually waned in the last decade, as
emergency department directors and hospital administrators are affected by the “specialty driven” policies
that emergency medicine has successfully promoted.

International Emergency Medicine

As emergency medicine has matured as a specialty in the United States, it has brought recognition and
academic strength to a field that was previously considered to be the domain of moonlighters. Twenty-five
(25) years ago, when the American Board of Medical Specialties recognized emergency medicine as a
“primary specialty”, it opened the door for acknowledgement that there is a unique body of knowledge in
emergency medicine. Prior to this, emergency medicine was defined by location (the emergency
“room”), rather than being defined by a body of knowledge and the skills necessary to practice this
specialty.

The literature on international emergency medicine is replete with examples of how family medicine and
other primary care specialties can provide a foundation for emergency medicine training and development. Internationally, family medicine training is recognized as providing the requisite skills that are easily
enhanced through focused clinical training (fellowships) in emergency medicine. In Anglophone countries
such as the United Kingdom and Australia, emergency medicine is a subspecialty with close associations
with the disciplines that provide access to this supplemental training. The title of a recent article in the
National Medical Journal of India speaks for itself: Developing Emergency Medicine through Primary
Care. Canadian physicians can either complete a one year emergency medicine fellowship after family
practice residency that leads to a recognized certification process (CCFP-EM), or can train in a 4-5 year
program intended to train “specialists” (FRCPCs).

New Standards

IOM Report Endorses Family Physicians in EM

The recent release of the Institute of Medicine report entitled “The Future of Emergency Care in the United
States Health System” describes the condition of emergency medicine in our nation and gives it a poor
prognosis unless dramatic changes occur. It describes in detail the developments in the last few decades,
but also describes a system that is fragmented and inconsistent in the level of quality that it provides. In
addition to focusing on issues such as overcrowding, poor coordination among emergency medical systems,
shortage of on-call specialists and lack of disaster preparedness, the report addresses in detail the “The
Emergency Care Workforce” and rural emergency medicine.

Comprehensive in scope and astute in analysis and prescription, the IOM Report stands as a challenge to
the current paradigms espoused by many health care experts in emergency medicine. The report concludes
with recommendations that point the way to “coordinated, regionalized and accountable” solutions that will
require change in a number of the ways that emergency care is structured in the United States. These
include more collaborative efforts between specialties, and core curricula for all physicians involved in
emergency care. The essential role of family physicians in rural areas is described in detail, and the need
for improved cooperation with academic emergency medicine is emphasized. Family physicians are
described as part of the “essential component of the Emergency Department (ED) workforce at many
hospitals, especially smaller facilities in suburban and rural settings. Although they are certifiably ABFM
rather than ABEM, they demonstrate a high level of competency in emergency care through a combination of residency and post-residency education, directed skills training, and on the job experience.

**Workforce Statistics**

**Access Across America**

The ACEP Workforce Studies of 1997 and 1999 estimated that there were 32,000 emergency physicians, and that 38 percent of these physicians were neither board certified nor residency trained in emergency medicine. 84 percent of these non-emergency medicine (EM) certified physicians had completed a residency in another specialty, with the largest percentage being family medicine trained (32 percent). \(^{(41, 42)}\)

Currently, there are more than 1000 emergency medicine graduates each year, and more than 135 emergency medicine residency programs. \(^{(43)}\) Growth in emergency medicine has exceeded growth in most specialties overall, but for several more decades, the workforce is likely to be dependent on emergency physicians who trained in other specialties. \(^{(44)}\)

Some emergency medicine leaders feel that the major problem is no longer a workforce shortage, but a maldistribution of residency-trained emergency physicians. \(^{(13)}\) This is certainly consistent with the data, since most emergency medicine training programs are in urban areas.

In rural areas, family physicians provide the overwhelming majority of emergency care. \(^{(45)}\) Out of 4,919 US community Hospitals in the United States, 2200 were rural hospitals reporting emergency visits (AHA 2001). The average rural emergency room census was 9500 visits (AHA 2001). According to the Graduate Medical Exam National Advisory Counsel report on the Number of Persons Needed To Support Specific Physician Specialties, 18,000 people would be required to support one emergency medicine residency trained physician. This explains in part why EM trained physicians tend not to settle or work in rural areas, and why many hospitals rely on local family physicians for emergency department coverage.

Compared to the 21,000 family physicians that live and work in rural America, only a fraction of this number of emergency physicians practice in rural areas. According to the Robert Graham center only 3323 emergency medicine trained physicians practice in Non-Metropolitan service areas, and the number of residency trained emergency physicians who practice in rural areas is less than 2000 physicians. Between 1997 and 2002, the percentage of residency trained emergency physicians practicing in rural areas decreased from 15% to 12%, even as the percentage of medical students entering EM training programs steadily increased. It should be noted that 50 million people or one fifth of the population of the United States reside within Non-metropolitan Service Area counties.

**Family physicians are uniquely qualified to provide emergency medical services in rural communities.**

Family physicians provide most of the emergency medical care in rural communities, since they live and work within these communities. One-fourth of family physicians practice in communities of less than 10,000 people, while one-fourth of the U.S. population lives in such communities. The IOM Report on emergency medicine addresses the essential role that family physicians have in providing rural emergency care, as well as the challenges, but may not adequately address the strengths that family medicine brings to rural issues.

Rural communities have emergency rooms with fewer patients, lower overall revenue and often cannot afford a full time EM trained physician. Rural hospital emergency rooms (ERs) report an average census of 9500 visits which is roughly half what is necessary to support an EM trained physician. Because of their broad scope of practice including procedural and obstetrical skills, family physicians have other sources of revenue, and can staff low volume EDs far more cost effectively. This can make the critical difference as to whether a community can afford emergency care.

Using community physicians in the emergency room allows greater physician staffing in the hospital and in the community, thus increasing hospital revenue and community safety. A well trained family physician can
generate additional revenues by performing diagnostic procedures,\(^{(47)}\) or obstetrical services\(^{(48)}\). Family physicians can evaluate patients in the ED, admit patients to the hospital, and follow them to discharge as the attending physician, which is necessary for hospitals with small medical staffs. Family physicians are trained to operate independently in communities without sub-specialist physicians, and rapid transfer of critical patients is often impossible.

Small communities often have strong ties with their local family physicians, and desire to see them when presenting to the emergency room. Access to health care in rural communities depends on numbers of primary care provider.\(^{(50)}\) Patient satisfaction for medical services in rural communities is greater than in urban or suburban communities, and the outcomes are equivalent or better.\(^{(51)}\) In rural communities, confidence in medical care is directly related to length of relationship between the provider and the patient\(^{(52)}\), and family physicians in rural areas care for their patients from the cradle to the grave, during chronic illness and acute, life-threatening events. Emergency care is an integral part of this relationship.

**Emergency Medicine Training**

**A Matter of Perspective**

Some may wonder why the American Board of Family Medicine (ABFM) hasn't supported the establishment of emergency medicine as the basis for a Certificate of Added Qualifications (CAQ). According to the rules of the American Boards of Medical Specialties (ABMS), primary certifying boards are prohibited from establishing subspecialties or CAQs in clinical domains where another major specialty already exists. Thus, since an American Board of Emergency Medicine (ABEM) is currently in existence, the ABFM cannot establish a CAQ in emergency medicine.

Joint training guidelines for combined residency programs in family medicine and emergency medicine have recently been announced.\(^{(58)}\) This is the outcome of efforts initiated more than 15 years ago when residency directors noted the substantial overlap in curriculum between the two specialties and medical students began inquiring why internal medicine and pediatrics had combined programs with emergency medicine, but family medicine did not. The joint training guidelines describe an integrated five-year curriculum with equal emphasis on the two disciplines. Resident physicians enrolled in such programs will benefit from the opportunity to train in the intense environment of advanced-level trauma centers, while at the same time reaping the educational advantages of continuous and comprehensive patient care in a family medicine center.

The contribution and impact of these programs on the workforce remains to be determined, but their development promises to improve academic cooperation. They are unlikely to solve many of the issues facing rural areas, because the length of the training programs may exacerbate the problem of recruiting these graduates to isolated areas. Even if most graduates become academicians, as do those who complete joint ABEM-ABIM (Internal Medicine) programs, they highlight the similarities instead of the differences between EM and FM.

**Within Family Medicine Residencies**

The 2006 edition of the Program Requirements for the Accreditation of Residencies in Family Medicine demonstrates increased attention to emergency care training within family medicine residencies.\(^{(59)}\) For example, the required curricular time has been increased, requirements for advanced life support have been clarified, procedures for both medical and trauma emergencies are specified, and the minimum experience with critical care patients have been defined.

Notwithstanding the changes in family medicine residency requirements, trainees in family medicine who plan to practice predominantly in an emergent care setting may need to further expand their clinical training. This would include additional skills in emergency procedures and trauma care,\(^{(56)}\) and more familiarity with the rapid, algorithmic approach that typifies advanced resuscitations.\(^{(60)}\)
Fellowships Enhancing the Core Curriculum

Fellowships in emergency medicine developed in the 1990s for family physicians and other primary care physicians in response to the need for additional training in emergency medicine in academic centers. One year fellowships [family medicine – emergency medicine] have been established as a logical extension of accredited family medicine residencies in West Virginia, North Carolina, Arkansas, Tennessee, Texas, and other states. These have been successfully used as pathway to credentialing in community hospitals and academic settings, or as a needed enhancement of acute care skills prior to frontier medicine, rural practice, or international missions. The advantages of these fellowships have been their flexibility and financial feasibility. Generally they can be self funded due to the high need for workforce in rural areas, and the fact that the learners are residency graduated physicians. These fellowships have successfully modeled the rural reality of simultaneously staffing the office, the ER, and the hospital, and provide access to enhanced training for graduates of family medicine residencies who plan to practice in rural areas.

Training Considerations for Rural and Remote Settings

In the emergency departments of rural and remote communities, the vast majority of patients presenting for care will be there as a result of minor injuries or exacerbations of chronic illnesses. In these areas, the ideal physician is a “generalist with expertise in emergency medicine”. The training environment for most of today’s emergency medicine residencies is one where specialty consultants and advanced technology are readily available to the emergency physician to assist in the assessment and care of their patients. Most rural and remote emergency departments lack those kinds of resources, and physicians caring for patients in those settings must depend upon their own best clinical skills and judgment to a greater degree than in the typical urban center. For this reason, it may be arguable that the training breadth of the family physician is better suited to the care of most emergency patients in rural and remote settings than the typical emergency medicine residency graduate.

A unique program has been recently developed for those family physicians who periodically face the challenge of providing “first hour” emergency care in rural areas. The Minnesota Chapter of the AAFP has created an innovative Comprehensive Advanced Life Support Course (CALS course). The curriculum includes teaching material from all the major advanced life support programs, and both family medicine and emergency medicine leaders are involved in its development. This project promises to strengthen the preparation of family physicians and other physicians and health care providers who currently practice in rural areas, and who need additional training in emergency medicine.

The success of this course could lead to a similar program for all rural physicians who provide emergency stabilization, and serves as a model for collaborative approaches between emergency medicine and family medicine. A team approach involving all EMS providers is integral to the program, and life-saving procedural skills and a core body of knowledge in emergency medicine are basic components of the curriculum. More such focused collaborative projects are necessary, and are part of the mandate delivered by the IOM report.

Research Agenda

The research agenda for family physicians should be collaborative, and practice-based with a focus on how family medicine can have an impact in such varied emergency environments as urban, rural and remote areas. Practice-based research networks (PBRNs) are designed to address such questions through the integration of research and everyday practice. The AAFP National Research Network includes more than 300 FPs in 45 states with integration of an electronic medical record system, Collaboration with Pediatric PBRNs and with emergency medicine research groups can allow for expanded research into new areas such as the economic impact of family physicians in emergency medicine, quality of care and efficient utilization of emergency resources, especially in rural areas.

Family physicians that practice full time emergency medicine, whether in academic settings or community hospitals, are part of the emergency medicine infrastructure. Institutions and physicians involved in this aspect of emergency medicine should be aware of the recommendations of the Institute of Medicine for
emergency care research, since it “involves many disciplines and cross-cutting themes.”(65) As academic cooperation increases between the specialties on the residency training level, family physician educators and graduates of joint training programs will be involved in these areas of research including resuscitation science, injury prevention, and epidemiology. Many of these areas are included in family medicine curricula, and evidence based research for acute care is a strength of 21st century family medicine.

A small database of research already exists on the unique aspects of emergency care that is provided by family physicians, but more data is needed to enhance the science of family medicine in this area. Many hospitals and communities are in financial distress, and additional research in rural and critical access hospitals on the cost effectiveness and quality of care of family physicians is needed. Other issues needing investigation and study include rural emergency care delivery, provision of “first hour” emergency care in family physician offices, trauma care in remote areas, and procedural skills. One successful example of this kind of project demonstrated that family medicine graduates providing care in Colorado emergency departments felt that they were adequately trained in emergency medicine, but would benefit from more exposure to trauma training and enhanced contact with EMS personnel.

**An Expanded Scope**

**Wilderness Medicine**

Family physicians have been actively involved in the practice and development of wilderness medicine. The broad diversity of training that is part of family medicine residency programs is easily adapted to the low-tech requirements of emergency care in remote areas.

The initial Wilderness Medical Society membership included family physicians and other specialists. Family physicians have flourished within the specialty and this organized body has been a strong educational support for family physicians that practice in rural/remote areas. Through this, they have encouraged the development of this unique discipline that integrates many aspects of emergency medicine and family medicine, as evidenced by such topics as high-altitude medicine, search and rescue, tropical and desert emergencies, emerging infections, and space exploration.(77) This field is built on cooperation between the two specialties and individual physicians who share a love of outdoor adventure and innovation, and should be a model for other areas of collaboration.

**Urgent Care**

Many physicians with either family medicine or emergency medicine training practice “urgent care.”

**Disaster Medicine**

The flexibility and depth of family medicine can be recognized in such areas as disaster preparedness and bioterrorism planning, which are a key part of the IOM’s recent recommendations for emergency care in the United States.(40) Given the potential for all types of disasters and the need for early recognition and immediate response, family physicians are essential to disaster medicine’s success, in both the clinical and the administrative setting. Family physicians represent a critical asset in natural or man-made disasters as exemplified by their involvement in the response to the Anthrax attack in the DC-Metropolitan area, the SARS epidemic in Toronto, the international crisis that developed from the Tokyo subway chemical incident, and most recently the growing Avian flu outbreak abroad. Through research and clinical practice, family physicians have been intimately involved in the development and improvement in surveillance techniques that led to the recognition of these developing global crises. Family physicians have developed systems of collection and analysis with state and local health departments on injury incidence, disease trends and bioterrorism community threats. In addition, family medicine leaders are actively involved in disaster preparedness planning at all stages, from leadership positions to first responders. Family physicians may be the first health professionals to identify diagnostic clues that are crucial in early infectious disease outbreaks in order to generate a quick, efficient public response.

Family physician educational leaders have been involved in disaster training, including different methods
such as distance learning, field exercises, drills and written material distribution. Family physicians both at the national and state levels have made a concerted effort to include disaster management and intervention as part of established professional curricula, continuing medical education and certificate programs. They also serve on hospital/EMS and other emergency board and committees to assist in developing strong interagency response networks, which will be critical in a live scenario. When a disaster takes place, it is most likely Family physicians will be involved at some level, either directly on the front-lines of recognition, or interagency communication of critical information, transport, regionally or nationally.

Disaster management in rural areas has not been as focused as it has been in urban environments. However, the threat of terrorism may be great in rural areas because of the remote locations of the most likely targets of terrorism, such as nuclear power plants, chemical facilities, and Air Force missile launch stations. Rural areas are faced with many problems in disaster preparedness including limited resources and staff, surge capacity problems within small hospitals and lack of equipment. However, family physicians in rural areas have learned to adapt and creatively overcome significant barriers that already exist in the rural health care system. This unrecognized expertise needs to be strengthened through integrated urban networks/communication systems in order to improve the national response to the next true catastrophic event. The Institute of Medicine report clearly identifies the need for improved disaster training for all physicians, and the critical need for improve disaster preparedness in rural areas. Family physicians are key to this process.

Conclusion

Critical Challenges

Providing comprehensive emergency medical services to a diverse population requires a cooperative relationship among a variety of health professionals.

Delivering quality, comprehensive emergency care requires that emergency medical care and workforce issues be based on “best practices” models that include all necessary and contributing specialties and disciplines. In the 21st century, competition should be replaced with cooperation built around joint training programs between ABEM and ABFM, as well as new policies which recognize and support the critical role of family physicians in emergency medicine in the U.S.

The most important objective of the physician must be the provision of the highest quality of care. Quality patient care requires that all providers should practice within their degree of ability as determined by training, experience and current competence.

The AMA, AAFP and most medical specialties have adopted the policy that medical practice privileges be based on “training, experience and demonstrated competence,” not arbitrary specialty. The IOM report emphasizes that high quality, efficient, and reliable patient care can best be achieved through integrative approaches. Core competencies in emergency medicine should be evidenced based and multi-disciplinary.

Family physicians are trained in the breadth of medical care, and as such are qualified to provide emergency care in a variety of settings. In rural and remote settings, family physicians are particularly qualified to provide emergency care.

Family medicine training equips physicians to provide urgent and emergent care to patients, with an appreciation for the full scope of longitudinal and continuing care. Whether in the hospital-based emergency department, the rural office practice, or in remote sparsely-settled terrain, family physicians draw from the wealth of all the medical and surgical specialties when managing emergency patients. In rural areas, these unique skills combined with strengths such as availability and cost effectiveness make family medicine the foundation of rural emergency care.

Emergency department credentialing should be based on training, experience and current competence. Combined residency programs in family medicine and emergency medicine, or additional training, such as fellowships in emergency medicine or additional course work, may be of added benefit.

Improving emergency care in the 21st century will require a “multi-pronged strategy ..... that includes improving efficiency and a coordinated, regionalized, accountable system” (IOM report). Practicing family physicians need to be integrated into this process. Joint training programs are another way to begin this cooperative approach, as are fellowships in emergency medicine (i.e., the Canadian model).

Supplement #1

The Canadian system may provide a helpful model for the United States, since residency trained emergency physicians provide academic leadership to the specialty, but family physicians are recognized for their essential role in providing emergency care. The College of Family Physicians in Canada (CFPC) offers a special competency certification in emergency medicine to qualified family physicians through either a two-year residency program, or a practice tract eligible pathway. All candidates must pass a rigorous “special competency” exam in the specialty. The Royal College of Physicians and Surgeons certifies residents who complete a four- or five-year program in emergency medicine. The first qualifying exam was offered in 1983, and grandfather eligibility through a practice track existed through 1987 (Royal College of Physicians and Surgeons of Canada, 1988). During this period a significant number of physicians became double boarded in Family and Emergency Medicine. Interestingly, just as in the United States, consideration for a conjoint certification by both Colleges occurred, but no agreement could be reached concerning the details of the training program. Both organizations, however, have continued to collaborate on clinical practice and quality of care issues.

The College of Family Physicians of Canada supports cross training in emergency medicine for family physicians, and there is greater acceptance of this within the medical community. The College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (RCPSC). The one-year post-graduate emergency medicine training program is also organized and directed by certified physicians from both disciplines. These collaborative efforts provide a model for cooperation that should be considered by medical associations and certifying boards in the United States.

Supplement #2

Rodney WM, et al. have posted their curriculum proposal on the Association for Rural Family and Emergency Medicine. These fellowships are likely to maintain a market advantage since they produce the same outcome in four total years as compared to the ABFM-ABEM proposal which requires five years. The joint training programs have an inherent academic legitimacy that ACEP and ABEM will accept. The fellowship programs are consistent with the AAFP position that: “Combined residency programs in family medicine and emergency medicine, or additional training, such as fellowships in emergency medicine or additional course work, may be of added benefit. This is an idea whose strength has been maintained despite opposition from ACEP. John Peter Smith Hospital has reported a very successful first year with its program which opened in 2005.

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Culturally Proficient, Health Care

See also

- Cultural Proficiency Guidelines
- Health Care
- Health Care for All: A Framework for Moving to a Primary Care-Based Health Care System in the United State
- Cultural Proficiency: The Importance of Cultural Proficiency in Providing Effective Care for Diverse Populations (Position Paper)

Family physicians encounter patients whose cultural/ethnic backgrounds may be different from his or her own. Such differences may impact the patient/physician relationship.

The American Academy of Family Physicians (AAFP) urges its members, and all those involved in the training of students, residents and other physicians, to be cognizant of cultural differences and how addressing those differences can improve the quality of care. The Academy urges all medical schools and family medicine residencies to educate students and residents about cultural and ethnic differences.

The AAFP recommends that all physicians learn about and respect the cultural/ethnic background of their patients. Sensitivity to cultural and individual perceptions of health, family and illness should be incorporated into a patient's care and the development of treatment plans as appropriate. When treating patients whose language differs from that of the physician, the physician must follow federal mandates to provide appropriate interpretive services. (1985) (2013 COD)
Cultural Proficiency Guidelines

See also

- Culturally Sensitive Interpretive Services - AAFP Legislative Stance
- Cultural Proficiency: The Importance of Cultural Proficiency in Providing Effective Care to Diverse Populations (Position Paper)
- Diversity, Assuring Sensitivity to Diversity in AAFP Education Activities
- Diversity in the Workforce
- Community and Migrant Health Centers
- Comprehensive Care, Access to

The AAFP believes in working to address the health and educational needs of our many diverse populations. Informational or CME material and programs should promote cultural proficiency, be sensitive to the issues of diverse populations of patients and physicians, and address specific health issues as they relate to diverse populations. (March Board, 2001) (2015 COD)
Cultural Proficiency: The Importance of Cultural Proficiency in Providing Effective Care for Diverse Populations (Position Paper)

See also:

- Cultural Proficiency Guidelines
- Culturally Proficient, Health Care
- Culturally Sensitive Interpretive Services - AAFP Legislative Stance
- Diversity, Assuring Sensitivity to Diversity in AAFP Education Activities
- Diversity in the Workforce
- Community and Migrant Health Centers
- Comprehensive Care, Access to

A position paper of the American Academy of Family Physicians (AAFP)

The vision of the AAFP is “to transform healthcare to achieve optimal health for everyone.” All persons, regardless of linguistic or other cultural characteristics, deserve access to high quality health services. However, in our nation and elsewhere, health inequities persist, and health outcome disparities remain an ethical and practical dilemma. Culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals, hold the promise to reduce these health outcome disparities. Such services are the hallmark of culturally proficient health care delivery for our nation’s increasingly diverse population.

Cultural proficiency is broadly recognized as the knowledge, skills, attitudes and beliefs that enable people to work well with, respond effectively to, and be supportive of people in cross-cultural settings. Cultural proficiency is not solely the acceptance of cultural differences, but rather a transformational process that allows individuals to acknowledge interdependence and align with a group other than their own. Culturally proficient health care, in particular, makes use of a patient’s language and culture as tools to improve outcomes for that individual.

“Culture” is a term whose meaning has evolved and broadened. In 2013, the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care define culture as:

“The integrated pattern of thoughts, communications, actions, customs, beliefs, values and institutions associated, wholly or partially, with racial, ethnic or linguistic groups, as well as with religious, spiritual, biological, geographical or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetime.”

The enhanced CLAS standards list the following elements of culture, acknowledging that culture is not limited to the following:

- Age
- Cognitive ability or limitations
- Country of origin
- Degree of acculturation
- Educational level attained
- Environment and surroundings
- Family and household compositions
- Gender identity
- Generation
- Health practice, including use of traditional healer techniques such as Reiki and acupuncture
Linguistic characteristics, including language(s) spoken, written or signed; dialects or regional variants; literacy levels; and other related communication needs
- Military affiliation
- Occupational groups
- Perceptions of family and community
- Perceptions of health and well-being and related practices
- Perceptions/beliefs regarding diet and nutrition
- Physical ability or limitations
- Political beliefs
- Racial and ethnic groups - including but not limited to - those defined by the US Census Bureau
- Religious and spiritual characteristics, including beliefs, practices and support systems related to how an individual finds and defines meaning in his/her life.
- Residence (i.e. urban, rural or suburban)
- Sex
- Sexual orientation
- Socioeconomic status

Cultural proficiency is an essential element for patient safety and adherence. The National Center for Culture Competence provides six reasons for the implementation of cultural proficiency:

1. To respond to current and projected demographic changes in the United States.
2. To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.
3. To improve the quality of services and primary care outcomes.
4. To meet legislative, regulatory and accreditation mandates.
5. To gain a competitive edge in the market place.
6. To decrease the likelihood of liability/malpractice claims.

These six reasons touch upon two overarching and intertwined themes: social justice and good business practice. Cultural proficiency, with its expected outcome, health equity, is not simply the “right thing to do.” In today’s era of accountable care and emphasis on improving care and controlling cost, cultural proficiency is a “must do.” Cultural proficiency potentially can save both lives and money.

The AAFP endorses the document, National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice, from the Office of Minority Health, US Department of Health and Human Services, April 2013. The Blueprint describes 15 distinct standards that are organized around 3 themes:

Theme 1: Governance, Leadership and Workforce
Theme 2: Communication and Language Assistance
Theme 3: Engagement, Continuous Improvement and Accountability

The Principal Standard of the Blueprint is, “To provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.” This standard frames the essential goal of the remaining 14 standards and aligns with AAFP’s vision “to transform healthcare to achieve optimal health for everyone.”

AAFP adopts the Principal Standard and the remaining 14 CLAS standards with the following family medicine-specific perspectives on the three themes listed above.

**Governance, Leadership and Workforce**
Creating an environment in which culturally diverse individuals feel welcome and valued is of great importance to AAFP in order to infuse multicultural perspectives into the plan, design and execution of AAFP-driven health initiatives, not just for AAFP members but the population as a whole. Recruiting and retaining culturally diverse individuals into the field of family medicine is an important strategy to reduce
Preparing and supporting a workforce that demonstrates the attitudes, knowledge and skills necessary to work effectively with diverse populations is another. Leadership in AAFP aspires to reflect the diversity of the community it serves. Leadership commitment to integrating cultural and linguistic competency is essential in order to move cultural proficiency from theory to action.

Structural and governance examples of AAFP’s leadership commitment to the principles of cultural proficiency include its Subcommittee on Health Equity, its cross-commission Cultural Proficiency Section and its National Conference of Constituency Leaders.

**Communication and Language Assistance**

The AAFP endorses the 2013 enhanced CLAS standards that improve patient safety and reduce medical error due to miscommunication. Patients need to understand their care and participate in decisions regarding their health. In order to ensure that individuals with limited English proficiency have equitable access to health services, AAFP supports the use of qualified interpreters who demonstrate special language aptitude in both the language of medical terminology and in health systems.

All AAFP members or their staff should be knowledgeable about the types of communication and language services available and be prepared to share this information with patients.

The AAFP supports private and public payer initiatives that facilitate access to, and reward the promotion and provision of, appropriate and professional language services in diverse care settings, particularly at the practice level. Without support from such initiatives to provide resources, these vital services will be beyond the practical reach of what many individual practices will be able to deliver.

Organizations must comply with requirements such as Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and other relevant federal, state and local requirements. Written materials (informed consent, instructions, notices of non-coverage of services, etc.) and signage should be easy to understand and translatable.

**Engagement, Continuous Improvement and Accountability**

With its vision “to transform health care to achieve optimal health for everyone”, AAFP integrates cultural proficiency in advocacy, policy-making and governance.

AAFP promotes cultural proficiency training of its members and their staff by providing enduring, updated materials and resources in multiple venues.

AAFP supports the ongoing collection of social and demographic data of all patients in all settings so that outcomes can be stratified, disparities will be identified and solutions to promote health equity may be planned and implemented. The patient-centered medical home standards, endorsed and promoted by AAFP, exemplify this commitment. An additional example of this commitment is AAFP’s participation in efforts to integrate public health and primary care. The sharing of community-based data and resources between the two entities holds the potential to promote health equity for local populations in all states.

AAFP supports its members’ direct engagement of community and rewards this behavior by conferring the status of Fellow to individual members who, among other activities, promote the health of their communities through education and service beyond the usual standards of medical practice.

AAFP is accountable to its members and to the communities its members serve. AAFP recruits diverse leadership and encourages its members to advocate for diverse populations. The AAFP’s governance structure promotes grass roots input: ideas and resolutions are presented and debated democratically by a diverse representation of membership.

**Summary**

AAFP supports the broad adoption of cultural proficiency standards by government, payers, health care organizations, practices and individuals. When cultural proficiency is an expected standard in health care
delivery, “optimal health for everyone” means every one.

References:

2) American College of Physicians, 2010; Griffith, Yonas, Mason and Havens, 2010.

Culturally Sensitive Interpretive Services -
AAFP Legislative Stance

See also

- Cultural Proficiency Guidelines
- Diversity, Assuring Sensitivity to Diversity in AAFP Education Activities
- Diversity in the Workforce
- Community and Migrant Health Centers
- Comprehensive Care, Access to
- Linguistically Appropriate Health Care
- Essential Community Provider
- Hearing Loss, Deafness and the Hard-of-Hearing

The American Academy of Family Physicians supports legislation to make funding available for culturally sensitive interpretive services for those who have limited English proficiency, or who are deaf and mute, or who are otherwise language impaired and also requests that the funding be made directly available to the interpreters for culturally sensitive interpretive services. (CGA) (2002) (2013 COD)
Data Stewardship

See also

- Electronic Health Records
- Transparency
- Information Technology Used in Health Care
- Pay-For-Performance
- Performance Measures Criteria
- Payment, Physician
- Physician Profiling, Guiding Principles
- Physician Performance Reporting, Guiding Principles

The amount of health data generated in digital form, stored in electronic databases internal or external to physician offices, and transmitted to and from family physicians’ practices continues to grow exponentially. The following data stewardship guidelines are intended to facilitate the appropriate collection, storage, transmission, analysis, and reporting of these data. Execution of these processes must be in a manner that is ethical and protects the interests, including the privacy and confidentiality, of both the patients and physicians generating this data.

These guidelines specifically address the conditions under which de-identified clinical and administrative data derived from physicians’ electronic systems is collected and used by third parties, e.g., public and private health plans, retail pharmacies, hospitals, clinical laboratories, and intermediaries, such as clearinghouses or application service providers, who store personal health data in remote systems.

NOTE: Nothing herein or below shall be construed as contravening the standards for health information contained in HIPAA relating to privacy, confidentiality, or security of personal health information. Generally, the recommendations below pertain to de-identified and aggregated data only.

1. Submission of data from physician practices to third parties must be voluntary.
2. Physician practices must reserve the right to submit data to entities of their own choosing, either in addition to or as part of the chain of data submission (e.g., to payers, health plans, or community data repositories), for purposes such as quality improvement, performance measurement and research programs.
3. A framework for managing patient and physician consent, with appropriate granularity, must be established and maintained. This would include the ability of independent third parties to audit data use/access and a responsibility to inform affected parties regarding inappropriate use/access of their data.
4. Third parties who collect, store, manage, or analyze data derived from physicians’ practices, must provide written policies detailing the intended uses of such data. Additionally, any change in the intended use must be relayed to participating practices prior to further data transfer. Notification must be in written form, provided in a timely manner, and allow physician practices the right to decline further participation without penalty.
5. Third party use policies must clearly distinguish between quality improvement, performance measurement, and research uses of submitted data. Allowable and non-allowable uses of data must be delineated in addition to prioritization of allowable uses.
6. Poor quality data must not be allowed to degrade patient safety and care. Data quality may include accuracy, validity, integrity, meaning, consistency and completeness and must be evaluated and managed at every step from collection to reporting.
7. Data storage must adhere to industry and regulatory standards for data of similar criticality and confidentiality. Retention and destruction of data must comply with legal requirements and the rights of data suppliers.
8. A timely and efficient process must be in place for physician practices to validate any data after transmission as well as any analyses and resultant reports. There must be adequate time for practices to perform this validation.
9. Entities that have collected data for quality or performance measurement purposes should allow real-time access to these data by the originating physician practices. Though a summary report is desirable, practice must have the ability to drill down into areas of interest with full access to applicable data, methods, and results.

10. Data for submission must have both a clearly defined purpose and format. Only data critical to fulfilling the stated objectives should be submitted.

11. To afford real-time access to the data and promote point-of-care use, reporting to participating physician practices should use industry standards for networking and data sharing either via the web or integrated into other applications through technologies such as application programming interfaces (API).

12. Risk and severity issues must be considered in data analyses to maximize the value of quality and performance data and resultant reports.

Dental Services

See also

- Fluoridation of Public Water Supplies

All Americans should have access to age-appropriate dental services. (2004) (2014 COD)
Definition of Family Medicine

See also

- Family Medicine, Quality Health Care in
- Family Medicine, Specialist in
- Family Medicine Faculty Training
- Family Medicine, Undergraduate Training in
- Medical Home
- Family Physician, Definition
- Primary Care Physician, Generic

Family medicine is the medical specialty which provides continuing, comprehensive health care for the individual and family. It is a specialty in breadth that integrates the biological, clinical and behavioral sciences. The scope of family medicine encompasses all ages, both sexes, each organ system and every disease entity. (1984) (2016 COD)
Diagnostic Ultrasonography in Women's Health Care
(Position Paper)

Introduction

Maternal/child care is integral to family medicine. The American Academy of Family Physicians (AAFP) strongly advocates that every family medicine residency training program train physicians in maternal/child care,¹ and many family physicians want to have comprehensive women's health care skills. The cost of equipment and development of office skills can be easily justified in family practices that deliver more than 100 patients per year, and, even those family physicians who do not deliver babies are faced with clinical questions for which diagnostic ultrasonography is indicated. For a number of reasons, modern family medicine requires access to diagnostic ultrasonography in the management women's health care issues:

- The need for clinical information at the time of patient contact in a remote setting
- The need for immediate assessment of urgent clinical problems
- The higher specificity of obstetric ultrasonographic information obtained by clinicians who know the patient
- Significant reductions in time and cost
- Improved continuity of care
- Improved patient access
- The likelihood that primary care allows more time than referral care for educational interaction between patient and provider

Family physicians who practice ultrasonography must at the same time guard against a number of potential negative effects:

- The potential for misuse of this technology, particularly in the area of recreational viewing and information acquisition for non-medical uses²,³
- The risk of over-utilization resulting from easy availability
- The potential for unrealistic societal expectations (These may relate to the power of the tool, the skill of the provider or patients' outcome expectations.)
- Ongoing inter-specialty conflicts regarding the utilization of this technology
- The possibility that the growing complexity of the technology will require providers to expand their knowledge more than their available time permits
- The possibility that increasing volume will lead physicians to ultrasonography to ultrasound technologists, thus distancing physicians and patients
- The possibility that other clinical duties may not allow time for ultrasonographic examinations in the physician's schedule

Section I: Scope of Practice for Family Physicians

Diagnostic ultrasonographic examination appropriately enhances the diagnostic and therapeutic capabilities of family physicians. The applications of ultrasonography in family medicine can be divided into the following general areas:

- First trimester diagnostic pregnancy care
- Second or third trimester diagnostic pregnancy care
- Gynecologic care
- Emergency care of acutely ill patients in labor and delivery, in the emergency department and in the office
- Ultrasound guided procedures (for instance, amniocentesis, external cephalic version, paracentesis, thoracentesis, organ biopsy, mass biopsy, dilation and curettage, intrauterine contraceptive device retrieval and insertion)
- Evaluation of specific small parts and surface anatomy

A number of continuing medical education courses presented by family physicians extensively review the clinical
Section II: Clinical Indications

Indications for ultrasonography in women's health care can be categorized under seven headings:

Maternal factors:
- Evaluation of pelvic mass
- Evaluation of hydatidiform mole
- Evaluation for ectopic pregnancy
- Evaluation for uterine anomaly

Prenatal diagnosis:
- In evaluating the risk of fetal anomaly
- In procedures such as genetic amniocentesis, ceroscopy, fetal transfusion, and chorionic villi sampling
- In evaluation of abnormal alpha-fetoprotein levels

In estimation of fetal age (accurate to within 1 week as assessed from between weeks 7 to 13, to within 2 weeks if measured in the early stages of the second trimester, and plus or minus 4 weeks during the third trimester) in various circumstances:
- Before repeat cesarean section
- In preterm labor
- In irregular menses
- In postterm pregnancy
- In premature rupture of membranes
- Before induction if presentation is uncertain
- In amniocentesis for fetal maturity
- When the date of the last menstrual period is uncertain

Growth abnormalities:
- Evaluation of growth when at risk, for instance in pregnancy-induced hypertension, diabetes mellitus, macrosomia, multiple gestation, or chronic maternal disease
- Evaluation of size/dates discrepancy
- Evaluation of poor weight gain

Fetal assessment:
- Determination of biophysical profile
- Evaluation of decreased fetal movement
- Confirmation of fetal death

Antenatal hemorrhage:
- Confirmation of intrauterine pregnancy
- Exclusion of placenta previa
- Evaluation of suspected abruption

Intrapartum:
- Confirmation of presentation
- Evaluation of cord position
- Evaluation of abnormal fetal heart rate
- Evaluation of abnormal patterns in labor
- Assistance in delivery of multiple gestations, including fetal assessment, determination of presentation, and version

Section III: Training Methodology
Training in ultrasonography may include programmed reading combined with didactic lessons, incremental introduction to equipment and patients, and scanning of patients followed by supervised practice. The efficacy of these methodologies has been established by direct examination of scanning capabilities, written tests, objective measurements of acquired basic data, compared patient outcomes, and matching family physicians' results to those of other practitioners.

In the ideal situation, physicians wanting to obtain skill in ultrasonography engage in a preliminary period of extensive reading, followed by a basic course that includes didactic and experiential activities. The physician then engages in a supervised practice either through auditing of recorded scans or direct supervision. This period of training is then followed by, with the learning curve dependent on the learner's enthusiasm.2

Section IV: Testing, Demonstrated Proficiency, and Documentation

The standard content of examinations by organ systems and clinical conditions has been defined, with very little disagreement, by the American Institute of Ultrasound in Medicine (AIUM), the American Congress of Obstetricians and Gynecologists (ACOG), and the American College of Radiology (ACR). Existing training methodology addresses the standard exam content.

The AIUM has guidelines available for ultrasonography of the abdomen, retroperitoneum, breast, female pelvis, prostate and surrounding structures, scrotum, thyroid, and parathyroid, as well as for pediatric neurosographic, obstetric antepartum, and Doppler vascular ultrasound examinations (www.aium.org/resources/guidelines.aspx). The American Society of Echocardiography has guidelines and standards for the performance of cardiovascular examinations (www.asecho.org/i4a/pages/index.cfm?pageid=3317). The documentation of experience and proficiency needs to demonstrate both an understanding of the technology and the ability to perform the procedure and interpret the information obtained in the context of the clinical question.

For family medicine residents, longitudinal curricula in diagnostic ultrasonography will allow for acquisition of skill, but the individual physician's success depends on time committed, patient volumes, and enthusiasm. For practicing physicians who are currently performing this procedure, myriad continuing medical educational courses and clinical journals allow for expansion of skill.

Section V: Credentialing and Privileging

Current Status and Systems

The issue of privileging is probably best viewed in two segments: office practice and hospital practice.

Office Practice. Office practice is currently unregulated in the sense that as long as an office-based physician has ultrasound equipment, the physician can use it as he or she sees fit. However, the AIUM has developed a system of accreditation for obstetric and gynecologic "ultrasound practices." (www.aium.org/accreditation/accreditation.aspx). This mechanism is similar to a system in use for vascular ultrasound laboratories. This accreditation system is open to any physician regardless of specialty and is based on meeting standard exam content, documentation, procedure volume, and maintenance standards. AIUM accreditation is now required by some payers before payment is issued.4,5

Hospital Credentialing/Privileging. The range of obstetric ultrasound services provided in hospitals varies from complete, standard examinations to emergency department applications and labor and delivery applications. For that reason, these three segments should be considered separately.

Complete or standard ultrasound examinations are usually performed in the department of radiology by technical personnel and interpreted and "validated" by radiologists (sonologists). Radiology departments generally guard their control of these studies. A variety of procedural, medical, legal, and financial arguments are raised against allowing nonradiologists access to the radiology department equipment. This, therefore, becomes an interspecialty issue involving OB/GYNs, family physicians, and radiologists.

Since most family physicians who perform obstetric ultrasound do so in their offices, this might not often be a significant issue. However, where the office practice and equipment are owned by a hospital, the radiology departments might try to assert their sovereignty over office imaging practice, including plain radiography and diagnostic ultrasound, and thus infringe on family physicians' office-based practices. This may include residency training situations in which residencies are
denied ultrasound equipment based on a radiology department's objections and despite evidence of the quality of ultrasonography performed in family medicine residencies. Still, a 2009 AAFP survey indicated that 17.5% of family physicians perform obstetric ultrasonography and 14.8% perform nonobstetric ultrasonography in the office.

Use of diagnostic ultrasonography in the emergency department is becoming recognized as clinically important and as within the scope of care of the physicians who practice there. Courses developed by family physicians in general ultrasonography have been attended by emergency department physicians. Family physicians conducting these courses have been asked to conduct similar courses specifically for emergency physicians. Training and credentialing in emergency department ultrasonography is currently an issue that faces some of the same challenges as are being addressed in this document.

Essentially every physician who delivers babies can make use of diagnostic ultrasonography for a limited number of applications that often arise suddenly and can have significant impact on patient care. These applications include the diagnosis of fetal life, fetal number, and fetal presentation as well as assessment of amniotic fluid and of placental location. These applications are widely recognized as being readily learned by family physicians and are included as an option in the AAFP-sponsored Advanced Life Support in Obstetrics courses. Modern obstetric care benefits from the availability of ultrasound equipment in, or readily accessible to, the labor and delivery area for these purposes. Accessibility of this equipment to all physicians who practice and the acquisition of these basic skills by all physicians who deliver babies is highly desirable.

Numbers and Outcomes. Any family physician desiring to perform obstetric ultrasound would be best advised to keep a record of the following:

- Courses taken, including the number of hours of formal learning involved
- The number of directly supervised scans performed
- The total number and types of scans performed, including standard examinations, labor and delivery scans, emergency department scans, and sonographically guided procedures performed

Documentation of outcomes is acknowledged as important in demonstrating proficiency and supporting credentialing. In the case of obstetric ultrasonography, the specific outcomes that are most likely to be scrutinized include these:

- Accuracy of gestational age assessment by correlation of eventual delivery date and gestational age at birth
- Accuracy of fetal anatomic survey by follow-up of infants suspected of having fetal anomalies or those in whom fetal anomalies were missed

Section VI: Miscellaneous Issues

Ensuring the quality of ultrasonography courses is important; quality can be fostered through the AAFP Prescribed credit mechanism using expert physicians within the AAFP or in other professional organizations.

The public health implication of expanding family physicians' use of diagnostic ultrasound is improved access to care for patients.

The financial implications of expansion of obstetric ultrasound skills for family physicians include the cost savings inherent in improved access. The implications for practicing physicians include the revenue generated by this procedural skill and the enhanced attractiveness to managed care organizations of practices that can provide more complete services.

The main educational research agenda items are clear definition of competency-based measures required for profiles in ultrasound, and analysis of outcomes.

References


Direct Contracting with Businesses by Family Physicians (Discussion Paper)

See also:

- Collective Negotiation
- Physician, Payment

Background

The majority of family physicians still rely on a fee-for-service model for their primary revenue stream. This includes commercial insurance and government sponsored health care funded through programs such as Medicare, Medicaid, the State Children's Insurance Program, (SCHIP), and occasionally other local tax-based programs for the indigent. Some physicians in community based practices have been pursuing alternate payment strategies.

The alternate strategies have included cash-based fee-for-service models, monthly retainer fees, and direct contracting either between physician and patients, or between a physician or physician group and local employers. This process of directly contracting with businesses in communities is evolving to include a more comprehensive level of service, longer appointments, and traditionally unreimbursed services such as phone calls and telemedicine visits.

Physicians contracting directly with business entities is not a new phenomenon, but in the past it has often focused on business-related services, such as worker’s compensation or occupational health and screening services. In this scenario, the services provided were limited and of a specific nature. Payment was typically pre-determined. The primary care physician may or may not have been involved in a cost control strategy to assist the patients and the business in reducing or eliminating unnecessary expenditures.

Discussion

Family physicians have often looked at direct contracting with businesses as a way to bypass the insurance industry's control of the revenue stream. Historically, the physicians involved in direct contracting were organized into large networks of physicians and other health care service providers to meet the needs of large or medium sized businesses. The direct contracting initiatives of the past often involved the provision of on-going primary care, and sometimes specialty care outside a traditional insurance program. In many instances the physician groups involved had difficulty organizing within the restrictive regulatory environment and competing with the ready access to providers available through an established competing insurance plan. These plans often included hospital care and were difficult for primary care providers to participate in.

As costs continue to escalate within the insurance based model, additional opportunities to develop alternative strategies emerge. More family physicians are offering services to help businesses control unnecessary expenditures and reduce the administrative burdens associated with health insurance.

The following are several types of services that family physicians may offer:

- Wellness and preventive services or programs to businesses. Examples of such services are health fairs, flu vaccine programs, cancer screenings, or osteoporosis screening programs.
- Traditional worker’s compensation services or return to work and stay at work programs under a direct contract.
- Occupational health screenings (drug and alcohol testing, Department of Transportation testing requirements, Federal Aviation Administration physicals).
- Comprehensive primary care services for episodic illness and chronic care under a direct primary care
(DPC) contract arrangement though their own clinic. These services may be offered at the family physician's usual practice site, or a worksite clinic may be established.

- Separate worksite clinics staffed by physicians or midlevel providers with physician oversight. These clinics include traditional occupational health or regulatory compliance or may offer complete primary care services for employees and/or their families. Chronic care may be referred to the primary office or performed at the worksite clinic.

There are multiple benefits for both the employees and the employer under such arrangements. Such services significantly reduce employee absences from work for minor illness and for routine follow-up for on-going illnesses. The services may also prevent unnecessary after-hours trips to the urgent care center or emergency room. Moreover the preventive care and chronic care services provide a usual source of care for patients who may not have an established site for care or a primary care physician. There is clear evidence that patients provided access to primary care have better outcomes and reduced total expenditures than patients who are unguided in the current US healthcare system, and employers are beginning to realize this.

Physician payment may be based on some combination of:

- A per employee per month fee that may vary depending on the demographics and size of the group and services provided.
- A negotiated flat fee that covers the total cost, including fees for the physician or any midlevel providers involved in providing care.
- There may be an additional co-payment paid by the patient.

Ideally, this revenue stream does not involve the patient’s primary health insurance. The payments are made directly to the physician and he or she is not required to bill a third party administrator. This reduces the self-funded employer's cost for this portion of employee health care, as the third party administrative charge is avoided (which can be up to 40 percent of the total).

The types of services included are the usual services provided by family physicians, and may include episodic care, chronic care and preventive care. In some cases basic radiology and/or lab fees are also included (through the physician's office or a negotiated discount between the physician and a commercial laboratory or radiology facility). Physicians who offer other ancillary medical services or in-office pharmaceutical dispensing can potentially add these to a direct contract with the self-insured employer. Additional preventive care services such as immunizations are often provided periodically at the work site.

For on-site clinics, the business may provide low cost or no cost onsite facilities. In other instances the employer may be responsible for funding the initial setup of a clinic facility and the ongoing onsite facility expense.

Physicians involved in these arrangements contend that the savings obtained by reducing claims expense to the company’s insurance or worker’s compensation costs more than offsets their expenditures on the physician’s services. This is especially true for companies that are self-insured and have a third party administrator processing the claims. Their overall utilization and cost of claims may be reduced and may provide them an advantage when renewing or renegotiating their contracts.

The greatest hurdle to overcome for most family physicians in promoting this type of alternative strategy is the need for physicians or their representative to educate the business owner and patients on the advantages and potential benefits of such arrangements and to prepare and negotiate a contract. (April Board 2010) (2015 COD)
Direct-to-Consumer Advertising of Infant Formula

See also

- Drug Switching Notices
- Breastfeeding (Policy Statement)
- Breastfeeding, Family Physicians Supporting (Position Paper)
- AAFP Promotions: Print Advertisials

The AAFP advocates breastfeeding as the primary and optimal method of infant nutrition whenever possible and safe. Advertising or promotion of infant formula to the public by any method should advocate that stance. (1989) (2015 COD)
Direct-to-Consumer Advertising of Prescription Pharmaceuticals, Nonprescription Medications, Health Care Devices, and Health-Related Products and Services

See also

- Drug Switching Notices
- AAFP Promotions: Print Advertorials
- Advertising: Youth Products
- Durable Medical Equipment, Unsolicited Vendor Requests

The AAFP supports efforts by manufacturers of prescription pharmaceuticals, nonprescription medications, health care devices and health-related products and services to provide general health information to the public. At the same time, the AAFP urges that any direct-to-consumer advertising of prescription drugs by pharmaceutical companies be based on disease state only, without mention of a specific drug by name. The AAFP believes direct-to-consumer advertising of these products and services is acceptable when the following conditions are met:

- Advertisements must conform to applicable laws, including FDA and/or FTC guidelines.
- Advertisements must be labeled as such.
- Information should be accurate, balanced, objective, and complete, not false or misleading, and should not promote unhealthy or unsafe practices.
- If specific properties or indications are mentioned, then negative or adverse reactions and effects should likewise be mentioned, in a manner that is equitable in respect to time, font size, speed of information, etc., to ensure information is accessible and understood by the consumer.
- Advertisements should not promote the use of products that have addictive or abuse potential.
- If advertisements direct the consumer to a physician, referral should be to the consumer's family or personal physician. The AAFP considers it inappropriate and unethical for an advertiser to act as a referring agent, due to the consumer's lack of awareness of any potential conflict of interest associated with such a referral.

Direct Primary Care

See also:
- Payment, Physician

The direct primary care (DPC) model is a variation of the retainer practice framework for primary care physicians. DPC practices charge patients a flat monthly or annual fee, under terms of a contract, in exchange for access to a broad range of primary care and medical administrative services. The retainer practice framework includes any practice model structured around direct contracting with patients/consumers for monthly or annual fees which serve to replace the traditional system of third party insurance coverage for primary care services. Typically, these “retainer fees” guarantee patients enhanced services such as 24/7 access to their personal physician, extended visits, electronic communications, in some cases home-based medical visits, and highly personalized, coordinated, and comprehensive care administration. The AAFP supports the physician and patient choice to, respectively, provide and receive healthcare in any ethical healthcare delivery system model, including the DPC practice-setting.

The DPC contract between a patient and his/her physician provides for regular, recurring monthly revenue to practices which typically replaces traditional fee-for-service billing to third party insurance plan providers. For family physicians, this revenue model can stabilize practice finances, allowing the physician and office staff to focus on the needs of the patient and improving their health outcomes rather than coding and billing. Patients, in turn, benefit from having a DPC practice because the contract fee covers the cost of all primary care services furnished in the DPC practice. This effectively removes any additional financial barriers the patient may encounter in accessing routine care primary care, including preventative, wellness, and chronic care services. Most patients, depending on affordability, choose to still carry some form of insurance, such as a high deductible health plan, for coverage of healthcare services that cannot be provided in the primary care practice setting, such as specialty care and hospitalizations.

Ideally, the DPC model is structured to emphasize and prioritize the intrinsic power of the relationship between a patient and his/her family physician to improve health outcomes and lower overall health care costs. The DPC contract fee structure can enable physicians to spend more time with their patients, both in face-to-face visits, and through telephonic or electronic communications mediums should they choose, since they are not bound by insurance reimbursement restrictions. For these reasons, the DPC model is consistent with the AAFP’s advocacy of the PCMH and a blended payment method of paying family medicine practices. (2013 COD)
Disaster Planning

See also

- Nuclear, Biological and Chemical (NBC) Warfare
- Nuclear Waste Disposal
- Nuclear Disarmament

The American Academy of Family Physicians supports civilian and military disaster planning including disaster planning for natural and human-created disasters, both intentional and unintentional. The AAFP supports planning for the prevention of potential disasters and the protection of the populace from toxic and infectious exposures resulting from such events. Family physicians are encouraged to become knowledgeable in the adverse effects and early response and treatment of toxic and infectious exposures resulting from these occurrences. This should include knowledge in the mobilization of support services. Family physicians are also encouraged to become knowledgeable regarding potential sources of disasters in their practice region and are encouraged to work with public health and other authorities in the development of evacuation and treatment plans to deal with the consequences of such events. (1987) (2012 COD)
Disclosure of Corporate Ties Affecting Formulary Choices and Drug Substitution

See also

- Patient-Centered Formularies
- Drugs, Physician Dispensing
- Drugs, Prescribing
- Drug, Therapeutic Substitution

The Academy supports full disclosure to physicians and patients of corporate ties and financial relationships between pharmaceutical manufacturers, mail order pharmacies, pharmacy benefit management (PBM) entities and pharmacists. Additionally, formulary decisions and “drug switching” should not be based principally on economic considerations, but on evidence-based therapeutic and quality of care considerations, to promote optimal patient care. (1998) (2015 COD)
Discrimination, Family Medicine Residency Graduates

See also

- Hospital Medical Staff, Board Certification for Membership
- Health Workforce Credentialing
- Resident and Student Education, Discrimination In
- Physician Payment
- Privileges

Managed care organizations should not discriminate against a family medicine residency graduate within one year of graduation in credentialing or payment who has not yet taken the American Board of Family Medicine or American Osteopathic Board of Family Physicians exam. (1996) (2015 COD)
Discrimination, Patient

See also

- Fairness in Federal Programs for All US Citizens
- Gender Equity on Drug, Testing, Procedure, and Preventive Coverage
- Hearing Loss, Deafness and the Hard-of-Hearing
- Resident and Student Education, Discrimination In

Patient

The AAFP opposes all discrimination in any form, including but not limited to, that on the basis of actual or perceived race, color, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, economic status, body habitus or national origin. (1996) (2015 COD)
Discrimination, Physician

See also

- Privilege Support Protocol
- Membership Evaluation, Discrimination in
- Equal Opportunity
- Health Workforce Credentialing
- Diversity in the Workforce
- Resident and Student Education, Discrimination In

The American Academy of Family Physicians (AAFP) strongly supports the principle that hiring, credentialing and privileging decisions for physicians should be based solely on verifiable professional criteria.

The AAFP supports the application of this principle for both practicing physicians and for physicians and medical students applying to residency training programs. The AAFP believes that by encouraging diversity in their physician workforces, physician groups and health care systems can help ensure their ability to deliver culturally competent care to all segments of their patient populations. (1996) (2015 COD)
Discriminatory Policing

The American Academy of Family Physicians (AAFP) recognizes that policing is effective in reducing crime and promoting safety when there is consistent communication, transparency, and accountability in all interactions between the police and the public they serve. However, discriminatory policing and the use of excessive force pose health and safety hazards to individuals and communities of targeted populations, particularly people of color and other minority groups.

The AAFP supports the recommendations outlined in President Barack Obama’s 2015 Final Report of the President’s Task Force on 21st Century Policing(www.cops.usdoj.gov). The AAFP particularly agrees with the statement that law enforcement agencies should adopt and enforce policies prohibiting profiling and discrimination based on race, ethnicity, national origin, religion, age, gender, gender identity/expression, sexual orientation, immigration status, disability, housing status, occupation, and language fluency. The AAFP supports the universal adoption of evidence-based de-escalation techniques and the use of the lowest level of force when force becomes necessary to maintain safety. (BC August 2016) (2016 COD)
Disease Management

SEE ALSO

- Patient Care, Concurrent

Disease management is a set of activities aimed at improving the health and clinical outcomes of a population of patients, defined by a chronic medical illness. These activities are often facilitated by the use of an electronic health record, identification of "outliers" or "high utilizers" or disease registry programs. Disease management is proactive, aiming to provide appropriate support to enhance patient self-management activities. Through monitoring of recommended care for each patient, a good disease management program will reach out to patients with reminders, education, and other materials. In such a way, patient self-management is optimized in the interval between visits with the physician. In addition, those patients at highest risk for complications or other negative outcomes can be identified, and appropriate interventions offered. Family physicians serve as the optimal care coordinator to assist patients not only with clinical care and information, but in understanding and navigating the health care system.

Care coordination activities are the responsibility of the entire care team and not only the primary care physician. Practice based care teams should engage community resources as needed for the best outcomes for patients.

The American Academy of Family Physicians supports population-based disease management coordinated with the leadership of a primary care physician. Primary care centered disease management is essential for delivering the highest quality of care and is a core component of the patient-centered medical home (PCMH). Programs that bypass or fail to coordinate care with the PCMH are strongly discouraged.

Diseases or conditions which lend themselves to the disease state management approach include:

- High cost per episode of care
- High volume of provided care
- Evidence of wide variations in care
- Condition for which evidence-based medical guidelines exist that lead to improvements in outcomes for defined populations
- Interest in reducing treatment variation and waste.

Successful disease management requires significant resources to develop and implement and may require some practices to collaborate with other entities to provide effective disease management. However, it is important for family physicians in all practice settings to familiarize themselves with disease management concepts, to review the cost and outcomes data, to recognize the potential for conflict of interest, and to manage care and advocate for their patients accordingly.

There are a number of components common to most effective disease management programs including:

- Patient education and involvement in self management support
- Focus on improving the quality of care and patient outcomes
- Clinical policies/best practices that center in the primary care setting but extend across the entire continuum of care
- Medication management and reconciliation across multiple points of care
- Clinical information systems, such as registries, with the capacity to identify, classify, and track defined patient populations
- Engagement and active participation of primary care physicians
- Team-oriented, multidisciplinary approach
- Regular review of patient’s care plan and planned care visits as needed

A comprehensive, well-planned and multidisciplinary approach to the management of health care is
consistent with the traditions of family medicine. However, a team approach to patient care does not relieve the family physician of the ultimate responsibility for the care of his or her patients. Physicians should be able to deviate from disease management practice guidelines when judged appropriate without incurring sanctions or jeopardizing coverage for such services. Deviations need to be documented and can provide the basis for improvement in the guidelines.

The AAFP supports disease management programs that include the following:

- Utilize the family physician and the practice care team as the patient’s care coordinator;
- Use an appropriate method to identify patient populations;
- Allow for voluntary patient enrollment into the disease management programs and activities;
- Engage the patient in self management;
- Emphasize the importance of prevention;
- Support the physician-patient relationship;
- Utilize evidence-based practice guidelines but allow for physician deviation when judged appropriate, without any negative financial and/or administrative impact to the physician and/or patient;
- Utilize standardized performance measurements for processes and outcomes;
- Promote collaboration between specialists and other providers of care with the family physician;
- Perform ongoing evaluations of clinical, economic, and patient outcomes focusing on improving health status;
- Maintain regular communication among all parties involved in disease management;
- Focus on providing appropriate and timely services;
- Employ/utilize physicians overseeing the DM program who are licensed to practice medicine in the jurisdiction of the program’s location;
- Support the family physician’s responsibility to coordinate ancillary support services or products as well as to refer patients to a specialist as needed.

Disease management is an evolving concept which requires ongoing, accurate and verifiable data collection and peer reviewed publications which document cost effectiveness and improvements in patient outcomes. (1996) (2013 COD)
Diversity in the Workforce

See also

- Diversity, Assuring Sensitivity to Diversity in AAFP Education Programs
- Linguistically Appropriate Health Care
- Medical Schools, Minority and Women Representation in Medicine
- Equal Representation of Women in Family Medicine
- Equal Opportunity

The AAFP will position itself in a leadership role in creating a medical workforce reflective of the patient populations family physicians serve. (2005) (2015 COD)
Diversity, Assuring Sensitivity to Diversity in AAFP Education Activities

See also

- Diversity in the Workforce
- Linguistically Appropriate Health Care
- Medical Schools, Minority and Women Representation in Medicine
- Equal Representation of Women in Family Medicine
- Culturally Sensitive Interpretive Services - AAFP Legislative Stance
- Equal Opportunity

The AAFP education process is designed to maintain and improve the ability of family physicians to provide high quality care to all patient populations. The AAFP supports the principle that continuing medical education (CME) and patient educational material, as well as guidelines for faculty who provide live, online or enduring education should include components that directly address and take into account the unique aspects of diverse populations.

Domestic Partner Benefits

See also

- Family, Definition of
- Health Benefits

The AAFP supports the legal recognition of domestic partnership benefits regarding health care in an effort to eliminate health care inequities. (2007 COD) (2012 COD)
Don't Text and Drive Initiative

See also

- Driver Education
- Graduated Driver's License
- Motor Vehicle Occupant Protection

The American Academy of Family Physicians supports efforts that would evaluate and reduce motor vehicle fatalities and injuries due to driver distraction. These distractions include but are not limited to: use of cellular phones while driving, children without appropriate required safety restraints, and other driver distractions frequently cited as causes for accidents. The American Academy of Family Physicians encourages family physicians to include distracted driving as part of preventive health care discussions.

The American Academy of Family Physicians (AAFP) supports national efforts to ban the use of text messaging while operating motor vehicles or machinery.

Driver Education

See also

- Don't Text and Drive Initiative
- Graduated Driver's License
- Motor Vehicle Occupant Protection

The AAFP recommends that driver education, including teaching rules of the road, respect for safety regulations and requirements, and the development of safe driver skills, should be an integral part of the secondary school curriculum and, further, that efforts should be made to offer such driver education by the states to all who plan to drive. (1967) (2013 COD)
Drug Enforcement Administration (DEA) - AAFP
Legislative Stance

See also

- Drugs, Physician Dispensing
- Drugs, Prescribing

Drug Switching Notices

See also

- Direct-to-Consumer Advertising of Prescription Pharmaceuticals, Nonprescription Medications, Health Care Devices, and Health-Related Products and Services
- Direct-to-Consumer Advertising of Infant Formula
- Advertising, Youth Products

The American Academy of Family Physicians supports patient-centered formularies. As a means to maintain such formularies and to reduce costs of prescription benefit programs, insurers and pharmacies sometimes request that a patient be switched from their current medication to a generic or therapeutically equivalent drug. Such “drug switching notices” (verbal and/or written) to using patient-specific data may be appropriate when such communications:

- are patient-centric, e.g., address patient safety and patient compliance, suggest appropriate generic or therapeutic alternative, etc.
- are drawn from evidence-based disease management guidelines;
- are HIPAA-compliant;
- are directed to specific individuals only;
- clearly indicate what organization is funding such a communication;
- are transparent regarding the financial impact to the patient and the pharmacy plan and/or health plan;
- emphasize patients should consult their personal physician about any potential change(s) in their prescribed medication(s) which may be done best in a face-to-face visit; and
- adhere to respective AAFP policies on drugs.

Drug Testing and Selection

See also

- Drugs, Physician Dispensing
- Drugs, Prescribing
- Drug Samples, Physician Dispensing
- Drugs, Therapeutic Substitution

The AAFP at all times, supports the proper testing of new drugs and biological agents for safety and benefit as measured by health outcomes of value to patients. The Academy supports legislation to protect the public from dangerous products. It believes this protection must be balanced against the need to promote the research, innovation, production, and distribution of useful new pharmaceutical agents. Previously approved agents should be available for research or scientifically supported clinical use for "off label" indications.

The final determination as to the selection of appropriate pharmaceutical agents in the treatment of an individual is best decided by the clinician and the individual patient. (1977) (2013 COD)
Drugs, Generic

See also

- Generic Drug Pricing - AAFP Legislative Stance
- Drugs - Identification
- Drugs, Therapeutic Substitution
- Drugs, Prescribing

The American Academy of Family Physicians (AAFP) maintains that the family physician is the patient's advocate. That advocacy demands that the family physician prescribe safe, efficacious pharmaceutical products to deliver high quality medical care, with sensitivity to the patient's individual medical and financial circumstances.

The AAFP recognizes that FDA-approved generic medications may be reasonable alternatives to brand name medications. While generic substitution may often be clinically appropriate and an effective measure to help allocate scarce resources, the AAFP opposes mandatory generic substitution. The Academy’s policy, Principles for the Development and Management of Patient-Centered Formularies, addresses the use of formularies, including generic drugs and therapeutic substitution policies, as a cost management tool.

The AAFP supports affordable generic medications and believes such medications should be readily available for family physicians to prescribe. The AAFP’s policy, Generic Drug Pricing – AAFP Legislative Stance, supports this position.

The AAFP supports the elimination of prior authorizations (PA) for generic drugs. The AAFP believes that this type of administrative burden undermines the doctor and patient relationship and lowers quality of care. AAFP resources on administrative simplification say, in part, "The AAFP is determined to help family physicians reduce these roadblocks by identifying and eliminating regulations and processes that add cost while undermining the efficient and effective delivery of quality care."

The AAFP supports the idea of uniform product identification codes for all tablets and capsules (brand-name and generic), including designators for manufacturer and dosage strength. It is only by such a coding system that physicians and pharmacists can identify and report product inequalities.

The AAFP supports the development of high quality, therapeutic equivalent, generic medications. These products should have adequate in vivo and/or in vitro evidence supporting bioequivalence (FDA designation AB) or no known or suspected bioequivalence problems (FDA designations AA, AN, AO, AP, or AT, depending on the dosage form).

The AAFP urges its members to participate in clinical research to expand the scientific and practical database regarding generic medications and therapeutic equivalency in various circumstances.

The AAFP recommends that further efforts be supported to enhance post-market medication surveillance for all generic and brand name pharmaceuticals. (1989) (2016 December BOD)
Drugs - Identification

See also

- Drugs, Generic
- Generic Drug Pricing - AAFP Legislative Stance
- Drugs - Therapeutic Substitution
- Drugs, Prescribing
- Drugs, Physician Dispensing
- Physician Dispensing of Drug Samples

The AAFP supports the use of a uniform identification code for individual drug capsules and tablets, as well as provision for complete labeling of drug containers listing the generic and brand names, dosage, manufacturer of the drug and expiration date. (1970) (2013 COD)
Drugs, Opposition to Mandatory Education for Drug Prescribing

See Also

- Drugs, Prescribing
- Chronic Pain Management and Opioid Misuse: A Public Health Concern

The AAFP opposes legislation or executive action that would require mandatory education of family physicians as a condition for prescribing specific drugs, such as opioids. The AAFP supports programs that would provide funding to all states to continue or to develop prescription drug monitoring programs and to make the interstate exchange of monitoring information easily available to prescribers and dispensers.

(August 2011 Board Chair) (2016 COD)
Drugs, Physician Dispensing

See also

- Drugs - Identification
- Pharmacists Dispensing Drugs - AAFP Legislative Stance
- Drugs, Generic
- Drugs, Therapeutic Substitution
- Drugs, Prescribing
- Drug Testing and Selection
- Physician Dispensing of Drug Samples

The American Academy of Family Physicians believes that physicians have the right under their medical license to diagnose, prescribe for, and dispense pharmacologic agents or other therapeutic products whenever and wherever it is appropriate. While the Academy believes that no regulation or laws should infringe upon that right, the Academy believes that physicians dispensing pharmacologic agents or other therapeutic products should be held to the same high standards as other professionals so privileged. (1986) (2015 COD)
Drugs, Prescribing

See also

- Drugs - Identification
- Pharmacists Dispensing Drugs - AAFP Legislative Stance
- Drugs, Generic
- Drugs, Opposition to Mandatory Education for Drug Prescribing
- Generic Drug Pricing - AAFP Legislative Stance
- Drugs, Therapeutic Substitution
- Drug Testing and Selection
- Pharmacists (Position Paper)
- Pharmacists' Right of Conscientious Objection
- Physician Assistants
- Physician Dispensing of Drug Samples
- Chronic Pain Management and Opioid Misuse: A Public Health Concern

The American Academy of Family Physicians opposes action that limits patients' access to pharmaceuticals prescribed by a physician using appropriate clinical training and knowledge, and opposes any actions by pharmaceutical companies, public or private health insurers, legislation, the FDA or any other agency, which may have the effect of limiting by specialty the use of any pharmaceutical product.

The AAFP believes that only licensed doctors of medicine, osteopathy, dentistry, and podiatry should have the statutory authority to prescribe drugs for human consumption.

Under physician supervision, physician assistants and advanced practice nurses may have the statutory authority to prescribe drugs for human consumption.

Pharmacists should not alter a prescription written by a physician, except in an integrated practice supervised by a physician or when permitted by state law.

In order to preserve patient confidentiality the Academy opposes any requirement that a diagnosis be placed on a prescription form. (1995) (2014 COD)
The AAFP strongly opposes any legislative or regulatory effort at the state or federal level to permit therapeutic substitution, that is the substitution of a therapeutic alternate, a drug product containing a different pharmaceutical moiety but which is of the same therapeutic or pharmacologic class. (1988) (2013 COD)
Durable Medical Equipment, Unsolicited Vendor Requests

Family physicians may receive unsolicited requests to prescribe durable medical equipment (DME) or supplies on behalf of their patients. These requests are often initiated from direct to consumer marketing to patients and may not be medically necessary. It is the policy of the American Academy of Family Physicians that when a family physician receives such unsolicited requests for DME or supplies from vendors, the physician may disregard the request without need to respond to the vendor or notify the patient. However, the physician is encouraged to discuss and educate their patient at the next appropriate clinic visit regarding the appropriate indication of the DME or supply. (2011 COD) (2016 COD)
Economic Credentialing and Network Participation

See Also

- Hospital Medical Staff, Board Certification for Membership
- Hospital Medical Staff and Other Health Care Organizations, Board Recertification
- Hospital Medical Staff, Liaison Between Governing Boards and
- Health Care Costs, Methods for Reducing

Cost-effectiveness is an integral element in the delivery of quality medical care nevertheless, the American Academy of Family Physicians opposes measures of cost per case or related utilization measures as the sole basis for terminating or excluding membership in healthcare organizations, such as hospitals or third-party insurance carrier networks. Family physicians are encouraged to collaborate with resource utilization efforts of healthcare organizations. (1992) (2014 COD)
Education, Physician Retraining

See also

- CME, Physician Remediation

The position of the American Academy of Family Physicians is that the best training in the knowledge, skills and attitudes of family medicine is provided through family medicine residency education. (1999) (2015 COD)
EGD, Training and Credentialing of Family Physicians In (Position Paper)

See also

- Privileges
- Privileges and Training for New Procedures
- Privilege Support Protocol

Esophagogastroduodenoscopy (EGD) is a useful procedure for the diagnosis of conditions of the upper gastrointestinal (GI) tract. For all upper GI problems except esophageal and gastric motility abnormalities, EGD can often be substituted for radiologic studies. The sensitivity and specificity of EGD are higher than those of radiographs for the diagnosis of upper GI tract inflammation, ulcers and neoplasm.

Becoming competent to perform EGD increases the family physician's knowledge of upper GI pathology and normal physiology and anatomy. The ability to detect significant pathology earlier enhances the quality of care family physicians provide.

Family physicians who perform EGD find it can increase patient satisfaction because patients often prefer to stay with their primary care physician. Patients may be pleased that their family physician is able to do this procedure and may appreciate having their physician with them during a somewhat intimidating diagnostic procedure. The patient-physician bond is strengthened, and the patient's confidence in the physician is increased.

Benefits for Family Physicians

Family physicians are under pressure today to make accurate diagnoses and efficacious treatment plans as efficiently and cost-effectively as possible. In this environment especially, EGD is a useful tool in the physician's armamentarium.

Furthermore, family physicians who do upper GI endoscopy invariably note an enhanced relationship with patients, a better working relationship with their gastroenterologist colleagues, a better understanding of the pathology in individual cases, and a much greater comfort level with the chosen treatment as a direct result of having done the procedure themselves.

In a review of 793 EGDs performed by a family physician, 451 biopsies were taken during 385 EGDs. 1 546 pathologic diagnoses were provided as a result of the biopsies. No major complications occurred -- only one minor complication (a rash from meperidine). The complication rate in this family medicine study was 0.13%. A series of 1,949 endoscopies, including 667 gastroscopies, performed by a Canadian family physician reported two complications for the series as a whole, neither of which arose from a gastroscopy. 2 Such complication rates compare favorably with others in the GI literature. In what is still probably the largest series published to date, a 1976 survey of more than 210,000 esophagogastroduodenoscopies reported an overall complication rate of 0.13% with a 0.008% death rate. 3

Office Versus Hospital GI Lab

Each family physician must assess the appropriateness of outpatient EGD in his or her office. The physician should consider his or her competence and comfort with the procedure, the expertise of staff, the set-up of the office, the local standards of care, the economic implications, and, in some cases, the local political climate surrounding procedures and privileges. The physician must also consider specific patient factors such as the urgency and timing of the procedure, and the patient's wishes regarding outpatient EGD.
Currently, economics favor the GI lab setting over the office setting for many family physicians. The scope, video and photography equipment, intravenous (IV) medications and supplies, and nursing staff are provided without additional charge to the physician. Physician payment today is generally provided at the same rate regardless of where the procedure is performed. Many insurance companies do not pay for supplies when procedures are performed in the office, which provides another economic incentive for physicians to do the procedure in the hospital outpatient area. The overall cost to the patient and payer, however, is considerably higher when the procedure is performed outside of the family physician's office.

EGD is safe and rarely causes significant physical stress for the patient. However, IV sedation does carry a measurable risk and thus significant post-procedure observation is required. Physicians who perform procedures requiring IV sedation in their offices should provide the same level of care as is available in an EGD lab in the hospital or out-patient setting. This would include appropriate personnel for assistance and observation and may include oximetry monitoring and telemetry for appropriate patients.

Not all patients are candidates for office EGD, particularly when the physician is first gaining experience with the procedure. For the beginning endoscopist, the following patient characteristics may preclude office EGD:

- Age > 70 years
- Age < 12 years
- Angina
- Aortic stenosis, post cardiac bypass
- Chronic Obstructive Pulmonary Disease (COPD)
- Cerebrovascular Accident (CVA)

Of course, these are guidelines and may be altered depending on the geographic area, available facilities, and experience of the endoscopist.

The Trend in Family Medicine and Support of EGD

The first national course in EGD for family physicians was sponsored by the American Academy of Family Physicians (AAFP) in 1989. Before that, state chapters provided accredited continuing medical education (CME) in EGD. Today, the AAFP and state chapters have expanded CME opportunities for EGD and other procedures.

Family physicians have gained hospital privileges for EGD in all 50 states, and the number of family physicians performing EGD continues to grow. According to a 2006 AAFP survey, 3.8% of family physicians surveyed had hospital privileges to perform EGD alone or under supervision or with consultation. By 2011, while the percentage with privileges to perform EGD alone dropped from 3.4% to 2.4%, the total percentage had risen to 6.8%.

According to a 2003 study, 32% of family medicine residency programs offered training in colonoscopy, and 13% reported actually training one or more residents in the procedure.

EGD has multiple indications. The most common in a study of 793 procedures performed by a family physician were these:

- Abdominal pain, dyspepsia
- Gastrointestinal bleeding
- Dysphagia
- Heartburn
- Anemia
- Abnormal upper GI radiograph
- Gastritis follow-up
- Barrett's esophagus follow-up
- Nausea/vomiting
A complete list is quite extensive. Indications include several pre-existing conditions, signs, and symptoms (depending on factors such as severity, response to treatment, length of symptoms, etc.):

- Cancer surveillance in high risk patient conditions (Barrett's esophagus, Menetrier disease, polyposis, pernicious anemia)
- Crohn's disease of the upper GI tract (pre-existing or suspected)
- Duodenitis, chronic
- Esophageal stricture
- Chronic esophagitis
- Failed medical therapy, for instance for Helicobacter--pylori
- Gastric retention
- Gastric ulcer monitoring
- Chronic gastritis
- Hiatal hernia
- Chronic peptic ulcer disease
- Pyloroduodenal stenosis
- Varices
- Abdominal mass in the upper-mid abdomen (when other diagnostic tests point to the stomach as the origin)
- Unexplained anemia
- Chest pain when the etiology is uncertain
- Severe dyspepsia
- Gross, but not massive GI bleeding
- Occult GI bleeding
- Severe heartburn
- Severe indigestion
- Chronic loss of appetite
- Chronic nausea (vomiting)
- Severe reflux
- Severe weight loss
- X-ray abnormality

The American Society for Gastrointestinal Endoscopy (ASGE) has published a list of indications for GI endoscopy in general (including EGD, colonoscopy, and other modalities) and for EGD specifically. That list appears in Table 1 below.

**Table 1**

**ASGE Guidelines for GI Endoscopy and for EGD**

GI endoscopy is generally indicated:
1. If a change in management is probable based on results of endoscopy.
2. After an empirical trial of therapy for a suspected benign digestive disorder has been unsuccessful.
3. As the initial method of evaluation as an alternative to radiographic studies.
4. When a primary therapeutic procedure is contemplated.

GI endoscopy is generally not indicated:
1. When the results will not contribute to a management choice.
2. For periodic follow-up of healed benign disease unless surveillance of a premalignant condition is warranted.

GI endoscopy is generally contraindicated:
1. When the risks to patient health or life are judged to outweigh the most favorable benefits of the procedure.
2. When adequate patient cooperation or consent cannot be obtained.
3. When a perforated viscus is known or suspected.
EGD is generally indicated for evaluating:
A. Upper abdominal symptoms that persist despite an appropriate trial of therapy.
B. Upper abdominal symptoms associated with other symptoms or signs suggesting structural
disease (e.g., anorexia and weight loss) or new-onset symptoms in patients older than 50 years of
age.
C. Dysphagia or odynophagia.
D. Esophageal reflux symptoms that persist or recur despite appropriate therapy.
E. Persistent vomiting of unknown cause.
F. Other diseases in which the presence of upper GI pathology might modify other planned
management. Examples include patients who have a history of ulcer or GI bleeding who are
scheduled for organ transplantation, long-term anticoagulation or nonsteroidal anti-inflammatory
drug therapy for arthritis, and those with cancer of the head and neck.
G. Familial adenomatous polyposis syndromes.
H. For confirmation and specific histologic diagnosis of radiologically demonstrated lesions:
   1. Suspected neoplastic lesion.
   2. Gastric or esophageal ulcer.
   3. Upper tract stricture or obstruction.
I. GI bleeding:
   1. In patients with active or recent bleeding.
   2. For presumed chronic blood loss and for iron deficiency anemia when the clinical situation
      suggests an upper GI source or when colonoscopy does not provide an explanation.
J. When sampling of tissue or fluid is indicated.
K. Selected patients with suspected portal hypertension to document or treat esophageal varices.
L. To assess acute injury after caustic ingestion.
M. To assess diarrhea in patients suspected of having small-bowel disease (e.g., celiac disease).
N. Treatment of bleeding lesions such as ulcers, tumors, vascular abnormalities (e.g.,
electrocoagulation, heater probe, laser photocoagulation, or injection therapy).
O. Removal of foreign bodies.
P. Removal of selected lesions.
Q. Placement of feeding or drainage tubes (e.g., peroral, percutaneous endoscopic gastrostomy,
   percutaneous endoscopic jejunostomy).
R. Dilation and stenting of stenotic lesions (e.g., with transendoscopic balloon dilators or dilation
   systems using guide wires).
S. Management of achalasia (e.g., botulinum toxin, balloon dilation).
T. Palliative treatment of stenosing neoplasms (e.g., laser, multipolar electrocoagulation, stent
   placement).
U. Endoscopic therapy of intestinal metaplasia.
V. Intraoperative evaluation of anatomic reconstructions typical of modern foregut surgery (e.g.,
evaluation of anastomotic leak and patency, fundoplication formation, pouch configuration during
bariatric surgery).
W. Management of operative complications (e.g., dilation of anastomotic strictures, stenting of
   anastomotic disruption, fistula, or leak in selected circumstances).

EGD is generally not indicated for evaluating:
A. Symptoms that are considered functional in origin (there are exceptions in which an endoscopic
   examination may be done once to rule out organic disease, especially if symptoms are
   unresponsive to therapy or symptoms recur that are different in nature from the original symptoms).
B. Metastatic adenocarcinoma of unknown primary site when the results will not alter management.
C. Radiographic findings of:
   1. Asymptomatic or uncomplicated sliding hiatal hemia.
   2. Uncomplicated duodenal ulcer that has responded to therapy.
   3. Deformed duodenal bulb when symptoms are absent or respond adequately to ulcer therapy.

Sequential or periodic EGD may be indicated for:
A. Surveillance for malignancy in patients with premalignant conditions (e.g., Barrett's esophagus,
polyposis syndromes, gastric adenomas, tylosis, or previous caustic ingestion).
Sequential or periodic EGD is generally not indicated for:

A. Surveillance for malignancy in patients with gastric atrophy, pernicious anemia, fundic gland or hyperplastic polyps, gastric intestinal metaplasia, or previous gastric operations for benign disease.

B. Surveillance of healed benign disease, such as esophagitis and gastric or duodenal ulcer.


The physician interested in learning EGD can obtain training through a medical school, residency, post-residency fellowships, CME conferences, preceptors, or any of a variety of self-study sources, including atlases, articles, videotapes, audio tapes, and computer-assisted programs. Related endoscopy skills include rigid and flexible sigmoidoscopy, colonoscopy, and nasopharyngolaryngoscopy.

The AAFP outlined requirements for demonstration of proficiency and documentation in 1999. Those requirements are reproduced in Table 2, below.

**Table 2**

**Demonstration of Proficiency and Documentation for EGD**

The learner shall demonstrate adequate clinical knowledge regarding the following:

- Indications
- Patient selection and contraindications (relative & absolute)
- Informed consent
- Preparation of patient
- Limitations of procedure
- Complications and their management
- Electrosurgical principles
- Indications and contraindications for simple biopsy, electrosurgical biopsy, ablation, and polypectomy
- Complications and management of biopsy
- Familiarity with disinfection, preparation of equipment, and Occupational Safety & Health Administration (OSHA) regulations regarding this procedure

The learner shall demonstrate technical and clinical skills as he or she does the following. (Since the procedure cannot be completed without all of these steps, possession of the entire skill set is required.)

- Identifies the parts of the scope and explains their use.
- Explains the equipment setup.
- Performs an oral examination on the patient.
- Inserts the scope into the patient's mouth using either the manual or the visual technique.
- Places the bite block between the patient's teeth.
- Advances the scope to the cricopharyngeus and demonstrates how it is traversed.
- Explains (or demonstrates) how he or she would handle a tracheal intubation.
- Demonstrates the passage of the scope through the esophagus.
- Discusses the decision whether or not to biopsy the distal esophagus.
- Demonstrates passage through the lower esophagus sphincter.
- Explains how the gastric pool would be aspirated upon entry into the stomach.
- Passes the scope through the stomach and demonstrates orientation and landmarks as he or she progresses.
- Demonstrates the approach to and passage through the pylorus.
- Demonstrates passage of the scope into the duodenum.
- Discusses orientation within the duodenum and the location of the papilla of Vater.
- Begins to withdraw the scope and demonstrates visualization of the duodenal bulb.
- Withdraws the scope into the stomach and identifies returning past the pylorus.
- Demonstrates the "J" or retroflexion maneuver and visualizes the cardia and the lower aspect of the gastroesophageal junction.

At this point, or earlier when in the lower esophagus, explains how the diaphragmatic level can be identified on the esophagus or stomach.

Straightens the scope and adequately visualizes the lining of the stomach, maintaining orientation.

Shows/explains how a biopsy will be done.

Correctly removes the scope from the stomach, correctly visualizing the esophagus and vocal cords.

If administering conscious sedation, the learner shall demonstrate that he or she has performed conscious sedation during the past 24 months with cases reviewed for choice of drug, interval, dosage, and outcome.

The learner shall demonstrate proficiency in post-procedure steps through the following:

- Appropriate aftercare of patient, including use of reversal medications if appropriate, orders, medications, and instructions.
- Preparation of endoscopic report.
- Appropriate post-procedure follow-up.

After the completion of upper GI endoscopy, appropriate documentation of the procedure is necessary for continuing care of the patient, medicolegal reasons, and billing.

Documentation can be performed by dictating a complete report or by using an endoscopy report form that allows notation of findings by circling the appropriate indications, medications, findings, and pathology. This type of documentation is also helpful when further clinical privileges are being requested and in clinical studies on EGD. A sample endoscopic report form is included as Appendix A.


The Hospital Accreditation Standards 2013 published by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) states Credentialing involves the collection, verification, and assessment of information regarding three critical parameters: current licensure; education and relevant training; and experience, ability, and current competence to perform the requested privilege(s)," (MS.06.01.03) and "The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process." (MS.06.01.05)

The Joint Commission's standards create no barriers to granting privileges for a given activity to more than one clinical specialty (for example, privileges to perform endoscopy granted to both surgeons and gastroenterologists). The overriding concern is that the physician demonstrate the appropriate education, training, and current competence to perform the procedure in question. The specific criteria regarding education, training, and current competence should be developed by the individual departments and, as specified in standard MS.06.01.05, "All of the criteria used are consistently evaluated for all practitioners holding that privilege."

The American Association for Primary Care Endoscopy (AAPCE) recommends, "that "credentialing for gastrointestinal endoscopy be based primarily upon documentation of prior and/or current proficiency in a clinical setting. Competency should be substantiated by documentation provided by the applicant from prior mentors and/or supervisors. Alternatively, the applicant may be observed performing actual cases by an unbiased proctor (agreed upon by applicant and hospital) who then renders an opinion to the hospital regarding the applicant's competency. The required number of proctored cases should usually be less than 10. For hospitals that choose to specify required numbers of procedures during training, these requirements should not exceed 50 colonoscopies or 35 esophagogastroduodenoscopies (EGD). No competent primary care physician should be denied privileges based on having been trained in primary care or on a specific number of required procedures during training."

Physician candidates may be required to provide written documentation of additional training beyond the core curriculum of family medicine residency. This training can include, but is not necessarily limited, to the following:
• Special selective training within a family medicine residency.
• Accredited continuing medical education.
• Verified preceptorship with a licensed physician.

The department may request written information regarding the number of cases performed and the presence of any complications related to the procedure.

Privileges for invasive procedures are usually granted provisionally with the requirement that the physician submit progress reports at designated intervals (for example, three, six, and 12 months). The family medicine department would monitor these progress reports for department members and make recommendations for advancement from provisional privileges to active privileges.

During the provisional period, the family medicine department should assign a physician for proctor the family physician monitored.

To ensure continuous monitoring of quality, physicians may be required to submit an annual census of all invasive procedures, listing many or all complications should they arise. This list should be reviewed by the department chair or his or her designee. Active privileges are renewed every one to two years by the authority of the department chair.

**Applying for GI Endoscopy Privileges**

The family physician wishing to apply for privileges to perform EGD should follow a several-step process as instructed below:

1. Prepare a brief resume that describes your educational background including college, medical school, residency, board certification, and recertification.

2. Include your affiliations with hospitals and, state and national medical societies, including the duration of these affiliations. Include any professional honors, elected offices, or committee chair positions.

3. Describe the accredited CME courses you have taken that pertain to GI endoscopy. Include CME and/or self study of gastrointestinal illness (atlases, articles, etc).

4. Describe your years of practice and your record in providing high-quality care for a variety of complicated cases. The physician with a record of exemplary service can point to these experiences as evidence of professional excellence.

5. Include a summary letter from your residency or state AAFP chapter that supports these privileges as being within the scope of the specialty of family practice.

6. Describe the number of rigid sigmoidoscopies, flexible sigmoidoscopies, colonoscopies, and/or upper GI endoscopies that you have performed. Include an inventory that lists the patients by name, age, sex, and indication. Provide diagnostic findings and prominently highlight your lack of complications.

7. Describe hands-on proctorship experiences and/or identify someone who is willing to do cases with you. A hands-on proctorship is not necessarily a prerequisite if you have equivalent training and/or experience.

8. Be prepared, if necessary, to discuss the criteria for EGD credentialing suggested by the ASGE and the AAFP's position that the ASGE's stance is not supported by current clinical evidence, and may reasonably be interpreted as more aligned with competitive marketplace concerns than patient access to quality care.

9. Describe your plan for quality assurance. This should involve tracking your cases, and providing these data to your department chair after a period of six to 12 months.

10. Provide evidence of your ability to obtain malpractice insurance coverage.
11. Be able to demonstrate an ongoing commitment to GI-related CME.


Public Health Implications

Unfortunately, little is known concerning the public health implications of family physicians performing EGDs. However, it is known that patients, particularly in rural areas, often have more ready access to family physicians than other specialists. Thus, when family physicians can offer EGD, it increases patients’ access to the procedure. Improved access should lead to earlier diagnosis and treatment as well as greater patient convenience.

Current Research Agenda

Research concerning EGD in primary care has been limited primarily to case series and descriptive studies. These investigations suggest that family physicians can safely, accurately, and effectively perform EGD compared with other specialists or established criteria.

Although findings from case series, descriptive series, and literature reviews are helpful, evidence from randomized, controlled trials or other more powerful study designs is needed. The AAFP supports the need for such research. Clearly, further research is needed in every area of procedural training, performance, and health services. The need to document benefits and harms of procedures, patient preferences, economic costs and savings, and utilization and alternatives will assume greater importance as time goes on.

Several measures might help facilitate needed research:

- Target research support from existing sources, such as the AAFP and AAFP Foundation (AAFP/F).
- Develop alliances with equipment or pharmaceutical manufacturers or other proprietary entities.
- Develop grant funding via the AAFP/F for procedural skills research.
- Work with HMOs, insurance corporations or health systems to develop funding.
- Work with the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH) or other federal granting agencies to develop requests for proposals centering on procedural skills.
- Approach foundations for funding.
- Explore opportunities to publish results of procedural skills research and experiences.

Relationship Between the AAFP and Other Physician Organizations

In an ideal world, the specialty societies would work together to improve patient care by disseminating technology and educating all physicians. Unfortunately, groups such as the ASGE have, in the past, been unwilling to work cooperatively with the AAFP on endoscopy issues. In such situations, the AAFP has had no choice but to develop its own educational programs. In situations where other specialty organizations are willing to partner with the AAFP, the AAFP welcomes the chance to work toward improved patient care by increasing the education of its members.

Informed Consent

An example of an informed consent form used by a family medicine program follows as Appendix B.

Appendix A

Patient's Name: _______________________ Location: ______________________

Date: _____________ Age: _______ Sex: M or F

Race: _____________ Physician:______________________

Office/Hospital ID# (if any): ______________ Assistant(s): ___________________

Pertinent Patient History (e.g., illnesses, medicines, surgery, allergies, duration of problem):
______________________________________________________________________
______________________________________________________________________

Has the patient completed 7-10 days of medical therapy ?  Yes  No

Circle the categories of drugs used and indicate the drug, dosage and duration of therapy, if known:

Antacid / Antibiotic / Cytotec / Bismuth / Carafate

PPI:_______________ H2 blocker:_______________ Other:________________

Has the patient been using over the counter or prescription NSAI Ds or other known gastric irritants?
If so, please list:____________________________________________________

What are the indications for these procedures? (Circle the numbers of those that apply.)

<table>
<thead>
<tr>
<th>Signs</th>
<th>Indications</th>
<th>ICD 9 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Abdominal Mass</td>
<td>789.3</td>
<td></td>
</tr>
<tr>
<td>2. Anemia, Unexplained</td>
<td>280.9</td>
<td></td>
</tr>
<tr>
<td>3. GI Bleeding, Acute</td>
<td>578.9</td>
<td></td>
</tr>
<tr>
<td>4. GI Bleeding, Occult</td>
<td>578.1</td>
<td></td>
</tr>
<tr>
<td>5. X-Ray Abnormality</td>
<td>793.4</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-existing Conditions</th>
<th>Indications</th>
<th>ICD 9 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Cancer Surveillance in High Risk Patients</td>
<td>V67.9</td>
<td></td>
</tr>
<tr>
<td>(e.g., Barrett's Esophagus, Menetrier Disease, Polyposis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Esophageal Stricture</td>
<td>564.2</td>
<td></td>
</tr>
<tr>
<td>19. Gastric Retention</td>
<td>782.0</td>
<td></td>
</tr>
<tr>
<td>20. History of Duodenitis</td>
<td>535.6</td>
<td></td>
</tr>
<tr>
<td>21. History of Esophagitis</td>
<td>530.1</td>
<td></td>
</tr>
<tr>
<td>22. History of Gastritis</td>
<td>535.4</td>
<td></td>
</tr>
<tr>
<td>23. History of Hiatal Hernia</td>
<td>553.3</td>
<td></td>
</tr>
<tr>
<td>24. Monitoring a Gastric Ulcer</td>
<td>531.9</td>
<td></td>
</tr>
<tr>
<td>25. Peptic Ulcer Disease</td>
<td>533.0</td>
<td></td>
</tr>
<tr>
<td>26. Pyloroduodenal Stenosis</td>
<td>537.0</td>
<td></td>
</tr>
<tr>
<td>27. Varices</td>
<td>456.0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Indications</th>
<th>ICD 9 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Dyspepsia, Severe</td>
<td>536.8</td>
<td></td>
</tr>
<tr>
<td>7. Dysphagia/Odynophagia</td>
<td>787.2</td>
<td></td>
</tr>
<tr>
<td>8. Early Satiety</td>
<td>789.0</td>
<td></td>
</tr>
<tr>
<td>9. Epigastric Pain</td>
<td>789.0</td>
<td></td>
</tr>
<tr>
<td>10. Food Slicking</td>
<td>787.2</td>
<td></td>
</tr>
<tr>
<td>11. Heartburn, Meal Related</td>
<td>787.1</td>
<td></td>
</tr>
<tr>
<td>12. Indigestion, Severe</td>
<td>787.3</td>
<td></td>
</tr>
<tr>
<td>13. Nausea, Chronic (Vomiting)</td>
<td>787.0</td>
<td></td>
</tr>
<tr>
<td>14. Pain (Substernal/Paraxiphoid)</td>
<td>786.5</td>
<td></td>
</tr>
<tr>
<td>15. Reflux of Food (Regurgitation)</td>
<td>787.0</td>
<td></td>
</tr>
<tr>
<td>16. Weight Loss, Severe</td>
<td>783.2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any Other Indications (please describe):</th>
</tr>
</thead>
<tbody>
<tr>
<td>28.</td>
</tr>
</tbody>
</table>

Medications Used: (Circle drugs used and indicate total dosage.)

<table>
<thead>
<tr>
<th>Conscious Sedation</th>
<th>Topical Anesthetic</th>
<th>Reversal</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Fentanyl</td>
<td>2. Lidocaine</td>
<td>2. Romazicon</td>
<td>2. Simethicone</td>
</tr>
<tr>
<td>4. Nubain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Versed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Valium</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Findings: (Circle one for each question)

1. Was esophagus well visualized? Yes No
2. Was pylorus well visualized? Yes No
3. Was duodenum entered? Yes No
4. Was Papilla of Vater seen? Yes No
5. Did you do a turnaround maneuver to see cardia/fundus? Yes No

Pathology Codes: (Codes apply immediately below.)
1. Mild erythema, patchy, no ulcers
2. Moderate erythema, diffuse in area, some petechiae, no ulcers
3. Severe erythema, limited focal mucosal degeneration (i.e., 1-3 ulcers are seen)
4. Severe erythema with diffuse mucosal degeneration (more than 3 ulcers)
5. Other (polyps, cancer, atrophy, or miscellaneous)

Circle one inflammation code for each area: (See above.)

<table>
<thead>
<tr>
<th>Esophagus</th>
<th>Pylorus</th>
<th>Gastric Area</th>
<th>Duodenum</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

Number of biopsies: (Circle one.) 0 1 2 3 4 5 6 7 8 9 10 More

Pathology: (location, size) _____________________________

Did you biopsy an area that appeared normal as a control? Yes No

Will you be requesting confirmation for the presence of the H. pylori? Yes No

What is your post-endoscopy working diagnosis? (Circle those that apply.)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD 9 Code</th>
<th>Diagnosis</th>
<th>ICD 9 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td></td>
<td>Gastritis</td>
<td>535.4</td>
</tr>
<tr>
<td>Esophagitis</td>
<td>530.1</td>
<td>Polyp(s)</td>
<td>M8210/1</td>
</tr>
<tr>
<td>Hiatal Hernia</td>
<td>553.3</td>
<td>Ulcer(s)</td>
<td>533.9</td>
</tr>
<tr>
<td>Tumor Growth</td>
<td>M8230/9</td>
<td>AV Malformation</td>
<td>447.0</td>
</tr>
<tr>
<td>Varices</td>
<td>456.0</td>
<td>Other (describe)</td>
<td></td>
</tr>
<tr>
<td>Duodenitis</td>
<td>435.6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Will you or did you order upper GI x-rays or barium swallow to confirm and/or complement your endoscopy findings? (Circle one.) Yes No

Were there any complications? (Circle one.) Yes No

Did this procedure change your management plan? (Circle one.) Yes No

Comments - Circle how your management plan or diagnosis changed: (Circle all that apply.)

1. New diagnosis  6. Suspected diagnosis now confirmed
2. Medication added/deleted  7. Previous diagnosis deleted
3. Medication will be continued  8. Diagnostic tests added or deleted
4. Consultation will be requested  9. Other (describe)
5. Endoscopy consult not necessary now
Appendix B

EGD is a way for your family doctor to look into your stomach or intestine with a flexible tube and possibly remove a small sample of tissue called a biopsy. The sample of tissue is sent to a lab for testing. EGD is also called by other names such as endoscopy or upper GI endoscopy.

What are the benefits of EGD?

EGD can help your family doctor find out what is causing your symptoms and find the cause. For example, your doctor may find that an ulcer has been causing your pain. The doctor can then recommend medicine or other treatments. EGD can also find early signs of cancer. With some cancers, early diagnosis increases the chances of a cure.

What are the risks of EGD?

EGD is a generally safe. It causes few complications. But, as with all medical tests or procedures, EGD does have some risks. Your doctor thinks the likely benefits are greater than the risks. Still, you need to understand the risks before you decide to have an EGD. Please read and understand the following:

1. Infection can occur, although this is rare. You might need medications after the procedure.
2. Bleeding can occur, but it is also rare. You could have some spotting or even enough bleeding to need a transfusion. This is not common, but it is possible.
3. Perforation (putting a hole in the intestine) is a serious complication, but it is uncommon. If a perforation occurs, you would need to go to the hospital and might need an operation.
4. You will be given some medicines during EGD. The medicines may have side effects, but your doctor will take steps to lower the risk. The medications your doctor will give you to prevent pain can cause a reaction. One rare side effect is a swelling and redness in the arm. Another might be a severe allergic reaction to the medications. Your doctor will take precautions to minimize this risk.

What are my choices?

You can choose to have EGD or choose not to. This sheet is designed to help you make that decision after talking with your doctor about it. You have several choices:

1. If you feel your questions have been answered and you understand and accept the risks and benefits, you can agree to have EGD by signing the bottom of this sheet.
2. If you are not yet ready to decide to have an EGD, you can ask for more time to think about it and discuss it with your doctor.
3. You can refuse to have EGD, but keep in mind that not having the procedure may also involve some risk. For example, your doctor may not be able to find the cause of your problem, or the cause may take longer to find. In the case of cancer, delaying could mean that treatment isn't started soon enough to cure the cancer.
4. In some cases, other tests could be done instead of an EGD. You can ask your doctor about alternatives to EGD. If there are alternatives that your family, friends, or other doctors have discussed with you, tell your family doctor about them so you can discuss whether they would be right for you.
Informed Consent

I have read and understood the above. I believe that the benefits of this procedure outweigh its risks. I agree to allow Dr. to perform the procedure.

______________________________________________________
Signature                                                            Date

_________________________________________
Witness

(August Board 2002) (2013 COD)
Elder mistreatment is any abuse or neglect of persons 60 years old or older by a caregiver or another trusted individual/group. Mistreatment of older adults may take the form of physical, sexual, psychological, or emotional abuse. Neglect, abandonment, and financial exploitation are other significant forms of abuse and mistreatment. Elder mistreatment is associated with physical and mental health problems, including physical injuries, depression, poor control of chronic diseases, and functional disability. Vulnerability of older adults to mistreatment is often related to higher rates of impairment of physical and cognitive functioning resulting in variable dependence of older adults in the context of their relationships with others (i.e., caregivers and trusted individuals/groups). However, elder mistreatment occurs among individuals with no significant physical or cognitive impairments. Family physicians should be aware of individual, relationship, community, and societal factors that increase the risk for experiencing elder mistreatment. Family physicians who provide ongoing care for patients and communities have a unique opportunity to help break the cycle of mistreatment by working with families and within their communities to prevent abuse. Family physicians should be aware of the prevalence of abuse in all sectors of society; be alert for risk factors as well as signs of elder mistreatment with each patient encounter; be capable of providing an appropriate response when these issues are identified; and be able to work to prevent mistreatment of patients who are at risk within their practices and communities. Family physicians should be aware of state regulations for reporting concerns of elder mistreatment and should be familiar with the process of referring cases of elder mistreatment to local protective services designated to evaluate the care of older adults. Family physicians can teach or help to establish education in their communities on caregiver stress and conflict resolution skills that promote respectful and peaceful personal relationships. Clinicians can obtain additional information at the National Center on Elder Abuse (http://www.ncea.aoa.gov), the Center of Excellence on Elder Abuse and Neglect (http://www.centeronelderabuse.org), and the AAFP's clinical recommendation on screening for elder abuse (http://www.aafp.org/patient-care/clinical-recommendations/all/domestic-violence.html).

References


(2014 COD)
Electrocardiograms, Family Physician Interpretation (Position Paper)

See also
- Privileges, Electrocardiogram Interpretation

Overview and Justification

Introduced in 1902 by Willem Einthoven, electrocardiography is still the most commonly used procedure for the diagnosis of heart disease. Electrocardiograms (ECGs) are interpreted not only by cardiologists, but by other specialists, including family physicians.

The ECG contributes significantly to the diagnosis and management of cardiac arrhythmias and the acute myocardial ischemic syndromes, the two conditions that account for the majority of cardiac catastrophes. The procedure itself is safe, easy to administer and available at a minimal cost.

Although computerized interpretation of ECG data is improving and is widely available, it is not reliable enough to obviate the need for physician over-reading and confirmation. Family physicians thus cannot rely on computer-based diagnostics and must maintain competence in the task.

Section I - Scope of Practice for Family Physicians

It is the position of the American Academy of Family Physicians (AAFP) that clinical privileges should be based on the individual physician's documented training and/or experience, demonstrated abilities, and current competence. The AAFP also advocates the development of specific patient-centered practice policies that focus on what should be done for the patient rather than who should do it. When policies address the issue of who should provide care, then recommendations for management, consultation or referral should emphasize specific appropriate competencies, rather than a clinician's specialty designation. This perspective is in line with the policies of other organizations with influence in the area of credentialing and privileging:

- The American Medical Association (AMA) policy on staff privileges states "Decisions regarding hospital privileges should be based upon the training, experience, and demonstrated competence of candidates, taking into consideration the availability of facilities and the overall medical needs of the community, the hospital, and especially patients. Privileges should not be based on numbers of patients admitted to the facility or the economic or insurance status of the patient. Personal friendships, antagonisms, jurisdictional disputes, or fear of competition should not play a role in making these decisions."

- The Joint Commission (TJC) maintains that the credentialing and privileging process should include "overview of each applicant's licensure, education, training competence, and physical ability to discharge patient care responsibilities."

It is well established that interpretation of ECGs is within the scope of family medicine. The diagnosis and management of cardiovascular disorders is routinely taught in family medicine residency programs. Moreover, the most recent AAFP statistics, from 2009, show that 94.4% of family physicians perform ECGs in the office.

Section II - Clinical Indications

Electrocardiography is the procedure of choice for patients who present with chest pain, dizziness or syncope, or for those with symptoms that may indicate risk of sudden death or myocardial infarction.

In its 2001 statement, the Task Force on Clinical Competence formed by the American College of Cardiology (ACC), the American Heart Association (AHA), and the American College of Physicians (ACP) noted the wide variety of indications for ECG: "There are numerous potential clinical uses of the 12-lead ECG. The ECG may reflect changes associated with primary or secondary myocardial processes (e.g., those associated with coronary artery disease, hypertension, cardiomyopathy, or infiltrative disorders), metabolic and electrolyte abnormalities, and therapeutic or toxic effects of drugs or devices. Electrocardiography serves as the gold standard for the noninvasive diagnosis of arrhythmias and conduction disturbances, and it occasionally is the only marker for the presence of heart disease."

Electrocardiography is not indicated for screening of healthy subjects without symptoms of heart disease, hypertension, or other risk factors for the development of heart disease.
The US Preventive Services Task Force states that for asymptomatic adults at low risk for coronary heart disease, the incremental information offered by ECG is “highly unlikely to result in changes in risk stratification that would prompt interventions and ultimately reduce coronary heart disease-related events.”

Section III — Training Methodology

Training for ECG interpretation begins in medical school, and is continued in the family medicine residency program curriculum. The Accreditation Council for Graduate Medical Education requires that family medicine residency training include a separate, defined critical care experience, and a structured clinical experience in cardiology. This would include training in the interpretation of ECGs. The depth of experience for each resident depends on the expected practice needs of the resident, especially in terms of practice location, available facilities, and accessibility of consultants. At times, the family medicine resident may find it appropriate to seek consultation from a cardiologist to either manage or co-manage a patient for optimal care.

Physicians who wish to undergo more extensive training may want to obtain a preceptor. Preceptors may be found by contacting staff members at local hospitals who have expertise in ECG interpretation. Other sources for obtaining a preceptor include local family medicine residency programs, local Academy chapters, and local medical societies.

The AAFP’s policy titled, “Procedural Skills, Residency Criteria,” holds that training in individual procedures includes a range of elements, among them clinical indications, contraindications, mechanical skills acquired under direct supervision, and prevention and management of complications.

Section IV — Testing, Demonstrated Proficiency, and Documentation

Testing and demonstration of proficiency in ECG interpretation may involve monitoring a physician’s interpretations or administering a test. The AAFP believes that local tests to ensure competence are appropriate as long as they apply equally to all physicians.

The ACC/AHA/ACP Task Force recommends that to ensure continued competence, a random sample of a physician’s interpretations should be periodically reviewed, because there are no data to support a correlation between the frequency of unsupervised interpretations and a physician’s skill.

Documentation of ECG interpretation in a supervised or teaching environment will help to facilitate attainment of privileges for this skill.

Section V - Credentialing and Privileges

The process for credentialing and delineation of family medicine privileges varies among organizations. Before a physician applies for ECG privileges, his or her documentation of training, experience, and current competence should be in order. The following guidelines will help with the credentialing process:

1. Collect letters of recommendation from past instructors, preceptors, those who have monitored the applicant’s clinical performance, and colleagues who have worked with the applicant throughout the years.
2. Assemble case reports including data about the number and types of cases, treatment outcomes, etc.
3. Assemble documentation records maintained during your family practice residency.

The physician should have complete documentation, case reports, and letters of recommendation in order at the time of application for medical staff privileges. It is important that a copy of each document be submitted and all original documents retained by the applicant, so that replacements may be sent in the event that application materials are lost or misplaced. The physician should maintain documentation of ongoing clinical experiences.

The AAFP recommends the establishment of family medicine departments in all hospitals departmentalized by specialty. The department of family medicine should have rights, duties, and responsibilities comparable to those of other specialty departments of the medical staff. It should have the right to recommend directly to the appropriate committee those privileges which fall within the scope of family medicine. Neither the assent nor the approval of any other department should be required.

Privileges for family physicians very often overlap those in other clinical departments, and there may be some confusion as to which department is responsible for recommending privileges. For example, a family physician may request “cardiology” privileges (in the department of family medicine) that would overlap those in the department of cardiology. The AAFP believes that the family medicine department should determine the criteria for and recommend privileges commensurate with the core curriculum and training offered in a family medicine residency program.
Some privilege problems arise because other specialists do not understand the scope of family medicine. In addition to the need to give other specialists general information about family medicine, specific issues include the following:

1. Clinical privileges should be considered on the basis of each physician’s documented training and/or experience, demonstrated abilities, and current competence.
2. Many specialties overlap.
3. No clinical privileges are the exclusive province of one department.
4. A vital part of a family physician’s training is in knowing when to consult and when to refer patients.
5. Continuity of care is a primary objective of family medicine, and this objective is consistent with high-quality patient care.
6. Family physicians are supported by the AAFP in their efforts to obtain privileges for which they are qualified.

The AAFP recommends that payment for the interpretation of ECGs be available for all eligible physicians with ECG privileges, regardless of the physician's specialty.

**Section VI - Miscellaneous Issues**

**Quality Assurance**

Family medicine departments should have an ongoing peer review process in place that monitors patient outcomes to ensure that members maintain their competence.

**Public Health Implications**

Family physicians are often the first and sometimes the only point of contact for many patients within the health care system. Expanding and improving family physicians' skills in ECG interpretation could improve access to cardiovascular care for patient populations in need.

**Research Agenda**

The research agenda for ECG interpretation should focus on the following:

1. Continued effort to document the outcomes of ECG interpretation by family physicians
2. Effective quality improvement programs to improve interpretation error rates
3. Continued research into training methods

**Formal Relationships With Other Organizations**

Cooperation in the development of quality improvement programs should be encouraged between the AAFP, the ACC, and the ACP.

**Section VII - Data Sources**

9. Standard MS.06.01.05. In *Joint Commission on 2012 Hospital Accreditation Standards.* Oakbrook Terrace, IL: Joint Commission Resources; 2012.

(March Board 2001) (2013 COD)
Electronic Cigarettes

See also

- Preventing and Treating Nicotine Dependence and Tobacco Use (Position Paper)
- American Family Physician Editorial — "Electronic Cigarettes: Cautions and Concerns"
- Ask and Act Practice Toolkit
- Tobacco and Smoking
- Electronic Cigarette Advertising to Children - AAFP Legislative Stance

The American Academy of Family Physicians (AAFP) recognizes the increased use of electronic cigarettes (i.e., e-cigarettes) especially among youth and those attempting to quit smoking tobacco. Electronic cigarettes are unregulated, battery-operated devices that contain nicotine-filled cartridges. The resulting vapor is inhaled as a mist that contains flavorings and various levels of nicotine and other toxic substances. Although e-cigarettes may be less toxic than smoking combustible tobacco cigarettes, there is no empirical evidence supporting the efficacy of e-cigarettes as a smoking cessation device. However, some physicians and public health groups consider the use of said devices as a viable harm-reduction strategy. Anecdotal accounts of people using e-cigarettes as a cessation device have led some to believe that these products have the potential to help them quit – especially the long-term, highly addicted smoker. Others are concerned that e-cigarettes may contribute to nicotine dependence, promote dual use of both products, and encourage nicotine consumption. E-cigarettes may also introduce children to nicotine and potential addiction.

There are concerns about the lack of any regulatory oversight by the Food and Drug Administration’s Center for Tobacco Products (FDA CTP) on the manufacture, distribution and safety of e-cigarettes. Therefore, the AAFP calls for rigorous research in the form of randomized controlled trials of e-cigarettes to assess their safety, quality, and efficacy as a potential cessation device. The AAFP also recommends that the marketing and advertising of e-cigarettes, especially to children and youth, should cease immediately until e-cigarette’s safety, toxicity, and efficacy are established. (2014 COD)
Electronic Cigarette Advertising to Children - AAFP Legislative Stance

See also

- Electronic Cigarettes

The American Academy of Family Physicians supports protecting children from electronic cigarette advertising. (2014 BOD)
Electronic Health Records

See also

- Data Stewardship
- Retail Clinics
- Information Technology Used in Health Care
- Medical Student Access to Electronic Medical Record (EMR)

The American Academy of Family Physicians (AAFP) believes that every family physician should leverage health information technology, which includes electronic health records and related technologies needed to support the patient-centered medical home (PCMH). These capabilities can support and enable optimal care coordination, continuity, and patient centeredness, resulting in safe, high quality care and optimal health of patients, families, and communities.

(March 2001 BOD) (2016 COD)
Emergency Department Call for Family Physicians (Position Statement)

See also

- Emergency Medical Care
- Emergency Medicine, Family Physicians in
- Emergency Medical Care (Position Paper)
- Privileges, Emergency Care Services

Hospital emergency department on-call coverage is a social and professional responsibility. An obligation to provide on-call coverage is often tied to hospital medical staff membership. Medical staff members who practice family medicine may find themselves disproportionately assigned to on-call schedules because they have clinical skills which cross multiple specialties. Such physicians may be assigned to on-call schedules for general medicine, pediatrics, neonates, obstetrics, etc. When this happens it may produce an untenable burden on the doctor and create a situation which is unfair and inequitable.

The AAFP recognizes that hospitals must meet their community responsibility and legal obligations to provide emergency medical care. This will generally require members of the medical staff to provide clinical expertise to supplement that provided by emergency department physicians. Family physicians should share in any on-call requirements in the same manner as their colleagues in other specialties. Family physicians should take call with a frequency that is comparable to their colleagues on the medical staff. For example, if the average frequency of call is three days per month, then a family physician should be on call no more than three days per month, even if some of this coverage is in pediatrics, some in general medicine, some in obstetrics, etc. If a hospital has not established a fair baseline of participation for each member of the medical staff it should be encouraged to do so. If a family physician is asked to take call at a rate greater than the baseline, he/she should be properly compensated for this requirement.

The practice of family medicine has become increasingly difficult in recent years, even as it remains a critical need in most communities. Despite their need to meet the requirements of the Emergency Treatment and Active Labor Act (EMTALA), hospitals and medical staffs must adopt policies which treat all physicians equitably. (March Board 2005) (2015 COD)
Emergency Medical Care

See also

- Emergency Department Call for Family Physicians (Position Paper)
- Emergency Medicine, Family Physicians in
- Emergency Medicine, Medical Care (Position Paper)
- Privileges, Emergency Care Services
- Good Samaritan Law
- Medical Identification

All people should have access to emergency medical care. An acute medical emergency is an actual or perceived disorder of vital systems, presenting as an immediate or potential threat to life or function, whether due to illness or trauma. Family physicians should have a basic understanding of resuscitation and emergency procedures. Those family physicians working in isolated areas are encouraged to seek more advanced understanding of these procedures. The American Academy of Family Physicians (AAFP) encourages all office-based family physicians to develop practice appropriate protocols and have adequate equipment to deal with office emergencies, taking into consideration the distance (mileage or time) to definitive care, staff training and experience and the availability of other community emergency medical services. Whenever necessary, patients should be transported to a facility capable of managing the immediate care of that patient until definitive care can be obtained. Repeated, episodic emergency medical services should not be substituted for ongoing comprehensive care. Appropriately utilized, emergency medical care should function to manage the patient temporarily until referral can be made for continuing care.

The AAFP strongly recommends that emergency medical treatment be an integral part of the training of family medicine residents. Additionally, appropriate opportunities should be provided for practicing members to maintain skills in emergency medical procedures. (1988) (2014 COD)
The provision of emergency medical care is an essential public service in the United States. Providing comprehensive emergency medical services to a diverse population requires a cooperative relationship among a variety of health professionals.

The most important objective of the physician must be the provision of the highest quality of care. Quality patient care requires that all providers should practice within their degree of ability as determined by training, experience and current competence.

Family physicians are trained in the breadth of medical care, and as such are qualified to provide emergency care in a variety of settings. Many family physicians currently provide quality emergency department and trauma care throughout the nation, including military, rural, and remote settings.

Speciality certification alone should not prevent family physicians from practicing in any emergency setting or trauma center at any level. Emergency department credentialing should be based on training, experience and current competence. Combined residency programs in family medicine and emergency medicine, or additional training, such as fellowships in emergency medicine or additional course work, may be of added benefit. (2006) (2016 December BOD)
Equal Opportunity

See also

- Discrimination, Physician
- Diversity in the Workforce
- Diversity, Assuring Sensitivity to Diversity in AAFP Education Activities
- Membership Evaluation, Discrimination in
- Fairness in Federal Programs for All U.S. Citizens
- Medical Schools, Minority and Women Representation in Medicine

The AAFP supports equal social, economic and professional opportunity for all members. (1978) (2014 COD)
Equal Representation of Women in Family Medicine

See also

- Diversity in the Workforce
- Diversity, Assuring Sensitivity to Diversity in AAFP Education Activities
- Medical Schools, Minority and Women Representation in Medicine

The American Academy of Family Physicians (AAFP) confirms its policies on women in family medicine by encouraging women to: (a) continue to enter the specialty of family medicine; (b) participate actively in all AAFP programs and activities, and (c) participate at all levels of leadership, thus ensuring that the personal and professional development of women family physicians is addressed. (B1983) (2015 COD)

The AAFP and its constituent chapters strive for proportionate representation for women in leadership roles in the AAFP. (1988) (2015 COD)
Equality for Same Gender Families

See Also

- Civil Marriage for Same-Gender Couples

The American Academy of Family Physicians (AAFP) supports full legal equality for same-gender families to contribute to overall health and longevity, improved family stability and to benefit children of Lesbian, Gay, Bisexual, Transgender (LGBT) families. (2011 COD) (2016 December BOD)
Essential Community Provider

See also

- Community and Migrant Health Centers
- Migrant Health Care
- Medically Underserved
- Rural Health Care, Access to
- Culturally Sensitive Interpretive Services - AAFP Legislative Stance
- Home Health Care
- Homelessness

The American Academy of Family Physicians supports the concept of Essential Community Provider (ECP) as a means of protecting access to essential services, delivered by qualified providers, and achieving favorable health outcomes for otherwise marginalized populations.

It is appropriate for federal and state governments to ensure the availability and accessibility of essential health care services to predominantly low-income, medically underserved populations by requiring payers to contract with a sufficient number and an appropriate geographic distribution of qualified local providers.

Such contracts should specify updated terms and conditions, and market-appropriate rates, including pay-for-value incentives, as appropriate to the circumstances.

Ethics and Advance Planning for End-of-Life Care

See Also

- Aging
- Health Care Facility Visitation Rights of Patients
- Hospice Care
- Long-Term Care
- Elder Mistreatment
- Home Health Care
- Integrative Medicine
- AMA Code of Medical Ethics

Advance Planning for Health Care Decisions

Advance directive is a term that is commonly used to describe the documents that specify the care a person wishes to have if he or she becomes unable to make medical decisions. The term is generally used for documents that include a living will, a durable power of attorney for health care and “Do Not Resuscitate” orders. The language of the actual document must be consistent with the laws of the state of residence. A number of web sites provide state specific forms and the Bar Association of the state of residence frequently makes the form available.

The American Academy of Family Physicians encourages the use of advanced directives including but not limited to living wills and durable powers of attorney for health care, so that the desires of the individual will be followed in the event he or she lacks the capacity to participate in health care decisions. If, because of mental infirmity or minor status, an individual with a terminal condition does not have the capacity to participate in health care decision-making and has not previously executed a living will or durable power of attorney, the law of the relevant jurisdiction should designate an appropriate surrogate to act on his or her behalf. (2007)

Core Principles for End-of-Life Care

Care at the end of life should embody the following principles:

1. Respect the dignity of both patient and caregivers.
2. Be sensitive to and respectful of the patient’s and family’s wishes.
3. Use the most appropriate measures that are consistent with patient and surrogate choices.
4. Ensure that alleviation of pain and management of other physical symptoms are a high priority.
5. Recognize, assess, and address the associated psychological, social, spiritual religious issues and cultural taboos realizing that different cultures may require significantly different approaches.
6. Ensure appropriate continuity of care by the patient’s family physician and consulting physician when applicable.
7. Advocate for the patient’s right to choose any therapy that may reasonably be expected to improve the patient’s quality of life, including alternative or nontraditional treatments.
8. Provide access to palliative care and hospice care.
10. Respect the physician’s professional judgment and recommendations, with consideration for both patient and family preferences.
End-of-Life Care

The family physician’s continuing partnership with his or her patients provides a meaningful context for quality care at any time, and may be especially helpful at the end of life. The American Academy of Family Physicians (AAFP) promotes the following beliefs:

1. The primary focus of end-of-life care should be on high-quality, compassionate and culturally sensitive patient care.
2. Family physicians should continue to stay current and competent in knowledge and skills in the areas of palliative medicine and medical management at the end of life.
3. Family physicians should continue to support the medical, psychological and spiritual needs of the dying patients and their families by initiating advanced directive discussions and end-of-life planning during times of relative health.
4. In this era of advancing technology and increasing discomfort with our ability to apply it wisely, the debate will continue regarding the difficult questions of physicians’ assistance in the patient’s process of dying. Only through dialogue can family physicians, their patients and society as a whole continue to explore what is reasonable and morally appropriate.
5. The AAFP believes that the highest-quality health care is an outgrowth of a partnership between the patient, the family, and the health professional or professional team. Within the context of this continuing relationship, family physicians must seek the underlying causes of suffering at the end of life, and then aggressively implement measures to correct them. Appropriate education in palliative care and medical management, advanced communication skills to discover the patient’s wishes and value choices, and appropriate sharing of decision-making with the patient and the patient’s family can go a long way toward alleviating suffering and improving care at the end of life. With careful attention to this critical phase in the life cycle, requests for physician-assisted death could be greatly reduced. Even in the face of such requests, family physicians should and will continue to provide assistance in dealing with the dying patient’s symptoms, needs and fears.
6. The American Academy of Family Physicians promotes the incorporation of advance directive discussions in a culturally sensitive and appropriate manner as a part of routine outpatient health maintenance. (1997) (2013 COD)

Experimentation, Unethical

The AAFP does not support the publication and citation of data collected from cruel, egregious and inhumane experimentation, such as the Nazi experiments and data collected from the Tuskegee study (1998) (2008)

(Note: The Principles of Medical Ethics of the American Medical Association are the principles of ethics for the AAFP. The AAFP’s Congress of Delegates, however, can by a two-thirds vote adopt policies or positions relating to ethical issues which add to or contradict the AMA Principles of Medical Ethics. The statement above on publication of data from unethical experimentation is a variance with an opinion of the AMA Council on Ethical and Judicial Affairs.)

Life-Prolonging Treatment, Foregoing

The AAFP believes that the ethical concerns involved in foregoing life-prolonging medical treatment are clearly outlined in the AMA’s "Current Opinions of the Council on Ethical and Judicial Affairs." Family physicians should be familiar with these opinions (particularly 2.20) to enhance their cooperative efforts with patients and families in appropriate medical decision-making regarding the withholding or withdrawing of life-prolonging medical treatment. (1990)

Life-Sustaining Treatment

The American Academy of Family Physicians supports the principle that each individual has the right to determine what medical treatment he or she will receive, including what life-sustaining treatment will be
provided when the individual has a terminal condition.

The AAFP encourages its members to do the following:

- Become familiar with applicable state laws on living wills and durable powers of attorney.
- Become knowledgeable about the risks and benefits of resuscitation under different medical situations.
- With consideration of culturally relevant beliefs and practices held by the patient and family, discuss the issue of life-sustaining measures with each of their patients before a medical emergency occurs; optimally, before institutionalization.
- Document in the patient's records that such a discussion took place and note what the patient wishes to have done.
- Include in the patient's medical records any advance directives executed by the patient, such as living wills and durable powers of attorney.
- Review the above information with the patient at reasonable intervals and as circumstances warrant.

(1989)

**Medical Orders for End-of-Life Care**

The AAFP supports efforts that help patients retain control over their end-of-life treatment, including portable medical orders such as Physician Orders for Life Sustaining Treatment (POLST) Paradigm Forms that inform medical personnel of their wishes. Further, the AAFP supports efforts to create and maintain free and voluntary centralized registries that contain accurate and up-to-date documentation regarding a patient's wishes related to end-of-life treatment and to allow members of the public to freely input their own wishes into such registries. When consulting a registry, it is important for medical personnel to confirm the filed forms are the patient's current expression of wishes.

**Postmortem Decisions**

The AAFP supports each patient's right to determine the disposition of his or her own remains, allowing him or her to die with dignity and peace of mind.

e-visits

See also

- Payment for Non Face-to-Face Physician Services
- Shared Medical Appointments/Group Visits

The American Academy of Family Physicians (AAFP) supports enhanced-access physician-patient interactions, including virtual/electronic visits or “e-visits” which occur over safe, secure, online communication systems. AAFP defines an e-visit as an evaluation and management service provided by a physician or other qualified health professional to an established patient using a web-based or similar electronic-based communication network for a single patient encounter.

Guidelines

Guidelines for e-visits:

1. e-visits are available only to established patients who have previously received care from the physician’s practice;
2. the patient initiates the process, and agrees to e-visit service terms, privacy policy, and charge for receiving asynchronous care from a physician or other qualified health professional;
3. electronic communication occurs over a HIPAA-compliant online connection;
4. an e-visit includes the total interchange of online inquiries and other communications associated with this single patient encounter;
5. the physician appropriately documents the e-visits, including all pertinent communication related to the encounter, in the patient’s medical/health record;
6. the physician or other qualified health professional has a defined period of time within which responses to an e-visit request are completed; and
7. e-visits should be a payable physician service.

Excessive Fees

See also

- Fees, Global Surgical
- Fee-splitting
- Fees for Patient Education
- Fees to Physicians for Referrals to Other Health Care Professionals

The AAFP is opposed to excessive fees charged by any physician, and in particular the overpricing of many procedural services. Each physician should make his/her own charges and be compensated for services rendered. However, each physician should be able to explain the basis for his/her fees.

The family physician, as the patient's advocate in health care quality and cost-effectiveness, should help the patient by selecting qualified consultants who charge reasonable fees and by advising the consultants of the need for special economic considerations for a financially disadvantaged patient. (1985) (2014 COD)
Expansion of Residency Training Programs at Federally Qualified Community Health Centers (FQHCs) and Teaching Health Centers (THCs)

See also:

- Family Physicians, Workforce and Residency Education

The AAFP supports expansion of residency training programs at FQHCs provided there is:

- An identifiable and sustainable funding stream for graduate medical education,
- An equitable distribution of the funding between education and service delivery, and
- A clear commitment of the organizational mission to education, including protected teaching time for clinical faculty.

Teaching Health Center Legislation: The AAFP supports teaching health center legislation as an incentive for increasing family medicine residency training. (2007 COD) (2016 December BOD)
Expectations of Family Medicine Residency Graduates

Family medicine residency graduates will be able to independently and competently practice the specialty of family medicine. They will have been trained to meet the six Accreditation Council for Graduate Medical Education (ACGME) competencies, and will be prepared to provide continuing, comprehensive and personal care within the context of family and the needs of the community. This document has been written for consideration by family medicine residency training programs as they prepare family physicians for future practice.

All family medicine residency graduates should:

1. Demonstrate continuous commitment to professionalism in the practice of family medicine.
2. Demonstrate current medical knowledge utilizing a bio-psychosocial model to provide evidence-based comprehensive patient care.
3. Be able to lead and practice within an interdisciplinary care team to provide comprehensive patient care.
4. Be able to provide care with a systems-based approach, while serving as a patient advocate.
5. Become board certified and successfully maintain board certification in family medicine through information mastery and life-long practice-based learning.
6. Be able to effectively communicate with the patient, family and healthcare team about the diagnosis, evaluation and management of a particular condition in a collaborative fashion.
7. Facilitate continuous learning and quality improvement for all members of the healthcare team.
8. Be competent in the care of patients throughout the continuum of life, managing their care in multiple environments including but not limited to home, office, acute care hospital and long-term care facilities. The graduate's role in each setting is defined by the relationship with the patient, the patient's need for services and needs of their respective communities, including providing maternity care that reflects the competency of the family physician.
9. Have the technical skill, knowledge and experience to perform clinical procedures within the scope of family medicine reflecting the graduate's training, experience and the needs of the community.
10. Demonstrate the ability to join or build a fiscally sound practice that meets the identified needs of the community served utilizing the principles of the patient-centered medical home.
11. Demonstrate competency in the following skills necessary for the successful practice of family medicine:
   1. Providing health care addressing specific social, cultural and community needs.
   2. Appropriately recognizing the need for consultation, and co-managing the patient when applicable or appropriate.
   3. Practicing cost-effective medicine and care coordination when ordering diagnostic tests, prescribing and utilizing other therapeutics.
   4. Recognizing and coordinating gaps in health of the individual patient and entire patient panel.
   5. Integrating appropriate available technologies (EHR, secure messaging, video visit, point of service references) to improve patient care and its documentation in practice.
   6. Providing evidence-based comprehensive, acute, chronic and preventive services to patients and their communities.
   7. Providing guidance to patients and families regarding advanced directives, end-of-life issues and unexpected diagnoses/outcomes.
12. Demonstrate knowledge and experience with understanding the public health issues in their communities, and coordinate care with community health agencies to improve the health of their patients and community.

Family medicine organizations developed Entrustable Professional Activities (EPAs) for Family Medicine End of Residency Training in 2015.

(http://fmahealth.org/sites/default/files/EPAs_for_FM_End_of_Residency_Training.pdf(fmahealth.org))
This list of 20 EPAs collectively define the type of care that the residency graduate can be trusted to deliver to the public. EPAs are an educational tool that allows faculty to make competency-based decisions on the level of supervision required by trainees. The list of expectations itemized in this policy extends beyond clinical knowledge and skills, and thus complement EPAs for Family Medicine End-of-Residency Training.

(April Board 2009) (2016 COD)
Expedited Partner Therapy

The American Academy of Family Physicians (AAFP) supports expedited partner therapy (EPT) according to the current Centers for Disease Control and Prevention (CDC) recommendations. Clinicians should determine state law requirements for EPT. (2012 COD)
Fairness in Federal Programs for All U.S. Citizens

See also

- Equal Opportunity

All U.S. citizens, including citizens of the territories, should be treated fairly in federal programs. (2006) (2016 COD)
Family, Definition of

See also

- Health Benefits
- Role Definition of Family Medicine

The family is a group of individuals with a continuing legal, genetic and/or emotional relationship. Society relies on the family group to provide for the economic and protective needs of individuals, especially children and the elderly. (1984) (2014 COD)
Family Medicine, Quality Health Care in

See also

- Role Definition of Family Medicine
- Family Medicine, Specialist in
- Family Medicine Faculty Training
- Family Medicine, Undergraduate Training in
- Performance Measures Criteria

Quality healthcare in family medicine is the achievement of optimal physical and mental health through accessible, safe, cost-effective care that is based on best evidence, responsive to the needs and preferences of patients and populations, and respectful of patients’ families, personal values, and beliefs. (2000) (2016 COD)
The American Academy of Family Physicians defines a "specialist" in family medicine as a physician who meets at least one of the following three criteria:

1. Current Board certification by the ABFM, or
2. Successful completion of an ACGME-approved family medicine residency program, or a three year AOA approved postgraduate family medicine residency program, or
3. Maintenance of eligibility requirements for active membership in the AAFP.

(1990) (2013 COD)
Family Medicine, Undergraduate Training in

The AAFP recommends that the curriculum of every medical school have preclinical and clinical student exposure to family medicine with the further directive that, where such is lacking, every possible means of correcting the deficiency be exercised. The AAFP is committed to making every effort to ensure that family medicine in the undergraduate curriculum with appropriate exposure to role models on the faculty be instituted in all medical schools.

The AAFP recommends that all medical schools provide mandatory family medicine clerkships completed by the end of the third year, and elective preceptorships and clerkships to their students. (COE) (1973) (2013 COD)
Family Medicine Clerkship

See also

- Family Medicine Department, Definition
- Preceptorships
- Family Medicine, Undergraduate Training in
- Family Medicine Interest Groups

Every medical student attending an LCME-accredited medical school should be required to successfully complete a third-year family medicine clerkship.  
(March Board 2003) (2014 COD)
Family Medicine Department, Definition

See also

- Family Medicine Interest Groups
- Family Medicine Clerkship
- Family Medicine, Undergraduate Training in
- Family Medicine Faculty Training
- Privileges, Family Medicine Departments and
- Family Physicians Workforce and Residency Education
- Medical Student Debt Relief
- Preceptorships

Departments of family medicine in U.S. medical schools should be recognizable administrative units with a clearly articulated mission that includes education, research and clinical service. These departments transmit the body of knowledge defined as family medicine throughout the academic and practicing communities. If, in addition to family medicine, a department includes other major disciplines, such as community or preventive medicine, these may be reflected in the departmental title. Departments must meet the membership requirements of the Association of Departments of Family Medicine (ADFM).

Each family medicine department requires an appropriate mix of faculty educators, investigators, clinicians and administrators with university-based professional appointments. Each department must exercise administrative control over faculty, space, facilities, budget, and research functions. Departments should have:

1. resources adequate to achieve the mission of the department and the institution; and
2. representation, funding, space and educational venues comparable to other important clinical departments taking into consideration departmental size and mission.

A department of family medicine must include among its functions leadership in the following that are applicable to its setting: Identifiable involvement in the medical student curriculum, particularly a required medical student rotation, and collaboration with other departments to achieve institutional objectives. Department faculty must be involved in scholarly activities, including the creation of new knowledge and peer-reviewed publications. (2003) (2014 COD)
Family Medicine Faculty Training

See also

- Family Medicine, Undergraduate Training in
- Role Definition of Family Medicine
- Family Medicine, Quality Health Care in
- Family Medicine Specialist
- Family Medicine Department, Definition
- Family Medicine Interest Groups

The AAFP strongly advocates that all chairs of departments of family medicine in medical schools, all directors of family medicine residencies, and all family physicians who regularly teach family medicine residents or medical students maintain current certification by the American Board of Family Medicine. (1975) (2013 COD)
The AAFP advocates a health care system anchored in primary care where all Americans have access to family physicians and will select family physicians as the providers of choice for their patient-centered medical homes. (November Board 2001) (2014 COD)
Family Medicine Interest Groups

See also

- Family Medicine Department, Definition
- Preceptorships
- Family Medicine Clerkship
- Family Medicine, Undergraduate Training in
- Family Medicine Faculty Training
- Family Physicians Workforce and Residency Education

The AAFP recommends that all medical students have an opportunity to participate in a family medicine interest group (FMIG), and encourages medical school departments of family medicine, family medicine residency programs, state chapters and community stakeholders to support local FMIGs structurally and financially. (1996) (2014 COD)
Family Physician, Definition

See also

- Role Definition of Family Medicine
- Family Medicine, Specialist in
- Family Physicians Workforce and Residency Education
- Family Physicians' Creed
- Medical Home
- Family Medicine in American Health Care
- Primary Care Physician, Generic

Family physicians, through education and residency training, possess distinct attitudes, skills, and knowledge which qualify them to provide continuing and comprehensive medical care, health maintenance and preventive services to each member of the family regardless of sex, age, or type of problem, be it biological, behavioral, or social. These specialists, because of their background and interactions with the family, are best qualified to serve as each patient's advocate in all health-related matters, including the appropriate use of consultants, health services, and community resources. (1975) (2014 COD)
Family Physician Workforce and Residency Education

See also

- Family Medicine in American Health Care
- Family Physician, Definition
- Family Physicians' Creed
- Family Medicine, Undergraduate Training in
- Family Medicine Department, Definition
- Family Medicine Interest Groups
- Family Physician Workforce Reform
- Expansion of Residency Training Programs at Federally Qualified Community Health Centers (FQHCS)
- Health Care Costs, Methods for Reducing

The AAFP should continue to monitor those factors necessary to determine on a regular basis the need for family physicians, enabling the Academy to establish the areas of highest priority for education in family medicine.

The Academy should continue its high level of support for education in family medicine residency programs and family medicine departments and divisions in medical schools. Such support could include:

1. Enhancing the teaching skills of practicing physicians who work with family medicine residents and medical students, through the establishment of teaching skills' workshops and being supportive of efforts with similar goals sponsored by the other academic family medicine organizations.
2. Continuing to support the activities of the Residency Program Solutions, which helps residency programs continually assess and improve the quality of their educational programs.
3. Monitoring the practice locations and practice scope of graduates of family medicine residency programs to assure that the public's needs continue to be met.
4. Encouraging and recognizing innovation in training that ensures future family physicians will meet the needs of their patients in the context of their communities.

The Academy must maintain the family physician's primary role in the delivery and management of health care, emphasizing continuing and comprehensive care and keeping the focus on the patient and quality of care regardless of the configuration of the health care delivery system.

Family Physicians' Creed

I am a family physician
one of many across this country.

This is what I believe:
You, the patient
are my first professional responsibility
whether man, woman or child
ill or well
seeking care, healing or knowledge.

You and your family deserve
high quality, affordable health care
including treatment, prevention
and health promotion.

I support access to health care for all.

The specialty of family medicine
trains me to care for the whole person
physically and emotionally, throughout life
working with your medical history and family dynamics
coordinating your care with other physicians when necessary.

This is my promise to you.

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(1994) (2016 COD)
Fee-splitting

See also

- Fees, Excessive
- Fees, Global Surgical
- Fees for Patient Education
- Fees to Physicians for Referrals to Other Health Care Professionals

The AAFP is firmly opposed to the practice of fee-splitting. The AAFP defines fee-splitting as any division of fees without the full knowledge of the patient and with the intent of influencing the choice of physician, consultant, assistant or treatment on any other basis than that of the greatest good of the patient. (1952) (2014 COD)
Fees for Patient Education

See also

- Patient Education
- Fees, Global Surgical
- Fees to Physicians for Referrals to Other Health Care Professionals
- Fee-splitting
- Fees, Excessive

The AAFP strongly supports and encourages adequate payment for patient education services that the family physician identifies as important to the health of the patient. At a minimum, these services include patient education for chronic conditions, lifestyle counseling, and instruction in complex regimens that the patient must learn.

The AAFP notes that the efficacy and cost-effectiveness of patient education have been well documented for some diseases such as diabetes and it calls for continuing research on the effectiveness and cost savings of patient education in the prevention of disease and in the management of illness. (1981) (2013 COD)
Fees to Physicians for Referrals to Other Health Care Providers

See also

- Fees, Excessive
- Consultations and/or Policies on Referrals
- Fees, Global Surgical
- Fees for Patient Education
- Fee-splitting

It is improper for physicians to receive payment from an entity, including non-monetary items of value, to induce or reward the generation of business by that entity. This policy is not intended to preclude any safe harbors defined within the context of the Federal Anti-Kickback legislation, Stark legislation, accountable care organization contracts, bundled episodes of care payment, or other similar business arrangements, such as legal gain sharing agreements or risk contracts. (1991) (2016 COD)
Fees, Global Surgical

See also

- Fees, Excessive
- Fee-splitting
- Fees for Patient Education
- Fees to Physicians for Referrals to Other Health Care Professionals

The American Academy of Family Physicians defines a global surgical fee as payment to the primary operating physician for all surgically-related services rendered to the patient for that specific condition from the date of an operation through a specified number of days following surgery. The fee does not include preoperative visits, except for one related evaluation and management encounter, subsequent to the decision for surgery, on the date immediately prior to or on the date of the procedure (including history and physical). It also does not include care for post-operative complications except those frequently associated with the specific surgical procedure. When medically indicated, additional payment to an assisting physician should be made for the intraoperative portion of such care. Also, pre-operative evaluations provided by family physicians not performing the procedure should be paid separately outside the global surgical fee. (1984) (2014 COD)
A fellowship is a post-family medicine residency period of structured training leading to additional knowledge and expertise in a particular area, which may or may not be a Certificate of Added Qualification. (May 2011 Board) (2016 COD)
Female Genital Mutilation

See also
- Child Abuse
- Children's Health

Female genital mutilation (FGM) (also known as female genital cutting or female circumcision) is a cultural practice affecting more than 125 million women and girls around the world, in which parts of the female genitalia (clitoris, labia minora and majora) are cut or disfigured.¹

It is estimated that more than 500,000 women in the United States have undergone or are at risk for FGM.²

While most affected women arrive in the U.S. already cut, there are reports of the procedure being conducted among immigrant populations locally by traditional practitioners. There are also reports that U.S.-born and raised young girls are being sent to the parents’ home country during summer vacation for the purpose of undergoing the procedure in their country of origin.

The practice is internationally recognized as a human rights violation, torture and a form of violence and discrimination against women and girls.¹

United States federal law (18 U.S. Code § 116 Female Genital Mutilation) makes it illegal to perform FGM in the U.S. or to knowingly transport a girl out of the U.S. for the purpose of performing FGM.³

The AAFP supports all measures to eliminate the practice of female genital mutilation in the United States. The AAFP also supports all other international efforts to eliminate the practice of female genital mutilation and to protect young girls and women at risk of undergoing the procedure.

The AAFP encourages family physicians to educate themselves about the practice, the health consequences of FGM and how to manage them in clinical practice, particularly during pregnancy and childbirth. Family physicians are encouraged to provide culturally sensitive counseling and education to the patient and her family members about the negative physical and emotional consequences of the procedure and discourage them from having the procedure performed.

The AAFP advises its members that the practice of reinfibulation (reapproximating the edges of the labia majora back together, usually following childbirth) is sometimes requested by women to restore a sense of normalcy and genital self-image. While allowed by federal law, reinfibulation is ethically complex and should merit careful thought and discussions with the patient and her family in the antepartum period.

Reinfibulation itself is not considered FGM, but if performed by a physician, it may appear to condone the practice. Therefore, the AAFP strongly cautions its members against performing reinfibulation.

Where possible, physicians should refer the patient to social support groups that can help them cope with changing societal mores.⁴ (1998) (2015 COD)

References:


Firearms and Safety Issues

See Also

- Violence (Position Paper)
- Violence as a Public Health Concern
- Prevention of Gun Violence
- Violence in the Media and Entertainment (Position Paper)
- Violence, Harrassment and School Bullying

Related Links

- Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association(annals.org)

The American Academy of Family Physicians recognizes firearm-related deaths, injury and violence as a significant public health problem. AAFP supports increased research into all areas of how gun violence affects public health, including but not limited to, research into the epidemiology, prevention, safety and risks related to gun violence in the United States.

Further, the American Academy of Family Physicians supports strong research regarding how gun laws and regulations have affected or will affect rates of injuries, deaths and suicides. The Academy supports other efforts to evaluate the effectiveness of regulations, interventions, and strategies for preventing injuries and fatalities caused by firearms.

The Academy supports strong and robust enforcement of existing federal, state, and local laws and regulations regarding the manufacture, sale and possession of guns. Increased efforts to enforce current laws on illegal gun trafficking should have high priority for federal, state, and local law enforcement agencies.

The Academy strongly supports legislation restricting unsupervised access to both firearms and ammunition by children.

The Academy opposes private ownership of weapons designed primarily to fire multiple (greater than 10) rounds quickly.


Related Links

- Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association(annals.org)
First Dollar Coverage for Preventive Care

See also:

- Co-Payments
- Managed Care Reform

The American Academy of Family Physicians (AAFP) recommends that all health insurance plans, including high-deductible health plans (HDHP), provide first dollar coverage for age, gender, and risk-appropriate preventive services as recommended in the AAFP "Summary of Recommendations for Clinical Preventive Services," without subjecting such coverage to a deductible or co-insurance. (2006) (2016 December BOD)
Fluoridation of Public Water Supplies

See Also

- Dental Services

Related Links

- Talk With Your Patients About Oral Health -- Resources From the American Academy of Pediatrics(www.ilikemyteeth.org)

The American Academy of Family Physicians supports fluoridation of public water supplies as a safe, economical, and effective method to prevent dental caries. Family physicians are encouraged to know the fluoride content of local drinking water supplies, educate patients to prevent excessive fluoride intake, and be knowledgeable about the health risks and benefits associated with fluoride. Dietary fluoride supplements are encouraged for children ages six months through 16 years when drinking water levels are suboptimal. (1993) (2013 COD)

An assessment and summary of the scientific evidence on the benefits and harms of community water fluoridation was developed to assist family physicians who may be called upon to offer a professional opinion regarding a local community water fluoridation decisions. See full systematic review (17 page PDF)

These policies are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient’s family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These policies are only one element in the complex process of improving the health of America. To be effective, the policy must be implemented.

See Also

- Dental Services

Related Links

- Talk With Your Patients About Oral Health -- Resources From the American Academy of Pediatrics(www.ilikemyteeth.org)
Framework Convention on Tobacco Control (FCTC)

"Frontier Areas," Medical Care Roles

See Also

- Maternal/Child Care (Obstetrics/Perinatal Care)
- Rural Health Care, Access to
- Integrative Medicine
- Rural Health Care in Medical Education
- Rural Health Care, Telemedicine
- Rural Practice, Keeping Physicians in (Position Paper)

The AAFP supports the concept of the designation of frontier areas (defined as counties with six or fewer people per square mile) as a means of recognizing unique problems and encouraging innovative approaches to health care delivery.

The AAFP further recognizes the unique skills and training requirements for competent frontier practice, and encourages ongoing development of appropriate training programs to produce competent frontier physicians.

Furthermore, the AAFP realizes the critical role of the practicing frontier family physician delivering appropriate emergency and primary health care services to frontier communities, and supports innovative solutions to providing accessible, affordable care in these areas.

The AAFP strongly supports the inclusion of physician representation in further development by the National Rural Health Association (NRHA) and other solutions and strategies for better health care in frontier areas.

The AAFP cautions that care should be taken in broadening the role of non-physician providers under state licensure when addressing the special health care needs of frontier areas. Midlevel practitioners should work only under the direction and responsible supervision of a practicing licensed family physician with skills and training in frontier medicine. Nonetheless, these communities are best served by family physicians with such skills and training.

(1986) (2009 COD)
Gender Equity on Drug, Testing, Procedure, and Preventive Coverage

See also

- Reproductive Decisions
- Discrimination, Patient

Employers and health plans should not discriminate by birth or the patient’s identified gender in the provision of health care benefits including a) prescription drugs and devices, b) elective sterilization procedures, c) diagnostic testing, and d) medically indicated surgical procedures. These benefits should be covered under the same terms and conditions as other prescription drugs, devices, elective surgeries, diagnostic testing, and medically indicated surgical procedures.

Coverage should include medically appropriate services for individuals requiring transition or transgender care as determined by best practice standards, the patient, and the attending physician.

This coverage should extend to the medically-appropriate, sex-specific recommended preventive services determined appropriate for a particular individual by the individual's primary care physician. (2002) (2016 COD)
Generic Drug Pricing - AAFP Legislative Stance

See also

- Drugs, Generic
- Drug Identification
- Drugs, Therapeutic Substitution
- Drugs, Prescribing

Good Samaritan Law

See also

- Emergency Medical Care

The AAFP approves of legislation that would grant immunity from civil actions for alleged negligence to any licensed doctor of medicine or osteopathic medicine who in good faith renders emergency care without compensation and through its constituent chapters seeks such legislation whenever and wherever it can be constitutionally sustained. (1960) (2013 COD)
Graduated Driver's License

See also

- Don't Text and Drive Initiative
- Driver Education
- Motor Vehicle Occupant Protection
- Substance Abuse and Addiction

The AAFP supports graduated licensing as an approach to help reduce the incidence of motor vehicle accidents for adolescents. While recognizing the need for variances by state, legislation for graduated licensing should minimally contain the following elements:

- Zero blood alcohol concentration allowed during the provisional licensure state.
- Driving curfew during provisional licensure.
- A minimum of six months without an accident or traffic offense while on a provisional license before advancement to an unrestricted license.
- Basic learner's permit conditions, to include required classroom and behind-the-wheel instruction.
- Physical distinction between provisional and unrestricted license.

Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants

See also

- Nurse Midwives, Certified
- Team-Based Care
- Nurse Practitioners
- Physician Assistants
- Non-Physician Providers, Family Physician Training With Payment, Non-Physician Providers

Introduction

Many family physician practices include non-physician providers (NPPs) such as physician assistants, nurse practitioners and less commonly nurse midwives. Moreover, family physicians have been at the forefront of innovation in practicing with NPPs, especially in underserved communities. The Academy has supported a wide variety of efforts by policy makers to improve access to health care services in underserved communities including the innovative utilization of NPPs.

The increasing variety of situations in which NPPs practice, the emphasis on practice teams, and the growing tendency of health policy makers to identify NPPs as a means of improving the availability of health care services raises important issues regarding the appropriate relationship between NPPs and physicians. Current Academy policy on NPPs stipulates that these providers should always function under the "direction and responsible supervision" of a practicing, licensed physician though in many states nurse practitioners have independent practice authority. Academy policy on "Integrated Practice Arrangements" supports practice teams including NPPs. The Academy, however, believes that practicing physicians, NPPs and health policy makers will benefit from a more detailed set of supervision guidelines.

These guidelines are intended to serve as a set of general principles with which physicians, NPPs and policy makers can assess the role of NPPs in providing patients a team-based medical home and in improving access to health care services.

It is important to note that an extremely varied set of laws and regulations defining the legal relationship between physicians and NPPs has been adopted by the federal government and all 50 states. It’s also important to note that there are major differences in state scope of practice statutes among nurse practitioners, nurse midwives and physician assistants. While these guidelines will provide general direction, physicians and NPPs are urged to fully comply with all federal, state and local laws and regulations regarding health care delivery. Health insurance plans and physician practices which include non-physician providers should provide information to members/patients regarding the possibility of being seen by a non-physician provider. Such information should be stated in clear terms in plan/practice advertisements and communications, the information should be made known to the patient at the time their appointment is made, and should be clearly stated by the non-physician provider at the time the patient is seen.

Physician Responsibility

The central principle underlying physician supervision of NPPs is that the physician retains ultimate responsibility of the patient care rendered when so required by state law. In these cases, physician supervision means that the NPP only performs medical acts and procedures that have been specifically authorized by the supervising physician.
Generally speaking, it is useful to conceptualize state NPP supervision laws as providing physicians with the authority to delegate the performance of certain medical acts to NPPs who meet specified criteria and who function under certain legal requirements for supervision. Accordingly, the tasks delegated to the NPP should be within the scope of practice of the supervising physician. The physician remains responsible for assuring that all delegated activities are within the scope of the NPP’s training and experience. The physician must afford supervision adequate to ensure that the NPP provides care in accordance with accepted medical standards.

**Supervision**

It is the responsibility of the supervising physician to direct and review the work, records, and practice of the NPP on a continuous basis to ensure that appropriate directions are given and understood and that appropriate treatment is rendered consistent with applicable state law. Supervision includes, but is not limited to: (1) the continuous availability of direct communication either in person or by electronic communications between the NPP and supervising physician; (2) the personal review of the NPP’s practice at regular intervals including an assessment of referrals made or consultations requested by the NPP with other health professionals; (3) regular chart review; (4) the delineation of a plan for emergencies; (5) the designation of an alternate physician in the absence of the supervisor; and (6) review plan for narcotic/controlled substance prescribing and formulary compliance. The circumstance of each practice determines the exact means by which responsible supervision is accomplished.

**Direction**

It is the responsibility of the physician to ensure that appropriate directions are given, understood, and executed. These directions may take the form of written protocols, in person, over the phone, or by some other means of electronic communication.

Protocols developed by the supervising physician and NPP should include guidelines describing and delineating NPP functions and responsibilities. Protocols should be as specific in their guidance as the physician and NPP require for their particular practice. Many states require that the physician and NPP develop detailed written protocols, and, in some instances, these protocols must be submitted to and approved by the state medical board. As a practical matter, it is not possible to cover all clinical situations in written protocols. Nonetheless, there must be a clear understanding between the physician and NPP regarding the actions that may be undertaken by the NPP in all commonly encountered clinical situations and, especially, under what circumstances physician consultation is to be immediately obtained. The physician and NPP must regularly review protocols to ensure their currency in regard to the physician’s scope of practice, the range of tasks that have been delegated by the physician and the evolving standards of medical practice. Immediate physician consultation will be indicated for specified clinical situations and in situations falling outside those specified in written and oral protocols.

**Review**

The supervising physician must develop and carry out a plan to ensure NPP quality of care. This plan must be in compliance with all applicable laws and regulations. The supervising physician must regularly review the quality of medical services rendered by the NPP by reviewing medical records to ensure compliance with directions and standard of care. The minimum frequency with which such review takes place is, in some instances, specified in federal and state law. In establishing the frequency and extent of record review, the physician may consider the scope of duties that have been delegated to the experience of, and the patient load of the NPP.

**Off-site Supervision**

In principle, supervision should recognize the diversity of practice settings in which NPPs practice. As a practical matter, the efficient utilization of a NPP will at times involve off-site physician supervision. Generally, off-site supervision of a NPP involves a physician-NPP team that has previously established a
working relationship. The supervising physician or a designated alternate physician of the same specialty must be available in person or by electronic communication at all times when the NPP is caring for patients. There should be established clear transportation and backup procedures for the immediate care of patients needing emergency care and care beyond NPP's scope of practice. As with on-site supervision, the appropriate degree of off-site supervision includes an overview of NPP's activities including a regular review of patient records; and periodic discussion of conditions, protocols, procedures, and patients. (1992) (2013 COD)
The AAFP acknowledges that hate crimes directed against protected classes, including race, color, religion, gender, sexual orientation, and disability status pose specific and distinct health risks for our patients. The AAFP supports the development and implementation of anti-discrimination and hate crime laws that seek to protect victims from perpetrators. The AAFP further supports research and educational programs directed at the prevention of hate crimes, and promotes interventions that address the health needs of hate crime survivors. (2003) (2014 COD)
Health Benefits

See also

- Family, Definition of
- Medically Underserved

The American Academy of Family Physicians supports the equality of health benefits to all individuals within the context of the AAFP definition of family. (1996) (2013 COD)
Health Care

See also

- Culturally Proficient, Health Care
- Health Care for All: A Framework for Moving to a Primary Care-Based Health Care System in the United States
- Health Care Costs, Methods for Reducing
- Health Care Delivery Systems

The American Academy of Family Physicians (AAFP) believes that all people of the world regardless of social, economic or political status, race, religion, gender or sexual orientation should have access to essential health care services. (B1986)

The AAFP encourages its members to continue the voluntary delivery of medical care without charges or at reduced charges to the financially disadvantaged. (1983) (2016 COD)
Health Care Costs, Methods for Reducing

See Also

- Health Care
- Family Physicians, Workforce and Residency Education
- Performance Measures Criteria
- Economic Credentialing and Network Participation
- Physical Activity in Children

The Academy should continue to educate physicians concerning the issue of medical liability risk management in an effort to reduce the incidence of medical liability suits. The Academy should also increase its public education efforts by linking the high costs of medical liability insurance to the escalating cost of medical care.

The Academy should maintain its efforts to provide public education which emphasizes the responsibility of the individual patient for his/her personal health and for rising health care costs. This campaign should emphasize the positive effects of exercise, nutrition and highway safety and the detriments of drug and substance abuse, obesity and smoking.

The Academy should continue to support mechanisms for training increased numbers of family physicians who emphasize health promotion and disease prevention, thereby avoiding more costly hospital care, and who are uniquely qualified to provide appropriate, cost-effective care to the people of America.

The Academy will continue as the representative of the patient -- the patient's advocate -- in negotiating with the government, and will continue to stress quality control, rather than cost containment, as the primary goal of regulation. The Academy further believes that each practicing family physician should set a practice example exemplary of high quality family medicine with careful attention to self-imposed cost containment. (1977) (2014 COD)
Health Care Delivery Systems

See also

- Reasonable Choice
- Health Care

The American Academy of Family Physicians (AAFP) supports universal access to basic health care services for all people. The AAFP believes this goal can be attained with a pluralistic approach to the financing, organization, and delivery of health care. A pluralistic health care delivery approach naturally involves competition based on quality, cost, and service.

The goal of any health care delivery system should be to foster optimal health outcomes by providing cost-effective, patient-centered, quality care with a service emphasis. Health care delivery systems should be designed to motivate patients and health care providers to make decisions consistent with this goal.

The AAFP supports the physician and patient option to choose any ethical health care delivery system. Because this policy advocates choice, the AAFP encourages its members to be well-informed about the continuously evolving health care delivery system options available to them and their patients. The AAFP also encourages its members to help their patients choose options that promote the above goals and that maintain the unique partnership embodied in the physician-patient relationship. To further support the goal, health care delivery systems should support physicians’ responsibilities to treat, comfort, and educate patients, while encouraging family physicians to be the patient’s primary physician. (1998) (2015 COD)
Health Care Facility Visitation Rights of Patients

See Also

- Ethics and Advance Planning for End-of-Life Care
- Elder Mistreatment
- Hospice Care
- Hospitals, Transfer of Patients

The AAFP supports the rights of patients to designate hospital and other health care facility visitors, including individuals designated by legally valid advance directives, to privileges that are no more restrictive than those of immediate family members. Consideration should be taken if there is a suspicion of intimate partner violence.

(May 2011 Board) (2016 COD)
Health Care for All: A Framework for Moving to a Primary Care-Based Health Care System in the United States

SEE ALSO:

- Health Care
- Homelessness

Introduction

The health care system in the United States is a non-system of uncoordinated, fragmented care, emphasizing intervention, rather than prevention and comprehensive management of health. Health care costs are rapidly increasing, access is declining, and quality is far from ideal.¹

The number of uninsured people in the United States is staggering, approximately 48 million according to the US Bureau of the Census' report Income, Poverty, and Health Insurance Coverage in the United States: 2012.² While the number decreased slightly from 2006, because of additional children eligible for the State Children’s Health Insurance program, the number of people insured through their employers decreased. Ensuring that all people in the United States have health care coverage is essential to moving toward a healthier and more productive society. However, as noted by the Commonwealth Fund, the design of a system to provide health care coverage to all people “will have a deep impact on its ability to make sustainable and systematic improvements in access to care, equity, quality of care, efficiency, and cost control.”³

The key to change is to reinvigorate the primary care infrastructure in the US, to redesign the manner of primary care delivery, and to re-emphasize the centrality of primary care. Compelling research indicates that the ever-increasing focus of resources on specialty care has created fragmentation, decreased quality, and increased cost. Studies confirm that if primary care practices redesign how they operate such that they are more accessible, promote prevention, proactively support patients with chronic illness, and engage patients in self-management and decision-making, health care quality improves along with the cost efficiency of care.⁴

Primary care is the only entity charged with the longitudinal continuity care of the whole patient, and it is the primary care relationship and comprehensiveness that has the most effect on health care outcomes. However, the current United States health care system fails to deliver comprehensive primary care because of the way primary care is financed.

According to the Center for Evaluative Clinical Sciences at Dartmouth, states in the US that rely more on primary care have lower Medicare spending (inpatient reimbursements and Part B payments), lower resource inputs (hospital beds, ICU beds, total physician labor, primary care labor, and medical specialist labor) lower utilization rates (physician visits, days in ICUs, days in the hospital, and fewer patients seeing 10 or more physicians), and better quality of care (fewer ICU deaths and a higher composite quality score).⁵

The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth, adults and the elderly. The PCMH is a health care model that facilitates partnerships between individual patients, their personal physicians, and when appropriate, the patient's family. Each patient has an ongoing relationship with a personal physician trained to provide first contact then continuous and comprehensive care. The personal physician leads a team of individuals at the practice level, and beyond, who collectively take responsibility for the ongoing care of patients.⁶
Fundamental change is required to shift the direction of the US health system toward one that covers all people and emphasizes comprehensive primary care and coordinated care through the patient-centered medical home. Resources must be deployed to achieve the desired results. Payment policies must change. Workforce policies must be addressed to ensure a strong cadre of family physicians, other primary care physicians and non-physician clinicians so integral to a high functioning health care team. Congress must enact comprehensive legislation to achieve this change. If Congress only addresses the uninsured and fails to fundamentally restructure the system to promote family medicine and primary care, a solution will not be reached.

**Goal**

To provide health care coverage to everyone in the United States through a primary care based system built on the patient-centered medical home.

**Key Elements of the Framework**

- Everyone will have health care coverage, including catastrophic protection
- Everyone will have a patient-centered medical home
- Health care will be a shared responsibility of individuals, employers, government, and the private and public sectors

**Coverage**

Everyone in the United States will have health care coverage. This will be achieved only if Congress enacts legislation requiring health care coverage for all, with a primary care benefit design featuring the patient-centered medical home, and a payment system to support it.

**Patient-Centered Medical Home**

The patient-centered medical home, as described in the Joint Principles of the Patient-Centered Medical Home, will be the basis of the health care system. Patient-centered medical homes will be designated by a process such as the Physician Practice Connection – Patient-Centered Medical Home® recognition program of the National Committee on Quality Assurance (NCQA).

**Benefits**

Primary care will be provided through the patient-centered medical home with benefits provided in the following manner:

The following services will have no financial barriers (co-payments):

1. Primary care provided by or through the medical home
   1. Prenatal care
   2. Well-child care
   3. Immunizations
   4. Basic mental health care
   5. Evidence-based preventive services
   6. Chronic care management
   7. Hospice Care

2. The following services will have shared financial responsibility (co-payments) UNLESS they are coordinated through the patient-centered medical home:
   1. Medications
   2. Hospitalizations
   3. Durable medical equipment
4. Emergency department visits  
5. Consultations and referrals  
6. Diagnostic tests and procedures  
7. Long-term care  
8. Other ambulatory-based care such as outpatient surgery and procedures

3. The following services will be the financial responsibility of the patient:  
   1. Elective Cosmetic procedures  
   2. Dangerous therapies  
   3. Therapies whose risks outweigh their benefits

4. Coverage will include protection from financial ruin from health care costs above a specified level of out-of-pocket spending.

Payment

The payment structure will be based on the following blended payment model:

1. Fee for Service  
Fee-for-service payments will continue for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described below, should not result in a reduction in the payments for face-to-face visits). These payments encourage physicians to remain accessible to patients.

2. Care Management Fee  
All levels of patient-centered medical homes will receive payment, through a care management fee. The amount of the fee will increase for each of the levels of designation as noted above in the discussion of the patient-centered medical home. The monthly care management fee will reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit, and coordination of care both within a given practice and between consultants, ancillary providers, and other health care providers. The care management fee should support adoption and use of health information technology for quality improvement and provision of enhanced communication access such as secure e-mail and telephone, recognize the value of physician work associated with remote monitoring of clinical data using technology, and take into account case mix differences in the patient population being treated within the practice. Further, the payment model will be supported by better coordination of care associated through the patient-centered medical home.

3. Pay for Performance  
A performance-based payment will recognize achievement of quality and efficiency goals through pay for reporting and pay for performance mechanisms.

Summary

This framework to move the United States toward a primary care based health care system where all people have coverage, are provided a patient-centered medical home, have primary care-oriented benefits and are protected from financial ruin can be achieved only if Congress acts to ensure that these policy objectives are implemented. All people in the United States must have health care coverage, but this is not sufficient to address issues of access, quality and cost. A fundamental change in the health care system to move toward a primary care based system is essential to improvements in access, quality and cost. Extensive worldwide research supports the value of a primary care based health care system in which all people are covered. This framework is grounded upon the documented value of primary care in achieving better health outcomes, higher patient satisfaction, and more efficient use of resources. Only through this framework of health care coverage for all that is foundationally built on primary care with the patient-centered medical home as the basic building block will the United States achieve the type of health care system that our people need and our Nation deserves. (2008)

References


Health Education

See also

- Health Education in Schools
- Patient Education
- School-Based Health Clinics, Guidelines
- Hygiene, Personal Hygiene in School Settings
- Obesity and Overweight

The American Academy of Family Physicians encourages members to take an active role in providing health education to their patients and the public. The AAFP believes that patients and members of the public who are educated about their health are better equipped to prevent disease and to play an important part in managing health problems which occur. (1990) (2013 COD)
Health Education in Schools

See also

- Health Education
- Patient Education
- School-Based Health Clinics, Guidelines
- Hygiene, Personal Hygiene in School Settings
- Obesity and Overweight

The AAFP supports the principle that health education should be included in the curriculum of grades K through 12 and continued in the community through adult education programs.

Students at all levels should be provided opportunities to:

1. Obtain accurate information on health, illness, and illness prevention.
2. Obtain accurate information on health topics most relevant to the student population, such as substance abuse, sexual abuse, suicide, safety, nutrition, obesity, eating disorders, sexual activity, teenage pregnancy, sexually transmitted diseases, mental health, family violence, risk taking behavior, coping with peer pressure and stress.
3. Gain understanding of growth and development from conception through adulthood. Gain an understanding of family health history and its impact on one's own health risks, and learn how one's health behavior is related to health status.
4. Discuss personal attitudes, values and beliefs relating to health. Discuss the processes through which social values are acquired and the ways in which they can affect health.
5. Develop critical thinking and decision-making skills in terms of health and sickness evaluation.
6. Develop an awareness of the limitations of medicines and medical science in their personal care.
8. Develop a personal life-long health life style plan, including areas of healthy eating, exercise, social relationships, and avoidance of risky behaviors.
9. Develop a sense of social responsibility and participate in promotion of health education to peers, family and community.

Through such well-designed programs of health education, an impact can be made to improve the environmental and life-style factors in health in many segments of the population. (1980) (2015 COD)
Health Equity

The American Academy of Family Physicians (AAFP) supports the attainment of the highest level of health for all people. Health includes the capacity to heal and to function within the context of the family, community, and environment. Numerous social, genetic, and environmental factors influence health to varying degrees. An individual's health is not measured simply by the absence of disease.

Family physicians promote health equity by considering the balance of social determinants that impact the health of an individual, family, community, population, and environment. Family physicians can mitigate health inequity by collaborating with government, business, and health and social service providers, to affect positive change for the populations they serve.

Definitions

Health equity: The AAFP adopts the Healthy People 2020 definition of health equity as, "The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

The WHO definition of health is modified by the AAFP to read as follows, "Health is a state of physical, mental, and social well-being and not merely the absence of disease or infirmity."

The WHO definition, although used internationally, has also been adapted to meet the needs of individual nations.

The AAFP is dedicated to improving the health of patients, families, and communities, and is a bold champion of health. As we call upon our organization’s leaders, our members, patients, and society to promote individual and population health, we must question outdated thinking and redefine health for those individuals and populations. Health is complex, yet achievable and personal. Its definition should be adaptable and comprehensive.

(2015 December BOD) (2016 COD)
Health Literacy

See also

- Promoting Early Literacy Development
- Social Determinants of Health

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health care decisions.\(^1\) The American Academy of Family Physicians champions the promotion of health literacy throughout all aspects of the healthcare system including but not limited to strategic and organizational design, research and quality improvement metrics and provision of direct patient care, especially to patients with low health literacy. Family physicians, medical staff, residents and medical students should receive training on health literacy and communication strategies to improve patient engagement and self-management.\(^2\)

References

Health Workforce Credentialing

See Also

- Ancillary Medical Personnel

The American Academy of Family Physicians endorses health workforce credentialing as an effort to upgrade the education and competencies of health care providers. (1977) (2013 COD)
Healthy Foods

SEE ALSO:

- Healthy Nutrition in Health Care Facilities and Other Workplaces
- Obesity and Overweight
- School Nutrition: Healthy Eating Options in Schools

The American Academy of Family Physicians supports the development of healthy food supply chains in supplemental nutrition programs so as to broaden the availability of healthy food to program recipients. (HP/S) (2013 COD)
Healthy Nutrition in Health Care Facilities and Other Workplaces

See also

- Obesity and Overweight
- School Nutrition: Healthy Eating Options in Schools
- Healthy Foods

That the American Academy of Family Physicians believes that sound nutrition is a cornerstone of health and should be reflected in all dietary offerings in health care facilities.

Further, the AAFP believes that high quality nutrition should extend to all workplaces that offer food to their employees and to the public at onsite cafeterias and vending machines.

(2005) (2011 COD)
The American Academy of Family Physicians encourages all family physicians to become knowledgeable in the prevention, evaluation and treatment of deafness and hearing loss in patients of all ages.

Family physicians are encouraged to counsel their patients to protect their hearing health and to prevent hearing loss, especially noise induced hearing loss, whenever possible.

Family physicians are further encouraged to consider the needs of their deaf and hard-of-hearing patients including cultural identification, educational history, measured hearing, hearing aids, cochlear implants and other assistive devices, and "Hearing Ear" dogs. Family physicians should ask whether deaf and hard-of-hearing patients prefer spoken or visual language. If possible, interpreters experienced in medical interpretation for the hearing impaired should be made available when requested by the patient.

Finally, family physicians should be sensitive to and use nomenclature acceptable to deaf and hard-of-hearing patients. (1988) (2011 COD)
Home Health Care

See also

- Medical Home
- Essential Community Provider
- Ethics and Advance Planning for End-of-Life Care
- Hospice Care
- Long-Term Care
- Long-Term Care Facilities, Continuity and Coordination of Care
- Long-Term Care Facilities, Criteria for Medical Directors
- Medical Waste Disposal in Non-Medical Settings

Home health care is direct patient care, plus the management and coordination of patient care services, in a residential setting.

Family physicians have always provided home health care. Since home health care often requires continuing and comprehensive patient care in a family context, family physicians are particularly well-qualified and trained to provide home health care. Thus, the patient's family physician should be directly involved in the initial decision to provide home health care services plus the subsequent planning, provision and management of those services. Additionally, adequate compensation for family physicians providing and managing home health care services will help ensure on-going home health care access and availability. (1986) (2015 COD)
Home Test Kits

See Also

- Screening

The American Academy of Family Physicians recognizes the proliferation of home diagnostic test kits for a variety of diseases and conditions. The American Academy of Family Physicians encourages patients to consult with their physicians regarding selection, use and interpretation of these tests. (1985) (2014 COD)
Homelessness affects the individual and family, and is hazardous to one's mental, nutritional and overall health. The AAFP supports legislation and programs that develop social and health-related resources for the homeless population in America. The AAFP also urges its members to care for this at-risk population. (1988) (2012 COD)
Hospice Care

See Also

- Health Care Facility Visitation Rights of Patients
- Life-Prolonging Treatment, Foregoing
- Life-Sustaining Treatment
- Home Health Care
- Ethics and Advance Planning for End-of-Life Care

The family physician, by virtue of unique training, is in a position to provide a leadership role in hospice care. The concept of hospice is one of comprehensive care for the dying.

Family physicians are personal doctors for people of all ages and health conditions. They are a reliable first contact for health concerns and directly address most health care needs. Through enduring partnerships, family physicians help patients prevent, understand, and manage illness, navigate the health system, and set health goals. Family physicians and their staff adapt their care to the unique needs of their patients and communities. They use data to monitor and manage their patient population, and use best science to prioritize services most likely to benefit health. They are ideal leaders of health care systems and partners for public health.

Family medicine addresses the psychosocial needs of the patient, coordinating across all levels and environments of care and functioning as leaders of interdisciplinary teams. In the forefront to provide continuity of care in the rural and underserved areas, the family physician may serve as hospice physicians and medical directors.

On the basis to provide an enduring partnership with patients and adapt care to meet the unique needs of the patient population, family physicians are in a position to serve as hospice physicians and medical directors.

(1979) (2016 COD)
Hospital Bylaws on Low Volume/ No Volume Privileging

The American Academy of Family Physicians (AAFP) unequivocally holds that all physicians on the medical staff should have the same opportunity for clinical privileges commensurate with their documented training and/or experience, demonstrated abilities, and current competence. In the event of low volume or no volume experience, the hospital should provide a method of determining competency that is consistent with Joint Commission standards. This competency assessment method must be applied equally and fairly to all medical staff so that any physician applying for privileges can prove competency in the event of low or no volume experience and/or case numbers. (2010 COD) (2015 COD)
Hospital Medical Staff, Board Certification for Membership

See Also

- Privileges
- Privilege Assignment in Departmentalized Hospitals
- Privileges, Documentation of Training and Experience
- Hospital Medical Staff and Other Health Care Organizations, Board Recertification
- Economic Credentialing and Network Participation
- Hospital Medical Staff, Liaison Between Governing Boards and
- Privilege Support Protocol
- Certification/Maintenance of Certification, Definitions

Medical staff membership and hospital privileges should be granted on the basis of the individual physician's documented training and/or experience, demonstrated abilities, and current competence.

The American Academy of Family Physicians is opposed to the use of specialty board certification as the sole or an exclusionary criterion in determining medical staff membership. (1990) (2014 COD)
Hospital Medical Staff and Other Health Care Organizations, Board Recertification

See Also

- Hospital Medical Staff, Board Certification for Membership
- Economic Credentialing and Network Participation
- Hospital Medical Staff, Liaison Between Governing Boards and Certification/Recertification, Definitions

In those instances where hospitals and other health care organizations elect to require specialty board certification for medical staff membership, this standard must be applied uniformly. If the standard is initial board certification, then this should be expected of all specialties. If the standard is current recertification status, then this should be universally applied to all specialties. (1991) (2015 COD)
Hospital Medical Staff, Liaison Between Governing Boards and

See Also

- Board Certification for Membership on Hospital Medical Staffs
- Hospital Medical Staff and Other Health Care Organizations, Board Recertification
- Economic Credentialing of Hospital Medical Staffs
- Economic Credentialing and Network Participation

The AAFP believes that physicians who are elected or appointed by a medical staff to a hospital board of trustees, and who are granted full voting rights, are the most effective liaisons between the medical staff and hospital governing authorities. The Academy encourages family physicians to seek representation on hospital governing boards. (1967) (2013 COD)
Hospital Use of Infant Formula in Breastfeeding Infants

See Also

- Breastfeeding (Policy Statement)
- Breastfeeding (Position Paper)
- Maternal/Child Care (Obstetrical/Perinatal Care)
- Breastfeeding Accommodations for Trainees

The AAFP encourages that hospital staff respect the decision of the mother who chooses to breastfeed exclusively by not offering formula, water or pacifiers to an infant unless there is a specific physician order.

The AAFP discourages distribution of formula or coupons for free or discounted formula in hospital discharge or physician office packets given to mothers who choose to breastfeed exclusively. (2007) (2012 COD)
Hospitalists Trained in Family Medicine

See also

- Patient Care, Concurrent
- Continuity of Care, Definition of

The opportunity to participate as a hospitalist should be open to all interested physicians whose education, training, and current competence qualify them to serve effectively in this role. Hospitalists are physicians whose primary professional focus is hospital medicine, the general medical care of hospitalized patients. Family physicians possess unique attitudes, skills, and knowledge which qualify them to provide continuing and comprehensive medical care to each member of the family regardless of sex, age, or type of problem.

During their training, family physicians acquire attitudes, skills, and knowledge that enable them to provide continuing and comprehensive medical care across the spectrum of care settings, including the inpatient setting. Education in the primary management of hospitalized patients occurs during the required general inpatient ward and intensive care unit experiences. In addition, family physicians are required to train with general surgeons and surgical subspecialists, enhancing recognition and understanding of surgical interventions and disease states upon which hospitalists are frequently asked to consult or co-manage. Family medicine training also encompasses additional skills essential to the practice of hospital medicine, including participation in quality improvement, addressing the psychosocial needs of patients, coordinating across levels and environments of care, and functioning as members of interdisciplinary teams. (2003) (2014 COD)
Hospitals, Transfer of Patients

See also

- Health Care Facility Visitation Rights of Patients
- Specialty Hospitals

Transfer of a patient from one institution to another ultimately must be in the best interest of the patient and in accordance with federal law.

The AAFP believes that the final decision regarding transfer of a patient must be made by the attending physician in consultation with the patient and/or the patient's family and the physician(s) involved with the referral. (1986) (September 2016 BOD)
Human Trafficking

See also

- Child Abuse
- Elder Mistreatment
- Intimate Partner Violence

Human trafficking is a problem affecting millions of women, men and children around the world. It is a term for activities involving someone who “obtains or holds a person in compelled service” and includes forced labor, sex trafficking, bonded labor, domestic servitude, forced child labor, and child soldiers. Human trafficking has been reported in all U.S. states and the District of Columbia. It is estimated that 18,000 individuals are trafficked into the U.S. each year, and many may go undetected for years.

All forms of trafficking may result in significant health effects, ranging from sexually transmitted infections and unintended pregnancies to injuries, chronic pain, and a wide range of psychological, psychiatric, and behavioral health problems.

Solid data are lacking about populations affected, their characteristics and special needs, and about the best methods for screening, assessing, reporting, treating, intervening, and preventing human trafficking. However, it is known that health care professionals may be one of few professions likely to interact with victims while enslaved. Studies suggest that about 30% of trafficked individuals will be exposed to the health care system at some point during their captivity, yet they are seldom recognized as victims. Clinicians cite lack of training opportunities as one factor contributing to their perceived difficulty to screen, identify, and care for victims of trafficking.

- The American Academy of Family Physicians (AAFP) recognizes that human trafficking is a serious problem affecting vulnerable individuals across the globe and in the U.S., and acknowledges the enormous health impact it has on victims, their families, and communities.

- The AAFP affirms that trained health professionals – including family physicians – are uniquely positioned to identify individuals at risk, including children and youth, and may serve as key stakeholders in the identification, management, and even prevention of human trafficking.

- The AAFP supports holistic, trauma-informed, and compassionate care of victims and survivors, and urges all physicians and other health care professionals to become informed of steps they can take to help identify and care for victims and survivors.

- The AAFP encourages training programs to integrate education on human trafficking into existing curricula (such as those on intimate partner violence, and child and elder abuse) at the pre-doctoral, residency, and CME levels.

- The AAFP supports collaboration with law enforcement and community-based organizations addressing human trafficking, and calls for increased funding for research on the health and public health consequences of human trafficking.

Members interested in educational resources can go to:

2. [https://healtrafficking.org/education/educational-programs/(healtrafficking.org)](https://healtrafficking.org/education/educational-programs/(healtrafficking.org))

Other resources:

1. [www.PolarisProject.org](www.PolarisProject.org)
2. http://211.org/services/human-trafficking(211.org)

(2016 September BOD)
Hydraulic Fracturing (Fracking): Health Effects and Disclosure of Proprietary Information

Hydraulic fracturing (fracking) involves the injection of toxic chemicals into the ground to liberate oil and natural gas deposits. Numerous chemicals used in fracking are known to cause serious health effects including cancer,¹ and due to accidents or poor construction, these chemicals have been found in personal water wells, ground water, and in the soil.² Further, many chemicals used in fracking are protected as proprietary information and may not be publicly disclosed. This becomes important to family physicians when a patient presents with suspected exposure to these chemicals, and the treating physician and their medical staff are not privy to the chemical makeup of the exposed solution. Further, some states have enacted legislation that makes it arduous for physicians to obtain chemical makeup for treatment purposes. In those instances, when the chemical composition of fracking fluid is obtained, physicians may be prevented from disclosing this information to their patients and other health care providers following regulations imposed in several states.³ Therefore, the American Academy of Family Physicians (AAFP) strongly advocates for rigorous research into the effects of fracking on human health and the environment. The AAFP also strongly opposes any state or federal legislation that prohibits disclosure of chemicals used in the fracking process and legislation that may interfere with physicians disclosing said information to their patients and public health officials.

References:


(2015 COD)
Hygiene, Personal Hygiene in School Settings

See also

- School-Based Health Clinics, Guidelines
- Health Education in Schools
- Health Education

All children and adolescents should have access to items and opportunities to maintain personal hygiene in school settings. Each child should have access to clean restrooms and have the appropriate hand washing materials available. In addition, each child should have confidential access to age-appropriate items of personal hygiene.

Schools should provide hygiene education to kindergarten and early grade school children to supplement the training provided by parents and guardians, to ensure that all children learn at an appropriate age how to protect themselves and others from preventable exposure to illness and other hygienic hazards. (2003) (2014 COD)
Imaging Personnel

See also

- Radiology (Position Paper)

In physician offices personnel with appropriate training, skills and experience perform a wide range of radiologic testing. In the physician's office, personnel are used to perform medical imaging work under the supervision of the physician, having been delegated the responsibility to perform requested radiologic procedures by the supervising physician. The personnel used to perform medical imaging may also assist the physician in providing necessary quality control measures, as may be required by law. The maintenance of this relationship between personnel used to perform medical imaging and the physician will assure continued patient access to quality office radiologic imaging. Physicians should be able to employ imaging personnel based upon an individual's training, skills, and experience. To require physicians to only employ imaging personnel with specific certification creates an unnecessary financial burden and a hardship in locating and employing individuals to perform necessary imaging, especially in underserved areas; thus, preventing or delaying patients from receiving needed healthcare services. (1977) (2016 COD)
Immunization Exemptions

See Also

- Clinical Recommendations
- Payment, Physician
- Immunizations

The American Academy of Family Physicians (AAFP) supports immunization of infants, children, adolescents and adults as defined by recommendations set forth in the Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices and approved by the AAFP. With the exception of policies which allow for refusal due to a documented allergy or medical contraindication, the AAFP does not support immunization exemption policies. (2015 September BOD) (2016 COD)
Immunizations

Access

The American Academy of Family Physicians (AAFP) endorses the concept that all children and adults, regardless of economic and insurance status, should have access to all immunizations recommended by the AAFP.

Cost of

The AAFP believes that the vaccine manufacturers and distributors should have payment policies that minimize the physicians’ financial risk involved in maintaining a vaccine inventory.

Government programs (e.g., Vaccines for Children (VFC), 317 Immunization Grants, or state “universal purchasing”) that subsidize the costs of vaccines at no cost to medical practices should be adequately funded by the federal and state government.

Requiring clinicians to stock separate supplies of vaccines for the VFC Program and for persons covered by other payers can be burdensome and adds unnecessary administrative costs to practices. Therefore, AAFP recommends that states allow physicians to intermingle storage of VFC and other vaccine supplies, with appropriate documentation and cost accounting.

Coverage of

The AAFP believes that all public and private insurers should include as a covered benefit immunizations recommended by the AAFP without co-payments or deductibles.

Distribution

The AAFP believes that the ultimate goal is to have vaccine manufacturers and distributors deliver adequate, timely, and complete orders of immunizations recommended by the AAFP to family physicians in a prioritized manner to most effectively achieve vaccination of patients within their medical home.

Medical Home

AAFP strongly recommends that patients receive all immunizations recommended by the AAFP in their medical home. When recommended vaccines are provided outside of the medical home all pertinent vaccine related information should be provided to the patient’s medical home.

Payment of

Where medical practices incur a cost for vaccines, the AAFP calls for adequate payment for the vaccine itself and all associated overhead costs (i.e., acquisition, storage, inventory, insurance, spoilage/wastage, etc.) of all immunizations recommended by the AAFP and their administration with no patient cost-sharing, as well as covering an evaluation and management (E/M) service during the same visit, when a significant and separately identifiable E/M service is provided and documented.
Supply

The AAFP believes that vaccine manufacturers should develop contingency plans for the timing and prioritization of vaccine supplies if an ample supply of the immunizations recommended by the AAFP is delayed and/or reduced.

Impaired and Clinically Deficient Physicians

SEE ALSO

- Marijuana

The AAFP defines a physician as impaired when (s)he is unable to exercise prudent medical judgment and/or is unable to practice with reasonable skill and safety without jeopardy to patient care. This may be due to factors such as medical illness, alcoholism or other forms of substance abuse, mental illness, and/or behavioral disorders. In some instances, such factors may be substantially alleviated by treatment. A diagnosis alone of a mental illness is not a proxy for impairment.

The AAFP defines a physician as clinically deficient when (s)he does not exercise prudent medical judgment and/or is unable to practice with reasonable skill and safety without jeopardy to patient care. When the physician behavior is not egregious these factors may, in some instances, be alleviated through education and/or behavioral modification.

AAFP members who are participating in educational, treatment and/or behavioral modification programs for impaired or clinically deficient physicians will be supported by the AAFP and not be excluded from membership solely because of their participation in such programs. This policy does not prevent restriction or revocation of AAFP membership and its privileges if the member fails to meet membership requirements as specified in the Bylaws. The AAFP supports state and local medical society efforts to provide programs and resources (e.g., referral services, support groups) for impaired and clinically deficient physicians. (1987) (2016 COD)
Independent Physician Associations (IPAs)

Definition

An independent physician association (IPA) is a business entity organized and owned by a network of independent physician practices for the purpose of reducing overhead or pursuing business ventures such as contracts with employers, accountable care organizations (ACO) and/or managed care organizations (MCOs). There are substantial opportunities for innovation in delivery system modeling and benefit design in the creation of physician networks. Specifically, creation of practice networks involving patient-centered medical home (PCMH) practices may accelerate important and necessary changes in health care delivery.

Introduction

The core business of family physicians is managing the care of patients. Patients value their relationship with their primary care physician above any other in the system. Patients also look for PCMHs led by physicians. This relationship, expertise, and training make physicians an indispensable resource in the health care system and provides them a point-of-difference in the healthcare marketplace. Physicians are exercising their market leverage through a variety of contracting and affiliation strategies which allow a group of physicians to speak with one voice. Such strategies also enhance physicians' access to the capital and management resources necessary to pursue cooperative business ventures such as managed care contracts and direct health care services contracts with employers.

Purchasers of health care services are more likely to sign contracts with larger groups of physicians who can provide comprehensive services, within a specialty or in a specific geographic area, demonstrate high quality outcomes, assume risk, and provide unique, innovative, or collaborative health care services. These services include comprehensive care of chronic medical conditions that benefit from collaboration among multiple entities such as specialty practices, imaging centers, home health agencies, and hospital systems working as a network. Such networks have and will likely continue to develop with different presence in different markets. Those IPAs capable of controlling medical expense for large numbers of patients and assuming full risk capitation can exercise maximal control in the current environment. Partial risk sharing, however, is more likely to be available to many IPAs. Optimally functioning IPAs can offer many potential benefits, including:

- Appropriate alignment of physicians' financial incentives
- Efficiencies in practice administration and management
- Political influence within the medical and wider provider community
- Peer support
- Optimized facilities
- Enhanced ability to negotiate favorable contracts with other entities such as MCOs, ACOs, radiology, laboratory, and hospital systems
- Autonomy and local financial and care management control in managed care
- Improved services, including, expanded hours, urgent care, outreach services for prevention, telephone triage, and follow-up expertise

Physicians considering the development of, or participation in, an IPA should be aware of the potential risks. This is especially true when the IPA accepts significant risk for healthcare expenditures. These risks include:

See also

- Payment, Physician
Underfunded capitation revenue, with risk of significant losses and/or bankruptcy
The trend of payers to decrease their payments to the IPA
Conflicts of interest for the physician between financial gain and optimal care for the patient
Restrictions on collective bargaining by physicians from the Federal Trade Commission and Department of Justice
Significant alienation between primary care physicians and contracted limited specialists

Physicians contemplating the development of, or participation in, an IPA should consider the following guiding principles:

**Guiding Principles**

1. IPAs should organize a health care delivery system which produces optimal health outcomes for patients.
2. IPAs should promote efficiency and effectiveness in the delivery of health care to patients that produces value. The financial benefits that result from this improved care efficiency and effectiveness should go to those who provided the improved care.
3. Family physicians should utilize their unique skills and expertise in care management, in management of the interface between specialists and hospitals, and in their focus on preventive health to create value.
4. Effective management of relationships between primary care physicians, limited specialists, and hospitals is critical to the optimal care of patients, to the success of an IPA, and to the satisfaction of physician participants.
5. An IPA must be able to demonstrate their incremental value to obtain contracts with health plans and other payers for covered lives.
6. Network physicians must have clinical autonomy and assume clinical accountability to optimize an IPAs value.
7. The unique partnership embodied in the doctor/patient relationship must be preserved.
8. Physician equity in IPAs is a critical issue for maintenance of desired degrees of control and autonomy and must be carefully considered by IPA physician participants. These principles may be valuable for physician education and for incorporation into IPA vision and mission statements.

Information Technology Used in Health Care

See also

- Electronic Health Records
- Data Stewardship

The American Academy of Family Physicians recommends that Congress:

- Use federal incentives to support a system of “Connected Patient Centered Medical Homes,” electronically networking patients with their family physicians and other medical-home providers in communities throughout the U.S. It is time to recognize that over 80 percent of health care is delivered in doctors’ offices, and to apply modern HIT in those settings.
- Provide differential payments to physicians who can demonstrate that they use Electronic Medical Records (EMRs) for care coordination, disease management, referrals, e-prescribing, and for communications with patients and other doctors. This means positive incentives for physicians who provide these services, but does not mean taking away money for those who do not yet have an HIT system.
- Target federal financial support for HIT to physicians who are serving the underserved or those at risk for health disparities. These vulnerable populations would benefit particularly from a system of connected patient centered medical homes.
- Support private sector efforts to apply broad computer and communications standards for portability and interoperability to health information exchange. While a long-term goal has been to establish a National Health Infrastructure, this goal could be accomplished in a more simple and efficient way by using the Internet.
- Ensure privacy protections apply to all parties who store, organize, manage, and transfer patients’ personal health information, not only to HIPAA-covered entities. (2007) (2012 COD)
Infringement on Patient Physician Relationship

See Also

- Confidentiality, Physician/Patient

A confidential relationship between patient and physician is essential for the free exchange of information necessary for sound medical care. Only in a setting of trust can a patient share the private feelings and medical, social and family histories that enable the physician to properly counsel, prevent, diagnose, and treat.

The AAFP opposes legislation that infringes on the content or breadth of information exchanged within the patient physician relationship because of the potential harm it can cause to the health of the individual, family and community.

Physicians should be free to have open and honest communication with patients about all aspects of health and safety. Physicians should be able to gather any information that can impact the health of their patients and their patients’ families.

(2011 COD) (2016 COD)
Integrative Medicine

See also

- Ethics and Advance Planning for End-of-Life Care
- Integrative Medicine, Credit for CME Activities

The AAFP believes that physicians can best serve their patients by recognizing and acknowledging the availability of integrative medicine in their communities. The AAFP advocates for the evidence-based evaluations of integrative medicine (also referred to as complementary and alternative medicine (CAM) treatments and practices, using scientific and ethnographic methods, including quantitative and qualitative outcomes research of efficacy and effectiveness. When examining integrative medicine methods from different traditions, considerations for cultural perspectives and explanatory models should be made during the design and conduct of the research and for the interpretation of results.

Furthermore, family physicians can pursue education relative to non-conventional methods of healing to better facilitate appropriate education, treatment and counseling of patients and consumers. (1997) (2014 COD)
Integrative Medicine, Credit for CME Activities

The American Academy of Family Physicians (AAFP) maintains there is value in providing information about integrative medicine (also referred to as complementary and alternative practices and other terms) to help family physicians respond to patients who use these therapies and who would consider using them. Family physicians need to understand new medical practices and products including integrative approaches to effectively counsel patients, understand potential drug or treatment interactions, and better evaluate patient outcomes.

Continuing Medical Education (CME) activities that include information about integrative medicine must meet all existing AAFP CME Credit Eligibility Requirements. Among these is the requirement that clinical content that is not considered to be evidence-based or customary and generally accepted medical practice must be deemed neither dangerous nor proven ineffective by the Commission on Continuing Professional Development (COCPD). The COCPD relies on its collective clinical expertise, as well as findings (meta-analyses or systematic reviews) reported by sources it deems acceptable. The COCPD considers diagnostic and therapeutic interventions in which the risks substantially outweigh the benefits to patients to meet the definition of "dangerous."

In cases where educational, ethical, and medical standards are not adhered to, or where the criteria for CME credit are not met to the satisfaction of the COCPD, the COCPD reserves the right to withhold CME credit. (B1998) (2014 COD)
Integration of Primary Care and Public Health (Position Paper)

Introduction

No one can discount the fragmented, broken US healthcare system, plagued with titles such as having the highest per capita investment in health care of any nation in the world yet ranking consistently low in quality measures compared to other industrialized nations. Efforts at reinvigorating the system have been focused on integrated, high-value health care that places Family Medicine within the Primary Care specialties as an important solution to the health care crisis. For it is “one of the first objectives for family physicians to understand the living conditions patients face when they leave our office or when they leave the hospital.” This is paralleled with a growing awareness of the social, environmental, and community determinants of health. However, for successful broad system change, Family Medicine within the Primary Care specialties must co-align with the public health sector, two fields with a common interest yet functioning independently for the last century.

The focus on population health management further touted within the Affordable Care Act (ACA), the development of new care models such as accountable care organizations (ACOs), and the patient-centered medical home (PCMH) recognize that individual health is inseparable from the health of the larger community which, working up the ladder, ultimately determines the overall health of the nation. To better align these individual and community forces, primary care and public health needs to reconnect. Ongoing efforts at integration with the IOM’s Primary Care: America’s Health in a New Era and The Future of the Public’s Health in the 21st Century developed momentum that led to the most recent release of the IOM’s Primary Care and Public Health: Exploring Integration to Improve Population Health, demonstrating successful models of integration and the accountability looked for in ensuring quality patient care.

Many local, state-level, and national efforts and collaboratives have been developed to facilitate mechanisms for this integration to occur at all levels. Despite the call of the Folsom Report for community health service delivery to occur in 1967, primary care, as the foundation for an improved health care system, needs further transformation to deliver community health in the concept of an expanded primary care team which includes public health. This position paper discusses the need for integration, a call to action for members, a review of the changing landscape of health care delivery and payment structure as well as educational reforms needed to provide for this new type of physician, and provides academy members with critical resources to learn more and pave the way to integration.

Call to Action

The AAFP urges its members to become informed about the importance, the value, and the movement for integration of primary care and public health. The AAFP has developed a Workgroup within the Commission on Health of the Public and Science which has been monitoring and been seminally involved with the national efforts taking place on this front. Family physicians play a critical role in integration and can continue to contribute through inclusion of local, regional, state, and national public health partners within the medical neighborhood.
The AAFP also urges all national, state, federal, and private sector institutions to partner with primary care and public health partners to ensure a more integrated delivery system is provided to improve population health. Bold initiatives throughout the health sector and not simply from within primary care and public health are necessary for this integration to be successful.

Family physicians play a crucial role in these efforts. In order to meet these needs, the AAFP calls for action in the following areas:

- **Physician Level**
  - Understand the role public health has to play for you, your patients, and the community you serve
  - Demonstrate awareness of integration efforts between primary care and public health

- **Practice Level**
  - Redefining population based on the public health definition as geographic as opposed to a practice patient panel
  - Recognition and incorporation of the public health infrastructure into the medical neighborhood
  - Continuous collaboration and communication to with the public health infrastructure to operate as a continuous unit with a common goal

- **Leadership Level**
  - Facilitate collaboration and communication amongst health systems and public health organizations
  - Drive change within hospitals or health systems to partner with public health organizations

- **Educational Level**
  - Drive change within undergraduate and graduate medical education to ensure physicians of tomorrow are prepared for a more integrated system

Through these and other actions, the AAFP, its constituent chapters, and its individual members will be the bold champions of integration and meet the overall goals of promoting population health which translates itself to improving the health of the nation.

**The Changing Landscape**

The changing landscape of healthcare is such that two major reforms are concurrently ongoing. One of which is occurring on a larger scale both nationally and at the state level with mechanisms to deliver on the triple aim of improving quality and access while reducing costs. Some of this is being done through payment and insurance reform models and other ways through expansion of medical insurance coverage to simply get people into care. The other major reform that is occurring is possibly a byproduct of or a contributor to the larger scale change and is occurring at the practice level. Both are seeking similar aims and certainly many of the local/grassroots efforts are already demonstrating the integration of primary care and public health at these levels; however, for the integration effort to be successful, it must transcend all levels.

**Population Health**

“Population health” is a term frequently used in both healthcare and public health. It has been used to mean different things, depending on context and perspective. In order to assist AAFP members to understand population health, this definition defines population health from the perspective of the family physician.

Population health is “the health outcomes of a group of individuals, including the distribution of such outcomes within the group”\(^{18}\). The population being considered may vary based on an individual’s perspective and goals. For the family physician, the most obvious “group of individuals” is their patient panel. This is where most AAFP members focus their energies and where they often have the greatest
impact. Population health also includes the health status and outcomes of the larger communities to which the physician and patient belong. It is essential when caring for their patients that family physicians consider the factors beyond the walls of their practice that influence their patients’ health. The family physician must consider the social and physical environments in which their patients live and work in order to effectively improve health outcomes.

As the healthcare system works to integrate primary care and public health, family physicians and the patient centered medical home will have more opportunities to partner with community resources and advocate for policies and interventions in these communities aimed at influencing social determinants of health and improving health outcomes.

As noted, some of the push for integration of primary care and public health arises from the realignment in care design to focus on population health. Population health, as currently described throughout the literature, is defined as health outcomes of a group of individuals, including the distribution of outcomes within the defined group. Some question, however, whether this definition represents what we mean when we focus on population health and some of the confusion arises due to the disjointed definitions of what we mean by a population.

Public health agencies define populations based on residential location, stratified by demographic factors such as race, ethnicity, gender, age, language, disability, or disease status. When considering the appropriate delivery of community-oriented primary care and delivering the promise of community of solution, this definition stands out as most reasonable given the social, environmental, and community determinants of health are based on geographic neighborhoods. A shift to such a definition requires a large professional culture framework shift from the current medical definition of population as an aggregate of individuals for whom an individual health care entity has provided care to over a period of time. This definition has guided the medical profession to its current thinking which aligns with many of the quality standards (National Council on Quality Assurance’s Healthcare Effectiveness Data and Information Set (HEDIS), Center for Medicare/Medicaid Services, Accountable Care Organization (ACOs), etc.).

This distinction in definition and the difficulty with which to make this leap to the public health sector’s definition is shadowed by the change of delivering a service within medicine to delivering a commodity. Delivering a commodity within the context of a series of buyers and sellers defines a specific group of individuals with “haves” and “have nots” that have led to health inequities. With large scale changes in insurance coverage and changes in access, it will be that much more important to define geographically where the population sits and provides for much greater opportunities to align with public health on initiatives. Public health competencies and tools are crucial for this realignment that facilitate a better understanding of the needs of the population, prioritizing activities according to epidemiological, organizational, and economic trends. Furthermore, like nephrons each contributing to a piece of renal function, each medical home unit with its medical neighborhood within the same community can lead to improved health and wellness regionally and so on up to a national level. However, until our definition of population aligns, we will never align the individual and community forces that can best foster health for all.

Patient-Centered Medical Home (PCMH)

PCMH by its very definition provides care that is patient-centered, comprehensive, team based, coordinated, accessible, and focused on quality. Models such as the PCMH that promote the team approach to care are essential to a changing health landscape as they ensure whole person orientation, follow evidence-based guidelines, and are dedicated to continuous quality improvement (CQI). While the primary care unit serves as the foundation of the medical home, it is critical to acknowledge the countless individuals within the medical neighborhood that contribute to the patient and his/her family’s care. These can include specialist physicians, allied health workers, community resources, behavioral health workers and organizations, schools, educational organizations, volunteer organizations, governmental organization, and notably public health organizations.

The inclusion of public health in the medical neighborhood is an essential component of integration. However, it is critical that it be viewed as a seamless unit in care delivery and not an entity fully outside of
the medical home unit as this continues the legacy of silos of care delivery that has been ongoing. For it was this line of thought and concern about “turf” that led to the schism of the two fields at the turn of the 20th century. This also further perpetuates the importance of aligning population definitions amongst primary care and public health to ensure our goals are congruous. To deliver the promise of a “community of solution”16 and commitment of delivering community care, we must emphasize community-oriented primary care (COPC) which is based on the principles of epidemiology, primary care, preventive medicine, and health promotion that sustains the goal of integration as well as the goal of population health.24-26

**Medical Education Reform**

As the system and delivery models change with an emphasis on population health with primary care and public health integration, pipeline and workforce issues must also be adapted. This includes both changes to undergraduate and graduate medical curriculum as well as faculty development programs to ensure faculty of medical schools and residency programs are able to provide students with the tools needed. Despite integration of public health into medicine largely focusing on primary care and public health integration, the tools for population health are those needed by all physicians across specialties and therefore it is essential both at the undergraduate and graduate medical education level.

Traditional undergraduate medical education occurs in large, tertiary care academic institutions with the majority of rotations and experiences being hospital-based. Many schools are evaluating and uprooting this model, recognizing that teaching chronic care, preventive medicine, and including features of interdisciplinary education and demonstrating team-based care at the undergraduate medical education level does not occur best in the inpatient setting. Increased ambulatory experiences either through block or longitudinal experiences with students as patient advocates or care navigators are being developed.27-29

There are no current best-practices for models in the undergraduate level for what prepares students best for practice with population health focus other than those from Canada and Europe whose medical education systems differ from our own.30

As medical schools seek to review and evaluate current curricula, departments of Family Medicine are poised as leaders within the effort and are charged to play a critical role in this process. Many academic Family Medicine departments have implemented COPC curricula, population health teaching, preventive care programs, and community outreach within Family Medicine and Ambulatory clerkships that are likely to be the foundation for such educational transformation.

At the graduate medical education level with initiation of the Milestones requirements,31 the Center for Disease Control (CDC) has taken the lead at developing academic partnerships with organizations to facilitate integration as well as developing population health milestones to evaluate the feasibility and direction to incorporating these elements into residency education.32 With the integration of public health partnerships into the medical neighborhood and Family Medicine residencies’ inclusion of PCMH training, it should naturally follow that these elements will be portrayed in a curriculum to prepare our residents for practice settings with full integration. Furthermore, a standardized Milestones-based competency evaluation tool will ensure that residents are receiving comparable training across different residencies.

**Role of the Family Physician**

The current role of Family Physicians within the healthcare system inherently holds many of the characteristics needed for public health-primary care interface. While primary care activities such as preventive clinical practices, screening and early preventive intervention, early diagnosis and intervention, quality driven and evidence-based care, health promotion and health advocacy reinforce public health activities, public health activities such as population surveillance, disease control, health promotion and action based on determinants of health, injury prevention, and policy generation facilitate primary care’s ability to function within the system. Indeed, despite operating independently for decades, the overlap and contribution of each with a common goal of both individual and population health is great.
As is already the case, many Family Physicians are working with their local, regional, and state health departments and public health offices. While the care of the individual, the importance of the relationship, and the personal connection remains a central focus for the Family Physician, the practice transformation that follows core principles of the Patient-Centered Medical Home, the promise of delivering community-oriented primary care, and payment models based on targets and meaningful use are already altering the way we approach care for patient panels and more importantly communities. Some of the challenge for physicians and practices is limited resources for health educators, community health workers, and outreach services. With the public health sector already doing many of these things, it is imperative that practices connect to ensure they can dedicate personal resources to alternate areas and not duplicate this work that is already being done.

The role of the Family Physician in integration will be a large one as Family Medicine is poised to be the leadership specialty of the new culture of medicine. Health systems as well as educational institutions, tasked with providing and promoting community health will undoubtedly be looking to their primary care specialties for advice. These leadership roles must start, however, at the individual physician level and move up to the practice level. Each physician has a part to play at a personal level and being informed about integration, its importance, the value, and the successes is the first step. The comprehensive role of the Family Physician with integration occurs at the previously defined 4 levels within the system.

Prepared by the AAFP Integration of Primary Care and Public Health Work Group:
David T. O’Gurek, MD - Chair
Patricia Czapp, MD
Lucius Lampton, MD, FAAFP
Michelle Quiogue, MD, FAAFP
Ada Stewart, MD, FAAFP, AAHIVS

Special thanks to the AAFP Staff:
Julie Wood, MD, FAAFP
Jennifer Frost, MD
Bellinda Schoof
Melanie Bird, PhD
Kevin Kovach

And to the members of the 2014 AAFP Commission on Health of the Public and Science:
Steven Brown, MD, FAAFP - Chair
Robert "Chuck" Rich, MD, FAAFP

Resources

American Academy of Family Physicians Patient Care Resource
http://www.aafp.org/patient-care.html

An up to date repository of public health related information including clinical recommendations, immunizations, and public health issues within different areas of patient care and the scope of Family Medicine.

A Practical Playbook: Public Health. Primary Care. Together
https://practicalplaybook.org/(practicalplaybook.org)

A collaborative effort from the de Beaumont Foundation, Duke University, and the CDC that provides an overview of the principles of integration, the value of integration, stages and strategies for integration, and success stories and examples of clinical and community settings where integration efforts are already occurring.

Association of State and Territorial Health Officials (ASTHO)- Supported Primary Care and Public Health Collaborative
http://www.astho.org/Programs/Access/Primary-Care-and-Public-Health-Integration/(www.astho.org)

A national collaborative whose work is directed as advancing the Strategic Map for Integration of Primary Care and Public Health which was generated through the work of ASTHO, the IOM, and the CDC. Efforts have been focused on successes, value proposition, resources, measurements, communications, and workforce issues.

Center for Disease Control’s Primary Care Public Health Initiative
http://www.cdc.gov/primarycare/(www.cdc.gov)

Information regarding the CDC’s work in integration with educational resources as well as information on the CDC’s Milestones project for population health education.

Health Resources and Services Administration (HRSA) Primary Care Public Health Initiative

Information regarding HRSA’s work in integration with information on integration of oral and behavioral health issues into the effort.

References


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24. Longlett SK, Kruse JE, Wesley RM. Community-Oriented Primary Care:


(2015 COD)
Intimate Partner Violence

Intimate partner violence (IPV) describes patterns of behavior that involve harm by a current or former partner or spouse. IPV can involve physical and sexual assault, emotional or psychological mistreatment, threats and intimidation, economic abuse, and violation of individual rights. IPV occurs among heterosexual and same-sex couples and does not require sexual intimacy. All patients are at risk for IPV. However, family physicians should be aware of individual, relationship, community, and societal factors that increase the risk for experiencing IPV. Family physicians who provide ongoing care for patients and communities have a unique opportunity to help break the cycle of abuse by working with families and within their communities to prevent abuse. Family physicians should routinely screen female patients of childbearing age for IPV. Brief, validated IPV screening instruments exist to support identifying patients experiencing IPV in primary care settings. Systemic reviews of the literature suggest most patients welcome IPV screening, and no harm to patients has been demonstrated from randomized controlled trials of IPV screening. Primary care-based interventions, including referral to community resources, brief office-based counseling, and home visitation, have been shown to reduce future episodes of IPV and improve outcomes for patients screened for IPV. Family physicians should recognize that IPV does not exist in isolation, and be aware that trauma across the lifespan impacts the health of our patients and perpetuate cycles of abuse. Family physicians can teach or help to establish education in their communities on parenting and conflict resolution skills that promote respectful and peaceful personal relationships.

REFERENCES:


Joint Development of Clinical Practice Guidelines with Other Organizations

The AAFP advocates the development of explicit patient-centered clinical practice guidelines which focus on what should be done for patients rather than who should do it. When clinical practice guidelines address the issue of who should provide care, then recommendations for management, consultation, or referral should emphasize appropriate specific competencies, rather than a clinician's specialty designation. The AAFP may participate with other medical organizations in the development of clinical practice guidelines (also known as practice parameters or clinical policies) when the appropriate criteria are met. (1995) (July Board 2013)
Laboratories, Physician Office

See also

- Laboratory Technicians

The AAFP believes that all physicians whose practices include clinical laboratory procedures done in their offices should be encouraged to participate in a recognized laboratory accreditation program, the cornerstone of which should be an approved proficiency testing program. (1988) (2011 COD)
Laboratory Technicians

See also

- Laboratories, Physician Office

In hospitals and physicians offices, laboratory technicians with appropriate training, skills and experience perform a wide range of laboratory testing. Specifically, in the physician office laboratory, the laboratory technician works under the direct supervision of the physician, having been delegated the responsibility to perform requested laboratory procedures by the supervising physician. The technician may also assist the physician in providing necessary quality control measures on specified tests as required by law. The maintenance of this relationship between the laboratory technician and the physician will assure continued access by patients to quality office laboratory testing. (1977) (2013 COD)
Laetrile

Scientific evidence has shown that Laetrile has no place in a treatment regimen for cancer patients. (1977) (2013 COD)
Leadership Development

Family physicians, by virtue of their position and accepted responsibilities in their communities, are uniquely poised to assume positions of leadership to improve the lives of individual patients, communities, and the health care system.

The training of family physicians emphasizes communication skills, interdisciplinary teamwork, and systems-based approaches to patient-centered care. Family physicians are encouraged to use their problem-solving skills to advocate for health care solutions at local, state, national, and international levels.

The American Academy of Family Physicians (AAFP) is dedicated to the development, improvement and transformation of leadership skills for family physicians, family medicine residents, and interested medical students through all phases of education and practice. By providing an integrated and progressive leadership curriculum through a multidisciplinary approach, the AAFP will empower family physicians to become life-long leaders and advocates to improve patient care quality, safety, and access, and to establish the standards of excellence within health care.

Legislative Activities

See also

- AAFP Public Statements
- Political Action

The goals of the AAFP legislative activities are built on the desire to serve as patient advocates and to promote family medicine.

The Commission on Governmental Advocacy actively works on legislative and regulatory issues of importance to its members, their patients and their communities, analyzes proposed laws and regulations and recommends Academy policy for Board consideration. Specific legislative proposals that affect family physicians undergo systematic review by Academy staff.

Communications with legislators and officials regarding the Academy's viewpoint, should be arranged and orchestrated by Academy officers, commission members, chapter representatives, and Academy staff. In addition to addressing federal issues, the Academy, through its Commission on Governmental Advocacy, monitors state legislative activities and provides resources and legislative support to Academy chapters as appropriate.

The Academy's legislative goals are best achieved through Board, commission, and member involvement with support from Academy staff. The Academy's national and state legislative efforts are best achieved when a family physician acts as Academy spokesperson. (1975) (2013 COD)
Liaison Guidelines

Guidelines for liaison adopted in order to ensure the most productive use of AAFP resources are to determine that the liaison or joint project will:

1. Help meet the health needs of the nation
2. Further the cause of family medicine
3. Benefit the AAFP and its members
4. Utilize the special abilities of the family physician
5. Not duplicate the activities of other organizations
6. Provide for representation at no cost when possible
7. Provide for termination of liaison when mutual goals or objectives are achieved, and
8. Require regular monitoring to determine the activity's effectiveness in return for AAFP expenditures

Liaison is intercommunication established and maintained between the AAFP and other organizations or units within the AAFP for the purpose of coordination of activities and cooperation to attain common goals.

(B1977) (2013 COD)
The AAFP supports the concept of licensure and relicensure at the state level, as presently provided, and opposes the concept of such licensure on a federal level. The AAFP encourages states to engage in reciprocity compacts for physician licensing, especially to permit the use of telemedicine. (CGA) (1976) (2013 COD)
Licensure/ Relicensure, Definitions

See also

- Licensure
- Professional Competence Evaluation
- Certification/Maintenance of Recertification, Definitions
- Licensure, Restricting Physician Licensure

To avoid possible confusion which could result from the use of these terms, the AAFP adopted the following definitions.

Licensure

Licensure is the mechanism whereby a state grants permission to individuals to engage in the practice of medicine. The act of licensure in and of itself confers on the licensee certain legal rights and privileges. Likewise, eligibility to become and remain licensed is dependent on meeting specified standards and obligations established by the appropriate state entity.

Relicensure

Relicensure refers to that mechanism whereby a state establishes the fact that those who have been licensed previously are qualified to retain such license. The term relicensure suggests that initial licensure would be valid for a particular length of time at the expiration of which the licensee would have to meet specified qualifications in order to continue to hold such license in the future. (1976) (2013 COD)
Licensure, Restricting Physician Licensure

SEE ALSO:

- Licensure
- Licensure/Relicensure, Definitions

The AAFP opposes making participation in a health plan a condition of physician licensure. (July 2011 BOD) (2016 COD)
Linguistically Appropriate Health Care

See Also

- Culturally Sensitive Interpretive Services - AAFP Legislative Stance
- Diversity in the Workforce
- Diversity, Assuring Sensitivity to Diversity in AAFP Education Activities

The American Academy of Family Physicians urges its members to use the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to make their practices more culturally and linguistically accessible in order to satisfy the federal health care mandates for their practice type. (2008) (2013 COD)
Long-Acting Reversible Contraceptives

See also

- Over-the-Counter Oral Contraceptives
- Reproductive Decisions
- Women's Health Care
- Contraception Methods for Medicare Patients

The American Academy of Family Physicians support a policy of adequate payment for Long-Acting Reversible Contraceptives (LARC) for all women, both as a contraceptive option and as a treatment for dysfunctional bleeding. (2015 COD)
The Academy supports the development of a federal policy for long-term care, including respite care, nursing home care and home health care, which includes but is not limited to the following characteristics:

- The need for the care should be verified by a physician;
- The care should be under a case management system, with family physicians given the opportunity to coordinate or provide care;
- Peer Review Organizations or approved state utilization review organizations should review medical care for quality assurance;
- The evaluation of the patient should be physician directed;
- The measure providing expansion of benefits should include a provision addressing spousal impoverishment;
- Eligibility for the assistance should be based on a functional/cognitive capacity assessment rather than diagnosis;
- The policy should include both public and private financing; and
- Physician visits to residents in long-term care facilities should be paid based on the appropriateness of service rather than mandated federal guidelines.

Long-Term Care Facilities, Continuity and Coordination of Care

See also

- Continuity of Care, Definition
- Long-Term Care Facilities, Criteria for Medical Directors
- Long-Term Care
- Home Health Care
- Aging
- Elder Mistreatment
- Primary Care

The American Academy of Family Physicians (AAFP) supports the role of family physicians in providing care of their patients following admission to long-term, subacute or extended care facilities by continuing as attending physicians when reasonable, or by coordinating care with other practitioners. Care coordination practices incorporate the provision of non face-to-face services and processes that helps patients transition back into the community after hospital and nursing home stays. For example, these processes can include the timely transfer of medical information, communication with patients’ family members, and resumption of direct care upon patient care transition event. Family physicians are encouraged to continue to be advocates for their patients' well-being by promoting the highest quality of health care in such facilities. (1982) (2013 COD)
Long-Term Care Facilities, Criteria for Medical Directors

See also

- Long-Term Care Facilities, Continuity and Coordination of Care
- Long-Term Care
- Home Health Care
- Aging
- Primary Care

The American Academy of Family Physicians supports the continued requirement of a physician (M.D./D.O.) medical director in every long-term care facility. The AAFP believes that the family physician is ideally suited to serve as a medical director. (1984) (2013 COD)
Managed Care Reform

See also

- First Dollar Coverage for Preventive Care
- Patient-Centered Formularies

The American Academy of Family Physicians supports managed care reform that ensures patients receive clear information and fair treatment from their health plans and protects the primary care physician's ability to act as the patient's advocate.

Below are provisions that the American Academy of Family Physicians believes are essential to include when advocating for comprehensive managed care reform:

The Academy supports:

- A requirement that basic information about covered and excluded benefits, financial obligations, plan providers, experimental benefits and other important plan provisions be available to all plan enrollees in a uniform format that is easily readable;
- A requirement that plans have an internal and external appeals process enabling meaningful and prompt access for patients and their physicians;
- A requirement that plans have a prudent lay person standard enabling patients to secure emergency care out of plan without prior authorization (a requirement that is as strong as the standard established for Medicare beneficiaries in the Balanced Budget Act of 1997);
- A requirement that plans honor the right of each physician and other health care providers to communicate freely with all patients;
- A requirement that plans have a policy protecting physicians who advocate on behalf of their patients for needed medical benefits;
- An assurance that "medical necessity" decisions will be made by physicians who have knowledge of a patient's particular medical history and circumstances;
- A requirement that self-funded ERISA plans be held responsible for medical outcomes, as are other plans, within any given state;
- The modification of ERISA to allow injured patients to seek recovery in federal court for improper coverage denials; and meaningful liability caps in federal court which will ensure health plans recognize their responsibility to guarantee patients have timely access to needed medical care;
- A requirement that plans have a process to enable use of non-formulary drugs when they are medically indicated;
- The inclusion of family physicians in any definitions of women's and children's health care providers to ensure access to all qualified physicians;
- An accurate definition of primary care, consistent with the AAFP definitions of primary care and family medicine;
- A requirement that managed care entities must regularly update their list of participating providers every 30 days and make it available to physicians and patients;
- A requirement that managed care entities should furnish physicians with a fee schedule showing what they will be paid for services that will be provided by that physician under the plan when negotiating with the physician to become or continue as a healthcare provider under the managed care plan;
- Recognition of the importance of the Patient-Centered Medical Home (PCMH). Managed care plans should encourage patients to utilize a PCMH and provide a graduated payment for physicians who meet recognized criteria for providing such an entity.
- The use of a uniform provider contract template.
- First dollar coverage for preventive services by managed care plans.

Background
The American Academy of Family Physicians supports managed care reform that ensures patients receive clear information and fair treatment from their health plans and protects the primary care physician's ability to act as the patient's advocate.

The Academy has 120,900 members delivering medical and preventive care nationwide and in all U.S. territories. Patients make 200 million office visits to family physicians each year -- 79 million more than any other specialty. In fact, one out of every four office visits in America is to a family physician. Family physicians see one out of every five children to provide their health care, and one out of every four women for their health care. Family physicians focus on the whole person, as well as the entire family, and play a central role in helping patients navigate today's complex health care system.

The Academy is equally concerned that comprehensive managed care reform promote quality health care, instead of hindering it. Nearly 80 percent of Academy members accept patients from one or more managed care plans. It is essential that health care quality measures be based in science. The Academy is committed to evidence-based research and has created a $7.7 million research initiative over the next five years to fund office-based primary care research. The Academy has also established the Robert Graham Center for Policy Studies in Family Medicine and Primary Care(www.graham-center.org) in Washington, D.C., to inform its policy initiatives. (March 2001) (2012 COD)
Medical Use of

The AAFP recognizes that there is support for the medical use of marijuana but advocates that usage be based on high quality, patient-centered, evidence-based research and advocates for further studies into the use of medical marijuana and related compounds. The AAFP requests that the Food and Drug Administration change marijuana’s classification for the purpose of facilitating clinical research. This process should also ensure that funding be available for such research.

The AAFP also recognizes that some states have passed laws approving the medical use of marijuana; the AAFP does not endorse such laws. The AAFP encourages its members to be knowledgeable of the laws of their states and consult with their state medical boards for guidance regarding the use of medical marijuana.

Recreational Use of

The AAFP opposes the recreational use of marijuana, however supports decriminalization of the possession and personal use of marijuana. The AAFP recognizes that several states have passed laws approving limited recreational use or possession of marijuana and therefore advocates for further research into the overall safety and health effects of recreational use as well as the effects of those laws on patient and societal health.

Maternal/Child Care (Obstetrics/Perinatal Care)

See also

- Obstetrics Privileges
- Nurse Midwives, Certified
- Cesarean Delivery in Family Medicine (Position Paper)
- Ultrasonography (Position Paper)
- Hospital Use of Infant Formula in Breastfeeding Infants

Maternal/child care is a core discipline of the specialty of Family Medicine. The scope of practice for family physicians in maternity/child care may range from only managing medical problems during pregnancy, prenatal care only, or comprehensive care of low-risk pregnancy to comprehensive care of high-risk pregnancy, including performing cesarean deliveries. The American Academy of Family Physicians (AAFP) advocates that ALL Family Medicine residents receive basic maternal/child care training and that those residents who plan to practice the full scope of maternal/child care receive advanced training to include management of complications and surgical intervention.

The American Academy of Family Physicians further advocates the maternal/child care privileges should be based solely on the individual physician’s documented training and/or experience, demonstrated abilities, and current competence and not by specialty-specific designation alone. This may be accomplished by providing documentation of acceptable supervised training and experience during residency and/or fellowship training, or successful completion of an approved, recognized course when such exists. Family physicians should evaluate fellow family physicians in credentialing and privileging determinations.

Both the American Academy of Family Physicians and the American College of Obstetrics and Gynecology (ACOG), the two major organizations of physicians who provide maternal/child care in the United States, recognize that there are health care disparities for women in rural areas and that in some rural areas these disparities include critical access to maternal/child care. Women living in rural settings tend to lack insurance, have a lower income level, and often rely on Medicaid and Medicare; due to the distance and access to care, they must often travel farther and have a decrease in frequency of care than their counterparts living in urban settings. ACOG recognizes that in some rural settings family physicians provide 100% of obstetric care.

The AAFP affirms that it remains committed to its policy of access to quality health care for all Americans and its willingness to collaborate with governmental and private agencies as well as ACOG and other appropriate professional organizations to provide appropriate access to maternal/child care for all women wherever they reside.

The AAFP will employ the following strategies to accomplish this goal:

1. Aggressively promote and support family physicians to provide maternal/child care, especially in rural settings.
2. Promote excellence in basic maternal/child care training for all family medicine residents by family physicians.
4. Encourage the expansion of rural medicine and maternal/child care fellowships.
5. Advocate with ACOG for its active support of the joint AAFP-ACOG guidelines for specialty-neutral credentialing at the state and local levels.
6. Reinforce and expand current efforts to:
1. Promote maternal/child care by family physicians to the public.
2. Advocate for national tort reform and specifically for relief in maternal/child care critical access areas.
3. Aggressively assist family physicians who have appropriate training and demonstrated competence in obtaining and maintaining privileges in maternal/child care.
4. Encourage research in outcomes-based data in maternal/child care provided by family physicians.

References:


(1989 COD) (2016 September BOD)
Medicaid, Core Principles

The AAFP supports specifying the following principles regarding the Medicaid program:

- The federal share should be increased if Medicaid enrollment is increased by federal legislation;
- Payment for primary care services should be at least equal to Medicare's payment rate for those services when provided by a primary care physician;
- The patient-centered medical home model of care with appropriate payment for case management and chronic care coordination should be implemented broadly and should include collaboration between the physician's practice and Medicaid case management programs;
- A benefit profile should be required that includes first dollar coverage of preventive services;
- Cost-containment should be determined by evidence-based research;
- Medicaid programs should use a clear definition of medical necessity that is based on evidence;
- Medicaid should support health information exchange through adequate infrastructure investment and electronic medical records by means of adequate payment for electronic visits and related services;
- Pay for performance and other quality improvement activities should be rooted in evidence-based research;
- Current pharmaceutical benefits for dual eligibles should be maintained if those benefits cover more drug costs than Medicare does;
- Coverage of tobacco cessation counseling, pharmaceuticals and other assistive methods should be included;
- Coverage should be mandatory for pharmaceuticals, counseling and treatment for substance abuse, and oral and mental health measures;
- Federal financial participation in territorial assistance programs should be equitable;
- Medicaid programs should provide continuous eligibility for at least twelve months; and
- A clearly defined appeals process should facilitate fair and prompt resolution of disputed claims and administrative issues, e.g., determinations of meaningful use and pay-for-performance decisions.

In addition, Medicaid Managed Care Organizations should be held accountable for:

- Adequacy of primary care and specialist networks (especially with regard to the number of available physicians and geographic availability).
- Assignment of beneficiaries to a primary care physician who is geographically proximate.
- Assurance of continuity of care for Medicaid patients from the primary care physicians of their choice.
- Beneficiaries’ access to all allowable and covered services under federal and state law.

Medicaid Services

see Also

- Medicaid, Core Principles
- Medicare/Medicaid Abuses
- Peer Review

The AAFP encourages members to participate in discussions and decisions that promote both high quality care and maintenance of basic essential health services for Medicaid recipients.

Medicaid coverage should include a uniform basic range of services. Medicaid payment for services should be fair and adequate.

The Medicaid program should be revised to include provisions whereby the homeless and medically uninsurable are covered.

The AAFP endorses the principle that peer review systems and utilization review systems will promote uniform quality of care to Medicaid beneficiaries. (1983) (2013 COD)
Medical Identification

See also

- Emergency Medical Care
- Emergency Medical Services (EMS)

In an emergency situation better medical care is possible when knowledge of previous pertinent medical history, drug allergies, current medication and current medical problems are available. Therefore, the Academy recommends that all individuals who have medical conditions or require medications important to be known in emergencies carry medical identification and information on their person that is immediately available and readable to emergency personnel. Items such as alert bracelets or necklaces and wallet inserts provide immediate access to vital information for first responders in the field. Thumb drives on key chains and patient portals accessible by cell phones provide more detailed background information to clinicians in the hospital or emergency department environment. (1973) (2013 COD)
Medical Home

SEE ALSO

- Role Definition of Family Medicine
- Home Health Care
- Definition of Family Medicine
- Co-Payments
- Continuity of Care, Definition of
- Workforce Reform

The American Academy of Family Physicians defines a medical home as one that is based on the Joint Principles of the Patient-Centered Medical Home (PCMH) and the five key functions of the Comprehensive Primary Care Plus (CPC+) initiative. These key functions are:

1. Access and Continuity
   Medical homes optimize continuity and timely, 24/7 first contact access care supported by the medical record. Practices track continuity of care by physician or panel.

2. Planned Care and Population Health
   Medical homes proactively assess their patients to determine their needs and provide appropriate and timely chronic and preventive care, including medication management and review. Physicians develop a personalized plan of care for high-risk patients and use team-based approaches to meet patient needs efficiently.

3. Care Management
   Medical homes empanel and risk stratify their whole practice population and implement care management for patients with high needs. Care management has benefits for all patients, but patients with serious or multiple medical conditions benefit more significantly due to their needs for extra support to ensure they are getting the medical care and/or medications they need.

4. Patient and Caregiver Engagement
   Medical homes engage patients and their families in decision-making in all aspects of care. Such practices also integrate into their usual care both culturally competent self-management support and the use of decision aids for preference sensitive conditions.

5. Comprehensiveness and Coordination
   Primary care is the first point of contact for many patients, and therefore is the center of patients' experiences with health care. As a result, primary care is best positioned to coordinate care across settings and among physicians in most cases. Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange.

The functions of a medical home depend on the support of enhanced and prospective accountable payments, continuous quality improvement driven by data, and optimal use of health information technology. (May Board 2008) (March 2017 BOD)
Medical Necessity for the Hospitalization of the Abused and Neglected Child

See also

- Child Abuse
- Adolescents, Protecting: Ensuring Access to Care and Reporting Sexual Activity and Abuse (Position Paper)

The family physician has a moral, ethical, and legal obligation to diagnose, treat, and protect a child suspected of being abused and/or neglected. The child requires a prompt evaluation in a protective environment where knowledgeable consultants are readily available. In communities without specialized services and/or facilities for the management of such children, inpatient hospitalization is an appropriate setting for their initial management. Medical, psychosocial and legal concerns may be assessed expeditiously while the child is housed in a safe environment awaiting final disposition by child protective services. The AAFP recommends that the hospitalization of children suspected of or being abused and/or neglected should be viewed as medically necessary by both health professionals and third-party payors. Financial concerns must not impede medical judgment, and third party payers have an ethical responsibility to cover such admissions. (1998) (2012 COD)
Medical Schools, Minority and Women Representation In Medicine

See also

- Diversity in the Workforce
- Diversity, Assuring Sensitivity to Diversity in AAFP Education Activities
- Equal Representation of Women in Family Medicine
- Equal Opportunity
- Minority Students, Family Physicians as Role Models for
- Preceptorships

The AAFP endorses the goal of equitable representation for minorities and women as medical students, staff and faculty at U.S. medical institutions. The AAFP supports programs that have the goal of increasing the number of minority and women student applicants to medical schools, the number of qualified minority and women student admissions, and the number of minorities and women in leadership positions in academic medicine. The AAFP recommends that medical schools and academic health centers stimulate interest in medical careers among minorities and women through specific outreach programs.

The AAFP further recommends that academic health centers, and professional societies for physicians, have programs of leadership development both for minority and women physicians, and medical students. These programs should include mentorship opportunities. Current and expanded efforts to increase the training of minorities and women in medical research should be supported. (1996) (2014 COD)
Medical Schools, Service to Minority, Vulnerable and Underserved Populations

See also

- Medically Underserved
- National Minority Health Month
- Rural Practice: Graduate Medical Education for (Position Paper)
- Reporting on Residency Status of Patients
- Homelessness
- National Health Service Corps

Access to the health care system and the provision of health care services to disadvantaged, disenfranchised, minority, vulnerable and underserved populations are vital roles and obligations for the medical schools and medical teaching programs of the U.S.

The AAFP supports the inclusion of education on health care for minority, vulnerable and underserved populations in medical school curricula.

The AAFP supports the priority of encouraging U.S. medical school graduates to practice in rural and urban underserved communities.

The AAFP encourages medical student recruitment from rural, minority and underserved population areas.

The AAFP encourages family medicine residencies to recruit medical students from rural, minority and underserved populations.

The AAFP supports the expansion of the National Health Service Corps (NHSC) as an appropriate strategy to improve the health care of rural, minority and underserved populations.

The AAFP encourages the federal, state and local governments to support initiatives that result in medical students and residents selecting family medicine careers in rural, minority and underserved population areas. (2003) (2014 COD)
Medical Student Access to Electronic Medical Record (EMR)

See also

- Electronic Health Records

The AAFP encourages teaching hospitals and clinical clerkship sites to allow medical student access to patient electronic medical records. Adequate medical student training depends on a student's ability to access relevant information available to other members of the care team, to document findings, to communicate with other providers, and to reflect independent clinical reasoning.

In addition, the AAFP recognizes the independence of each teaching site to develop policies regarding student access to electronic medical records with the goals to protect patients, recognize different EMR capacities, comply with federal and payor regulations, reduce administrative burden and to ensure appropriate reimbursement. Such policies might include, but are not limited to:

1. Read-only access;
2. Special designations of medical student documentation in the EMR;
3. Medical student documentation outside the EMR;
4. Co-signature requirements;
5. Guidelines for acceptable parts of documentation by medical students and supervising physicians; and
6. Development of EMR safeguards and/or templates to ensure institutional policies are met.

(2012 COD) (2017 February Board Chair)
Medical Student Debt

See also

- Medical Student Debt Relief

The AAFP promotes the expansion of the workforce needed to ensure that all Americans have access to a primary care patient-centered medical home. Consequently, because the debt incurred by pursuing medical training (including leading up to, during and following medical school) serves as a barrier to choosing family medicine, the AAFP supports efforts that assist in reducing that debt burden. (2007) (2016 COD)
Medical Student Debt Relief

See also

- Family Medicine Department, Definition
- Rural Practice: Graduate Medical Education for (Position Paper)
- Student Choice of Family Medicine, Incentives for Increasing
- National Health Service Corps
- Rural Practice, Keeping Physicians in (Position Paper)
- Medical Student Debt

Medical student debt relief may be a significant contributing factor in family medicine career choice. The AAFP calls for expanded funding for federal loan programs targeted to support family medicine and primary care, allowing the deferment of interest and principal payments on medical student loans until after completion of postgraduate training and allowing the tax-deductibility of interest on principal payment for such loans. The AAFP recommends for the development of innovative programs that promote direct and indirect medical training debt relief for family medicine and primary care. (2006) (2016 COD)
Medical Waste Disposal in Non-Medical Settings

See also

- Home Health Care
- Patient Education

Home based health care can create medical waste that must be disposed of properly. It is hazardous to dispose of such waste with ordinary household refuse through the septic system or in any other potentially dangerous manner. This practice can lead to the inclusion of medical waste with municipal waste which eventually goes to landfills with the potential of ground water contamination. Such practices may pose a significant health risk to the public.

Medical Waste Definition: Medical waste is generally defined as any solid waste that includes but not limited to: soiled or blood soaked bandages, unused medications, discarded gloves, needles, swabs, syringes and other sharps.

Therefore, the AAFP supports:

1. Education about safe disposal of medical waste to the public,
2. Community based disposal programs that are readily available and affordable, and
3. Policies to encourage and programs that provide safe community disposal of medical waste from non-medical settings.

Medically Underserved

See also

- Community and Migrant Health Centers
- Migrant Health Care
- Criminalization of Medical Practice
- Essential Community Provider
- Health Benefits
- Homelessness
- Reporting on Residency Status of Patients
- Urban/Inner-City Training Program in Family Medicine
- Medical Schools, Service to Minority, Vulnerable and Underserved Populations
- National Health Service Corps

The American Academy of Family Physicians reaffirms its commitment to the medically underserved of this country and urges each and every one of its members to become involved personally in improving the health of people from minority and socioeconomically disadvantaged groups.

The Academy supports:

1. cooperation between local family physicians and community health centers;
2. promotion of health education in schools, faith-based organizations, and community groups;
3. continuation of beneficial programs, which serve to promote health and disease prevention;
4. simplified regulations and improved payment, which encourage the establishment and success of physician practices in underserved areas; and
5. development of programs which encourage the provision of services by physicians and other health care professionals in underserved areas.

Medicare/ Medicaid Abuses

See also

- Medicare Payment
- Medicaid Services
- Medicaid, Core Principles

The AAFP deplores abuses of Medicare/Medicaid or any health assistance programs by anyone. The AAFP urges and expects that due process be followed. (1976) (2014 COD)
Medicare Payment

See also

- Medicare/Medicaid Abuses
- Payment, Physician
- Payment, Non-Physician Providers

The AAFP calls for a realignment of Medicare payment to reflect more equitable payment for services provided by family physicians. With regard to payment for physicians' services under Medicare, the AAFP:

(a) Continues to oppose mandatory assignment for physicians under the Medicare program;

(b) Opposes the (limiting charge) program that unfairly limits the payment of nonparticipating physicians;

(c) Supports the need for Medicare beneficiaries to receive clear and understandable reports about the payments made, or not made, on their behalf, while avoiding potentially unsupportable phrases, such as "not medically necessary;"

(d) Supports the use of a single conversion factor, if a conversion factor exists, for all physician services under the Medicare Physician Fee Schedule, except for purposes to achieve specific public policy goals;

(e) Opposes expenditure targets in favor of a system based on the Medicare Economic Index or another fair representation of physicians' costs of delivering care;

(f) Supports practice expense relative value units (RVUs) that are based on the actual resources, both direct and indirect, which physicians use to provide services and that are adjusted in a timely and understandable manner;

(g) Supports work RVUs which appropriately value evaluation and management services relative to procedural services;

(h) Supports the elimination of all geographic adjustment factors from the Medicare Physician Fee Schedule except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in underserved areas);

(i) Supports additional payment models including, but not limited to, a per-patient per-month care management fee for family physician practices that function as a patient-centered medical home;

(j) Supports Medicare payment for physician services according to a Resource-Based Relative Value Scale (RBRVS) that supports primary care;

(k) Supports a performance bonus based on evidence-based performance measurement; and

(l) Supports development of alternative payment models to assure fair payment for primary care services.

(1973) (2016 COD)
Membership Designation

See also

- New Physician, Definition

AAFP Fellow

It is proper and ethical for an Academy member to indicate membership in the Academy by placing after the letters M.D. or D.O. the letters AAFP and term Fellow, American Academy of Family Physicians or FAAFP may be used when appropriate. (1971)

AAFP Member

The AAFP favors the inclusion for membership in the Academy of any duly-licensed physician in the practice of medicine who meets the AAFP membership requirements. (See Reprint No. 56, current AAFP membership classification chart, for detailed information on membership requirements.) (1973)

ABFM Diplomate

It is ethical and proper for AAFP members who are diplomates of the American Board of Family Medicine to use the designation "Diplomate, ABFM" or "DABFM" following name and degree designation. (1981)

(2014 COD)
Membership Evaluation, Discrimination in

See also

- Equal Opportunity

The AAFP opposes all discrimination in any form, including but not limited to, that on the basis of actual or perceived race, color, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, economic status, body habitus or national origin. (1968) (2015 COD)
Mental Health Care Services by Family Physicians (Position Paper)

See also

- Mental Health, Physician Responsibility
- Mental Health, Parity in Coverage for Patients

While psychiatric professionals are an essential element of the total health care continuum, the majority of patients with mental health issues will continue to access the health care system through primary care physicians. The desire of patients to receive treatment from their primary care physicians, or at least to have their primary care physicians more involved in their care, has been repeatedly documented. Improving mental health treatment requires enhancing the ability of the primary care physician to screen, treat and appropriately manage the psychiatric care given to patients. To achieve those goals, the AAFP advocates the following principles:

- The AAFP, working through the accredited residency programs, will continue to emphasize the importance of mental health care through clinical rotations in both inpatient and outpatient centers of psychiatric care and continued exposure to psychiatric diagnosis and management through the resident continuity clinic.
- The AAFP will continue to advocate for the maintenance and expansion of state, federal and private insurance funding for mental health care. This funding should include adequate funding for inmate mental health care as well as funding for the growing number of military veterans and their dependents requiring mental health services.
- The AAFP will continue to advocate for parity in payment to primary care physicians for the mental health care of our patients;
- The AAFP will advocate for the reduction of mental health care “carve outs,” recognizing that through the Patient Centered Medical Home and other models of care, primary care physicians are increasingly locating psychologists, psychiatric social workers and even psychiatrists in the primary care physician office to provide better access to psychiatric services to their patients. The AAFP will further advocate for payment mechanisms that allow adequate funding of mental health care provided in such collocated practices in order to assure its continued availability in the primary care physician office.
- The AAFP supports the development of new treatment strategies to improve the percentages of patients receiving adequate treatment and follow-up through both primary care and mental health specialty care providers.

Background

Mental health services are an essential element of the health care services continuum. Promotion of mental health and the diagnosis and treatment of mental illness in the individual and family context are integral components of family medicine.1,2

Through residency training and continuing medical education, family physicians are prepared to manage mental health problems in children, adolescents, and adults. The continuity of care inherent in family medicine makes early recognition of problems possible. Because family physicians treat the whole family, they are often better able to recognize problems and provide interventions in the family system. Family physicians are also able to treat individuals who would not access traditional mental health services because of the social stigma associated with mental illness.

Mental health issues are frequently unrecognized and even when diagnosed are often not treated adequately.3-9 Recognition and treatment of mental illness are significant issues for primary care physicians, who provide the majority of mental health care.10,11 In a recent national survey of mental...
health care, 18% of the surveyed population with and without a DSM-IV diagnosis of a mental health disorder sought treatment during a 12 month period, with 52% of those visits occurring in the general medical (all primary care) sector. Estimates are that 11% to 36% of primary care patients have a psychiatric disorder, with one recent survey of mental health conditions in urban family medicine practices revealing that over 40% of survey respondents met criteria for a mental health disorder.

Traditionally, managed care organizations have "carved out" mental health services from primary care and placed put them in the hands of separate mental health management organizations. These self-contained behavioral health companies usually contract only with psychiatrists and nonphysician mental health care providers. Managed care companies that use "carve-outs" exclude coverage for mental health treatment provided by the patients' personal physicians, often family physicians. The resulting fragmentation of services disrupts continuity of care and compromises the family physician's role as a cost-effective coordinator of the patient's health services—a disruption that is particularly unfortunate in the setting of the Patient Centered Medical Home. Because of comorbidities and the effect of mental health problems in generating or exacerbating physical symptoms, fragmentation of mental health treatment is particularly detrimental to patients' overall health.

Although primary care physicians are major providers of psychiatric care, they are discriminated against by payment mechanisms that create a disincentive to thorough and comprehensive mental health screening. The issue of appropriate payment is critical when national surveys reveal that the majority of both diagnosed and undiagnosed patients of a mental health disorder sought their care from general medical providers, with this trend greatest for those in traditionally underserved groups such as the elderly, various minorities, the poor and uninsured and those in rural areas. Denying or discounting payment to family physicians and other primary care physicians is, in fact, denying access to care for a significant percentage of patients.

More and more often, the poor and disadvantaged have limited access to traditional secondary sources of mental health care, with a resulting increase in demand for those services from primary care practices, hospitals and other institutions, which are sometimes inadequately prepared to provide that care. The reasons for that decline in mental health services are numerous, including but not limited to a decrease in state and federal funding for those services. The net effect has been a reduction in the resources available to provide mental health care to those in greatest need of it.

Prevalence and Cost of Mental Health Disorders

Psychiatric problems are a major health issue. In the United States, neuropsychiatric disorders have now surpassed other disorders such as cardiovascular diseases and malignant neoplasms as the number one cause of disability as expressed as disability-adjusted life years. According to the most recent data available, mental health expenditures in the United States, expressed as a percentage of total health care expenditures, were more than 6%. For the year, that amounted to a cost approaching $100 billion. Analysis of the sources of payment for those expenditures for the same year revealed that 10% of Medicaid funding and more than 20% of state and local funding was spent on mental health care. Suicide remains a significant cause of death and lost productive lives, with the most recent U.S. data (from 2007) showing that almost 35,000 people died that year from all forms of suicide.

Among adults, depression ranks as a significant cause of disease and disability, with a lifetime prevalence of over 16% and a 12 month prevalence at any time of 6% to 7%. When analyzed by sex, the 12 month prevalence of depression averages about 8% to 9% for women and 4% to 5% for men. Lifetime prevalence of depression is 70% greater for women than men. When depression is broken down into various degrees of severity, more than 30% of U.S. adult cases identified in 2007 are listed as being in a “severe” category. Approximately 52% of those adults received some form of treatment, with 38% receiving what was considered adequate treatment.

Similarly, anxiety disorder represents a significant cause of disease and disability among adults, with a 12
month prevalence of 18% in 2004. Twenty three percent of those affected patients were classified as having “severe” disorder.12

Approximately 37% of adults with anxiety disorder receive treatment in any 12 month period, with only 34% of those patients receiving adequate treatment.12

Depressive disorders of all types are found to have a lifetime prevalence of 11% of 13- to 18-year-olds, with 3% of those affected having “severe” disorder.23 The prevalence of depressive disorders at any one time is thought to be approximately 8%.23 As in adults, the prevalence of depression in girls age 13 to 17 is nearly 3 times as great as that in boys for the same age group.23 Anxiety disorders of all types occur with a lifetime prevalence of 25% of 13- to 18-year-olds, with approximately 5% to 6% of those affected classified as having “severe” disorder.23 Again, statistics for anxiety disorder in this age category show a significant female predominance.23

Two subgroup of adults have a higher-than-average prevalence of mental health disorder and deserve special mention. A higher-than-average number of U.S. military veterans of Operation Enduring Freedom (Afghanistan) and Operation Iraqi Freedom (Iraq) reported mental health problems, (11.3% and 19.1% respectively) compared with the entire population of post-deployment U.S. military veterans in the survey period.24 Thirty-five percent of Iraq veterans were reported to have accessed mental health services during the year after returning home.25 The suicide rate in this population was not appreciably higher than in the general population of post-deployment veterans, although certain subgroups (those veterans with selected mental health diagnoses) were observed to have a higher than normal rate.25 The other subgroup of U.S. adults with higher than average occurrence of mental health disorder is the U.S. inmate population. In data from surveys of inmates in state, federal and local jails, the 12 month occurrence of all mental health disorders was found to be 56%, 45% and 64% respectively.26,27 Fewer than 50% of the affected inmates ever received any treatment for their disorder.26,27

Information about mental health care delivered in physicians' offices is available through the National Ambulatory Medical Care Survey (NAMCS), conducted by the Centers for Disease Control and Prevention (CDC). According to 2008 data, the most recent available, an estimated 956 million visits were made to physician offices, of which 39,831,000, or 4%, were for psychiatric diagnoses.28 Based on an assumed need of 10%, there should have been almost 96 million psychiatric visits. The Surgeon General estimates that less than one third of adults with a diagnosable mental disorder receive treatment in one year. The National Mental Health Association (NMHA) states that only 49% of patients with clinical depression and 52% of patients with generalized anxiety disorder are receiving treatment.29

When considering the costs associated with mental illness, it is important to keep in mind that mental health problems have a significant impact on physical health. Research found that among elderly patients with high mean depressive scores, the risk of coronary heart disease increased 40% while the risk of death increased 60% compared with elderly patients with the lowest mean depressive scores.30 The risk of disability in persons with major depression is 4 1/2 times the risk in asymptomatic persons.4 The risk is 1 1/2 times greater in persons with minor symptoms of depression, although because of its greater prevalence minor depression resulted in 50% more days of disability. Patients with mental disorders have higher utilization rates for general medical services and higher related medical costs than patients without mental disorders.6

**Family Physician's Role in Diagnosis and Treatment**

In many respects family medicine represents the unification of the psychiatric and physical models of illness. Family medicine residency training includes clinical psychiatric rotations of one or more months in addition to mental health encounters generated by the continuity clinics. The Academy’s recommended curriculum for human behavior and mental health was developed in cooperation with the American Psychological Association. An element of that curriculum is “that the family medicine resident should have sensitivity to,
and knowledge of, the emotional aspects of organic illness. Family physicians must be able to recognize interrelationships among biologic, psychologic and social factors in all patients." In a survey of directors of primary care training programs (family medicine, internal medicine, pediatrics, OB/GYN), only family medicine directors felt that their programs were "optimal to extensive" in terms of adequacy of psychiatric training.31

Family physicians typically manage multiple symptoms and problems.3 A visit to a psychiatric professional typically lasts at least 30 minutes and is focused on a clearly defined issue.5 In contrast, primary care visits last an average of 13 minutes and include an average of six patient problems.4,5,11,32,33 Detecting and managing mental health problems must compete with other priorities such as treating an acute physical illness, monitoring chronic illness, providing preventive health services, and assessing compliance to standards of care.5,34

Another important distinction between psychiatric practices and family medicine practices is that while patients who present for psychiatric treatment usually have severe symptoms that leave little doubt about the diagnosis, patients in the family physician's office typically present with vague somatic complaints such as "fatigue," "feeling nervous," etc., without an established psychiatric diagnosis. Unlike the psychiatric professional whose patients accept the diagnosis and the need for treatment, the family physician has to identify mental health problems that are frequently obscured by patient reluctance to acknowledge the problem or by physical symptoms that mask the underlying problem.

The general reluctance of patients to seek care for mental health problems complicates the diagnosis of mental illness. Survey results show that 40% of patients with major depression do not want or perceive the need for treatment.11,32 Patients consistently underreport emotional issues to their physicians. One study found that only 20% to 30% of patients with emotional/psychologic issues reported these to their primary care physicians.4 Many patients somatize their psychologic issues. One in three patients who go to the emergency department with acute chest pain is suffering from either panic disorder or depression.13 Eighty percent of patients with depression present initially with physical symptoms such as pain or fatigue or worsening symptoms of a chronic medical illness.35 Although this type of presentation creates a challenge for family physicians, these patients are not likely to seek care through the mental health system.

The major cause of mortality from mental illness is suicide, which may occur before a patient seeks care for a mental health related symptom. More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, influenza, and chronic lung disease combined.36 For adults ages 18 to 65, suicide ranked number 4 of the top 10 causes of death from the most recent death certificate data available (2007).24 Screening for suicide risk and access to lethal means, even in apparently asymptomatic patients, is a critically important part of the family physician's role in reducing mortality and morbidity from mental illness.36

There is no evidence, however, that an improved level of diagnosis without a concomitant improvement in therapy is beneficial.9 Enhanced diagnostic accuracy must be connected to structured programs that provide effective treatment.35 Research indicates that improving the treatment of mental health issues in primary care requires properly organized treatment programs, regular patient follow-up, monitoring of treatment adherence, and the use of mental health specialists for the more severely ill.4

In one survey, 87.5% of family physicians indicated that it was their responsibility to treat depression, compared with 73% of general internists and 41% of obstetricians/gynecologists surveyed. Among family physicians, 35% were very confident and 48% were mostly confident about their overall ability to manage depression.33 However, although primary care physicians prescribe 41% of antidepressants, the requisite follow-up visits do not always occur per guidelines, with national survey data revealing a median number of visits for general medical providers of 1.7 versus 7.4 for mental health specialty providers for those patients receiving treatment during the 12 month survey period.12,37,38 Studies demonstrate that patients treated with antidepressant medication have a visit frequency far below that recommended in the guidelines issued...
Evidence indicates that optimal treatment of depression includes interpersonal psychotherapy. Family physicians routinely provide encouragement and supportive therapy to their patients, and some provide more formal psychotherapy. However, not every physician needs to be proficient in the provision of psychotherapy. Referral to psychiatric nurses, counselors, psychologists, or psychiatrists either attached to the practice or in other organizations is also appropriate. Whatever the mechanism, however, every physician has an obligation to ensure that patients are made aware of psychotherapy as an option and assisted in accessing it.

Family physicians recognize the importance of understanding the patient's values when providing mental health care. By incorporating an assessment of those values into the overall diagnosis and treatment plan, family physicians are able to improve patient acceptance of a diagnosis of a mental health disorder and improve compliance to a treatment plan tailored to the patient's understanding of that diagnosis.

Payment

Payment for office visits with a mental health diagnosis code has traditionally been discounted by Medicare for primary care. Many managed care plans do not pay family physicians for the provision of psychiatric care, even though family physicians are frequently in the position to diagnose and provide the care. While lack of payment is not the only reason for the documented failures in mental illness detection, the absence of payment has an impact on the lack of screening in primary care practices. This policy is also contradictory to the public's stated preference for care. A survey conducted for the NMHA indicated that 72% of diagnosed patients and 61% of symptomatic but undiagnosed people want greater involvement of their primary care physician in their treatment. This not only reflects the level of rapport between patients and family physicians, but it is also indicative of the level of apprehension caused by the potential stigma attached to mental illness and to accessing the formal mental health system.

Because of patient desires to avoid the stigma of mental illness or because of payment issues, many family physicians have reported or coded the symptoms of mental illness rather than documenting the actual diagnosis. Failure to diagnose properly, whether a function of uncertainty or sensitivity to patient concerns or insurance coverage, has been estimated to range from 45% to 90%. It does appear, however, that family physicians address mental health problems more frequently than it appears from either billing or medical records.

Prevailing payment structures are not only an impediment to the family physician's ability to maintain continuity of care but can result in greater overall health care costs. Recognition and management of mental health problems reduce the inappropriate use of medical and surgical care, thus reducing health care costs.

This is an issue of particular significance for employers who require optimal employee productivity. According to the Kaiser Family Foundation Employer Health Benefits 2000 Survey, over the past several years there has been an appreciable decline in the level of mental health coverage provided by employers. Sharp decreases have occurred in the percentage of workers with unlimited outpatient mental health visits, and most plans also limit the number of inpatient mental health days. These payment limitations have an effect on the patient's ability to access mental health care. The American Academy of Family Physicians supports parity of health insurance coverage for patients, regardless of medical or mental health diagnosis. Health care plans should cover mental health care under the same terms and conditions as those governing coverage of other medical care.

Conclusion

While psychiatric professionals are an essential element of the total health care continuum, the majority of patients with mental health issues will continue to access the health care system through primary care.
The desire of patients to receive treatment from their primary care physicians, or at least to have their primary care physicians more involved in their care has been repeatedly documented. Improving mental health treatment requires enhancing the ability of the primary care physician to treat and be appropriately paid for that care. Payment mechanisms should recognize the importance of the primary care physician in the treatment of mental illness as well as the significant issues of comorbidity that require nonpsychiatric care.

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(2001) (2011 COD)
Mental Health, Parity in Coverage for Patients

See also

- Mental Health, Physician Responsibility
- Mental Health Care Services by Family Physicians (Position Paper)

The AAFP supports parity of health insurance coverage for patients, regardless of medical or mental health diagnosis. Health care plans should cover mental health care under the same terms and conditions as that provided for other medical care. (1998) (2014 COD)
Mental Health, Physician Responsibility

See also

- Mental Health, Parity in Coverage for Patients
- Mental Health Care Services by Family Physicians (Position Paper)

Family physicians have traditionally focused on treating the whole patient, and recognize the mind, body and spirit connection. Promotion of mental health, diagnosis and treatment of mental illness in the individual and family context are integral components of family medicine.

Family physicians are uniquely positioned to recognize and treat problems in the continuum from mental health to mental illness. Through residency training and continuing medical education family physicians are prepared to manage mental health problems in children, adolescents, and adults of all ages. The continuity of care inherent in most family medicine settings makes early recognition of problems possible. Treating family members allows better recognition of problems as well as intervention in the family system. Family physicians are able to treat those individuals who would not access traditional mental health services because of the perceived stigma of mental illness. Consultation with and referral to other specialties as appropriate is a part of family medicine in regard to mental health/illness as it is in all other areas of patient care.

Reduction in the availability of behavioral health providers, expansion of treatment options via the patient centered medical home, improved pharmacologic treatments and care guidelines, combine to make the treatment of mental illness in the family physicians office more practical, necessary and appropriate.

Family physicians can draw the clinical practices of medical care and behavioral health closer together by supporting team-based specialist, and likewise, supporting behavioral health practices that include family physicians. This “bi-directional” care coordinates medical and behavioral health services for the benefit of patients.

Family physicians can support appropriate public mental health policy, and when possible support and coordinate with other organizations to promote better mental health services for those with mental illness. These efforts include prevention of mortality through early intervention and appropriate and timely treatment, and prevention of mortality through careful use of medications and suicide prevention. (1982) (2012 COD)
Mercury in Food as a Human Health Hazard

The AAFP supports the continued testing and reporting levels of mercury in seafood by appropriate local, state, and national agencies. Family physicians are encouraged to be knowledgeable about, and tell their patients of, the dangers and benefits of eating various types of freshwater and ocean seafood. In particular, the developing fetus and young child are at greater risk of harm from significant mercury exposure. Family physicians are in a position to recommend healthy choices regarding various types of seafood, including that which is caught and sold locally. Consumption guidelines for various populations, particularly pregnant and breastfeeding women, as well as children and adults, should be made readily available in a consumer-friendly format by the Environmental Protection Agency and/or the Food and Drug Administration and should point out the relative mercury content of various species, in order to maximize benefit and minimize risk of consuming seafood. (2007) (2012 COD)
Migrant Health Care

See also

- Community and Migrant Health Centers
- Criminalization of Medical Practice
- Criminalization of the Provision of Medical Care to Undocumented Individuals
- Essential Community Provider
- Medically Underserved

The AAFP believes that physicians and the public should be educated about health care problems of seasonal/migrant workers and encourages involvement by family physicians in identifying and addressing issues which impact the health status of migrant and seasonal workers. (1980) (2013 COD)
Military Service, Physicians' Draft

The American Academy of Family Physicians is opposed to a separate physician draft and believes that instead of instituting such a draft, various alternatives for physician recruitment into the armed services should be vigorously pursued.

If a military service draft is instituted to mobilize the citizens for the defense of the United States, the AAFP favors local administration under explicit federal regulations of a general draft that uses human resources efficiently and respects the dignity of the individual as much as possible, while addressing the public need. (1980) (2013 COD)
Minority Students, Family Physicians as Role Models for

See also

- Resident and Student Education, Discrimination In
- Medical Schools, Minority and Women Representation in Medicine

The American Academy of Family Physicians is concerned about the underrepresentation of minority groups in medicine. The impetus to become a physician may be made early in a child's life; possibly as a result of a significant contact with his or her family physician. As community leaders and ambassadors of the profession, family physicians, therefore, have a responsibility to be positive role models and advocate for family medicine. It is incumbent upon the AAFP members to take an active interest in the educational aspirations of their young patients, especially populations underrepresented in medicine, and work personally in helping young people shape their career goals in family medicine. Further, the AAFP encourages family medicine residencies to incorporate into their outreach activities efforts to engage and expose youth in their community, especially those from minority populations, to the challenges and rewards of family medicine. (1985) (2014 COD)
Motor Vehicle Occupant Protection

See also

- Don't Text and Drive Initiative
- Driver Education
- Graduated Driver's License
- Motorcycle and Bicycle Helmet Laws
- Motorized Recreational Vehicles

The American Academy of Family Physicians strongly endorses the appropriate use of seat restraints by all occupants -- children and adults -- of motor vehicles, and encourages its members to take an active role in developing strategies to promote increased use and availability of restraint systems including air bags. The American Academy of Family Physicians supports primary enforcement of occupant restraint system legislation. (1983) (2014 COD)
Motorcycle and Bicycle Helmet Laws

See also

- Protective Equipment for Recreational and Competitive Sports Activities
- Motor Vehicle Occupant Protection

The American Academy of Family Physicians endorses the concept of legislative measures to require the use of helmets when riding or driving a motorcycle or bicycle, and the AAFP urges constituent chapters to support the enactment of or preservation of state motorcycle and bicycle helmet laws. (1981) (2013 COD)
Motorized Recreational Vehicles

See also

- Motor Vehicle Occupant Protection
- Motorcycle and Bicycle Helmet Laws
- Protective Equipment for Recreational and Competitive Sports Activities

The Academy recommends that family physicians become well educated with the potential dangers associated with the use of motorized recreational vehicles (including mini-bikes, all terrain vehicles, snowmobiles and personal watercraft) and advise patients about their safe use including information about appropriateness for developmental age. The AAFP also supports the development of laws establishing speed limits, separation of motorized recreational vehicles from non-motorized vehicles or pedestrians and prohibiting the operation of such vehicles while under the influence of alcohol or other mind-altering drugs. (1973) (2013 COD)
The AAFP:
(a) supports the objectives of the National Health Care Corps and will remain in productive communication with the Corps leadership;
(b) assists the Corps in making information available to family medicine residents regarding practice opportunities and benefits in the Corps;
(c) if requested by the Corps, will assist in identifying communities in need of additional primary care physicians; and 
(d) supports both the loan and scholarship programs of the National Health Service Corps, with emphasis on the loan repayment program. (1974) (2013 COD)

The American Academy of Family Physicians advocates for reauthorization and appropriate funding of the National Health Service Corps (NHSC) and for reinstatement of the goal of full funding for the training of the health workforce and zero disparities in health care due to race, class, income, geography, language, or immigration status. (2002) (July 2013 Board)
National Minority Health Month

See also

- Community and Migrant Health Centers
- Medical Schools, Service to Minority, Vulnerable and Underserved Populations

The American Academy of Family Physicians recognizes April as National Minority Health Month, an opportunity to promote improved health in minority populations and to promote interest in family medicine.

Naturopathic Practice

See also

- Non-Physician Providers, Family Physician Training With

The American Academy of Family Physicians (AAFP) opposes licensure of naturopaths. Naturopathic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been accepted widely by the scientific community. Moreover, the scope and quality of naturopathic education do not prepare the practitioner to properly and accurately diagnose illness or provide appropriate treatment. Governmental endorsement of naturopaths through licensure will jeopardize the health and safety of patients.

In those states that permit licensure of naturopaths, the AAFP opposes any expansion of naturopaths’ scope of practice that is not supported by naturopathic education and training. The AAFP believes that naturopathic education and training do not prepare naturopaths to safely or effectively prescribe medications, perform physicals for school or employment, or perform surgical procedures.

A naturopath must not be allowed, under any circumstances, to use the title "physician," nor should a naturopath ever be considered a "primary care physician."

Public and private payers must not be compelled or mandated to pay for naturopathic services.

The AAFP’s position is that, like the training for all other providers offering health care services to patients, the training programs preparing naturopaths should be monitored constantly to assure the quality of the training provided. (2012 COD)
Needle Exchange Programs

The AAFP supports syringe service programs (SSPs)/needle exchange programs (NEPs) as an effective harm reduction strategy to prevent the spread of HIV, Hepatitis C, and Hepatitis B, as well as to engage individuals in treatment for substance use disorders. Such programs reduce the transmission of disease, do not increase the rate of substance use, and increase the likelihood that individuals will enter drug treatment programs. SSPs/NEPs may also provide additional health and preventive services to vulnerable and high risk populations. Physicians should be knowledgeable about their states' statutes regarding SSPs/NEPs, possession of syringes and needles, and available mechanisms for needle procurement. (July 2016 BOD) (2016 COD)
Neonatal Circumcision

See also

- Community and Migrant Health Centers
- Criminalization of Medical Practice
- Criminalization of the Provision of Medical Care to Undocumented Individuals

There are potential health benefits from neonatal circumcision. The evidence is strongest for the prevention of UTI in newborn males. The number needed to treat to prevent one UTI is about 140 and to prevent one hospitalization for UTI is 195. Circumcision also prevents penile cancer, but this is a rare disease (0.6/100,000), and the number needed to treat to prevent one case is approximately 300,000. In addition, about 1/3 of penile cancers are caused by human papilloma virus and may be prevented by HPV vaccine. There is also evidence that circumcision can prevent some other STDs, including the acquisition of HIV, but the evidence for this comes from studies of adult circumcision in Africa and may not be generalizable to neonatal circumcision in the U.S.

Circumcision can also result in complications. Acute complications can include bleeding (0.8-1.8/1,000), infection (6/10,000), and injury to the penis (4/10,000). Late complications can include incomplete circumcision, excessive skin removal, adhesions, meatal stenosis, phimosis, inclusion cysts. The rate at which these late complications occur is not well defined.

The potential health benefits from circumcision justify it being a covered medical service by third-party payers, and it should be an available service for those who desire it.

The decision whether to circumcise a newborn male is affected by parents’ values and beliefs and should be made by parents after a discussion of the benefits and harms. Family physicians should provide this information in an unbiased manner, and the parents’ decision should be respected.

Circumcision is preferably performed in the newborn period. When circumcision is performed, topical or local anesthesia techniques should be used to minimize newborn discomfort. (2013 COD)
New Physician, Definition

SEE ALSO

- Membership Designation

New physicians are defined as "those who completed residency or extended training immediately following residency seven years ago or less." (1991) (2015 COD)
Never Events and Hospital Acquired Conditions

The American Academy of Family Physicians (AAFP) strongly supports efforts to implement the best evidence-based guidelines to improve health care, including the ultimate goal of eliminating National Quality Forum (NQF) Never Events (NE) and Centers for Medicare and Medicaid Services (CMS) identified Hospital Acquired Conditions (HAC). While there is preliminary evidence that ideal systems of care can reduce or- in select cases- eliminate many of these events, there are substantial gaps in current evidence, systems of care, and scalable practices to conclude that all such outcomes are reasonably preventable. Moreover, there is little evidence linking payment denial with improved outcomes.

Therefore, the AAFP supports incentives for performance improvement including the implementation of robust systems to reduce reasonably preventable conditions. The AAFP recommends the development of standard definitions for NE and HAC along with non-punitive reporting frameworks, such as the Patient Safety Organizations sponsored by the Agency for Healthcare Research and Quality. In addition, the AAFP recommends further research to delineate evidence-based practices that address such conditions in an actionable and scalable fashion for both inpatient and ambulatory settings. (2010 COD) (2015 COD)
Non-Physician Providers, Family Physician Training With

See also

- Nurse Practitioners
- Team-Based Care
- Physician Assistants
- Ancillary Medical Personnel
- Guidelines on Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants
- Nurse Midwives, Certified
- Naturopathic Practice
- Payment, Non-Physician Providers

To prepare family medicine graduates to deliver the Quadruple Aim\(^1\) of improving the health of populations, enhancing the patient experience of care, reducing the per capita cost of health care, and improving the work life of clinicians and staff, it is necessary for residents to learn to share responsibility for care delivery as a part of high-functioning interprofessional teams. Residents should be trained together with a variety of other health care professionals. The types and numbers of other health professionals, both learners and practitioners, in the learning environment may vary based upon the local environment. They may include nurse practitioners, physician assistants, behavioral health specialists, nurses, pharmacists, care managers or coordinators, social workers, physical and occupational therapists, midwives, and others.

In this educational setting, there should be deliberate teaching and experiential learning about the roles, responsibilities, and potential contributions of each team member. Interprofessional education should be focused on four main competency domains\(^2\):

- Work with individuals of other professions to maintain a climate of mutual respect and shared values.
- Use the knowledge of one’s own role and those of other professions to appropriately assess and address the healthcare needs of the patients and populations served.
- Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease.
- Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient-/population-centered care that is safe, timely, efficient, effective, and equitable.

References:

Nuclear Disarmament

See also

- Disaster Planning
- Nuclear Waste Disposal
- Nuclear, Biological and Chemical (NBC) Warfare

The American Academy of Family Physicians support the elimination of nuclear weapons.

(2015 COD)
Nuclear, Biological and Chemical (NBC) Warfare

See also

- Disaster Planning
- Nuclear Waste Disposal
- Nuclear Disarmament

The American Academy of Family Physicians endorses the concept of worldwide, verifiable moratorium on testing, production and deployment of nuclear, biological, and chemical weapons.

Nuclear Waste Disposal

See also

- Nuclear, Biological and Chemical (NBC) Warfare
- Disaster Planning
- Nuclear Disarmament

The American Academy of Family Physicians supports safe handling, transportation, and storage of all nuclear waste. The AAFP also supports continued investigation and research to improve safety and efficiency of nuclear reactors and further limit possible exposure to nuclear waste materials. (2003) (2014 COD)
It is AAFP policy that the term "certified nurse midwife" should be reserved for those who undergo specific training programs following attainment of an R.N. license. Following licensure as a registered nurse, the nurse desiring to function as a certified nurse midwife should be certified rather than licensed as a certified nurse midwife.

The AAFP position is that certified nurse midwives should only function in an integrated practice arrangement under the direction and responsible supervision of a practicing, licensed physician qualified in maternity care.

It is AAFP policy that training programs preparing certified nurse midwives, like training programs for all health care providers, should be constantly monitored to assure the quality of training provided and that the number of graduates reflects demonstrated needs.

The Academy supports the concept of patient and third-party payment for services of certified nurse midwives where services are provided in an integrated practice arrangement. (1990) (2014 COD)
The AAFP position is that the term "nurse practitioner" should be reserved for those who undergo specific training programs following attainment of a Registered Nurse (R.N.) license. Following licensure as an R.N., the nurse desiring to function as a nurse practitioner should be certified rather than licensed as a nurse practitioner.

The nurse practitioner should not function as an independent health practitioner. The AAFP position is that the nurse practitioner should only function in an integrated practice arrangement under the direction and responsible supervision of a practicing, licensed physician. In no instance may duties be delegated to a nurse practitioner for which the supervising physician does not have the appropriate training, experience and demonstrated competence.

The AAFP position is that the training programs preparing nurse practitioners, like the training for all other health care providers, should be constantly monitored to assure the quality of training provided and that the number of graduates reflects demonstrated needs.

The AAFP supports the concept of patient and third-party payment for services of nurse practitioners only where services are provided in an integrated practice arrangement. (1984) (2014 COD)
Nursing Profession

See also

- Nurse Practitioners
- Nurse Midwives, Certified

The AAFP recognizes the valuable contributions of the nursing profession. We believe that physicians and nurses occupy interdependent roles in the delivery of quality, comprehensive health care. The discerning observations and contributions of nurses who provide direct patient care greatly enhance the knowledge and skills of physicians and enhance the quality of care provided to patients.

The AAFP continues to promote and support effective nurse/physicians interaction in clinical settings through policies that engender cooperation in patient care and a climate that fosters mutual respect and trust.

The AAFP expresses the highest regard and professional respect for educated, dedicated and caring nurses. (1983) (2013 COD)
Obesity and Overweight

See also

- Health Education in Schools
- Health Education
- Patient Education
- Physical Activity in Children
- Healthy Nutrition in Health Care Facilities and Other Workplaces
- School Nutrition: Healthy Eating Options in Schools
- Healthy Foods

Family physicians should counsel all patients on nutrition, physical activity, and behavioral strategies to prevent inappropriate weight gain and obesity. Family physicians should screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. (Intense counseling involves more than one session per month for at least 3 months). Overweight and obesity are defined as the Centers for Disease Control and Prevention (CDC) defines them. Reasonable and necessary diagnosis and treatment should be paid by all third party payers.

Family physicians participate in local, state and national efforts to improve nutrition and encourage physical activity for both children and adults. (2004) (2014 COD)
Officer and Director Duties

See also

- Officers' Protocol

Detailed position descriptions have been developed for each AAFP officer as well as those serving as directors. These position descriptions are updated regularly and include position responsibilities, qualifications and terms of office, time required and remuneration provided. To obtain the current position description for AAFP officers and directors, contact the Academy's executive vice president at the headquarters office. (1997) (February 2014 BOD)
Officers' Protocol

See also

- Officer and Director Duties

The protocol adopted by the Board of Directors on the listing of officers of the American Academy of Family Physicians (AAFP) is as follows:

President
President-elect
Chair of the Board of Directors
Speaker of the Congress of Delegates
Vice Speaker of the Congress of Delegates
Executive Vice President

AAFP letterhead lists the officers as indicated above. (B1989) (May 2016 BOD)
Organ Donation: Addressing the Shortage of Registered Organ Donors

The American Academy of Family Physicians (AAFP) recognizes the chronic and growing national shortage of donor organs to meet public demand and the disproportionate manner in which minorities may be affected. Family physicians and trainees are encouraged to expand their knowledge and understanding of the principles and practices of organ donation, and the manner in which patient's cultural believes, fears, and preferences may pertain to organ donation. Family physicians should have an open dialogue with their patients, especially those populations proportionally less represented as organ donors, and preferences should be document and maintained in the patient's medical records and communicated with the patient's family.

The AAFP supports the study and implementation of systems that increase the available supply of viable organs, such as opt-out (presumed consent) programs, where donation occurs automatically unless a person specifically opts out; or by providing increased opportunities for opting-in, including mandated choice policies on governmental forms, such as voter registration, driver license renewal, or Medical/Physician Orders for Life-Sustaining Treatment (MOLST/POLST).

Over-the-Counter Oral Contraceptives

See also

- Reproductive Decisions
- Reproductive Decisions, Training In
- Contraception Methods for Medicare Patients
- Long-Acting Reversible Contraceptives
- Coverage, Patient Education, and Counseling for Family Planning, Contraceptive Methods, and Sterilization Procedures

The American Academy of Family Physicians recognizes that unintended pregnancies are a major public health concern, accounting for approximately 50% of US pregnancies. Access and cost are commonly cited reasons why women have gaps in contraceptive use or do not use contraception. While oral contraceptive pills are widely considered to be safe and effective medications, they continue to require a prescription for use, further restricting access. The AAFP recognizes that though contraindications to these medications do exist, women have been shown to correctly self-identify contraindications to use when using a standardized check-list. Over 100 countries round the world currently provide oral contraceptive pills over the counter without a prescription. The AAFP supports over-the-counter access to oral contraception without a prescription. Under the Patient Protection and Affordable Care Act, private insurance must cover all contraceptive methods approved by the FDA. The AAFP supports insurance coverage of oral contraceptives regardless of prescription status in all insurance plans.

References:


(2014 COD)
Parental Leave During Residency Training

1. Any parental leave plan utilized by a family medicine residency program must:
   a. Safeguard the health of the parent and child,
   b. Assure that the resident fulfills all educational requirements, and
   c. Assure that the patient care is uninterrupted by the resident's absence.

2. There are a number of factors which will affect the specific provisions in a parental leave plan, and which must be taken into consideration in developing the plan. The factors include:
   a. Compliance with Certifying Boards. The American Board of Family Medicine (ABFM) has established requirements with respect to the amount of time a resident may be absent from his or her training program in any 12-month period and still retain eligibility to make application for the ABFM examination. The ABFM's most current version of these requirements may be found at https://www.theabfm.org/cert/absence.aspx. The American Osteopathic Board of Family Physicians’ (AOBFP) requirements may be different than those of the ABFM and have varied over time. The AOBFP staff should be consulted to ensure compliance with the relevant current requirements. https://www.aobfp.org.
   b. Some residency programs may be subject to various federal and state laws, including the Family and Medical Leave Act (FMLA). These laws may impose certain requirements on parental leave plans utilized by family medicine residency programs and may guarantee certain rights for residency programs and for residents taking parental leave.

3. Subject to applicable law, the AAFP recommends that the following be incorporated in residency programs parental leave plans:
   a. Expectant mothers must be allowed the same sick leave or disability benefits as other residents.
      i. Expectant partners and adoptive parents should be allowed the same leave or disability benefits as other residents.
   b. The category of leave credited (sick, vacation, parental, short-term) should be specified.
   c. Whether leave is paid or unpaid should be specified.
   d. The minimum duration of parental leave for residents should be based on the written recommendations of the physician(s) caring for the resident and infant and/or state and federal laws. The resident should be encouraged to take the longest leave that is feasible for the resident and the program to enhance parent-infant bonding and facilitate breastfeeding initiation.
   e. Residency programs are encouraged to allow residents to design home-study or reading electives which should comply with Review Committee - Family Medicine (RC-FM) requirements, for use around the estimated delivery date (EDD) or adoption and after delivery to
minimize the time needed away from the residency. Such home study electives would be likely to include some Family Medicine Center (FMC) time weekly in order to meet RC-FM continuity requirements for the FMC.

f. The expectant or adoptive parent should notify the program director and those responsible for scheduling of rotations and call as soon as pregnancy or adoption is confirmed. Coverage of responsibilities during the leave should be arranged as early as possible.

g. Efforts should be made to schedule the most demanding rotations earlier in the pregnancy, allowing for the least strenuous rotations to be performed around the time of the resident's EDD.

h. The rotation performed around the time of the EDD or adoption should be one in which the resident is not essential to the service and which would allow time off without jeopardizing patient care or disadvantaging the other residents in the program.

i. The expectant or adoptive parent's call schedule should be arranged to have no call around the time of EDD or adoption and while on leave. The resident is expected to make up call before or after the leave, so other residents aren't disadvantaged.

j. Residents taking parental leave must be able to return to the residency within a reasonable period of time without loss of training status.

k. Provision for the continuation of the resident's insurance benefits during the leave should be made and who pays for the premiums should be specified.

l. Communication to each resident should be made regarding how the leave will impact the resident's graduation and ability to sit for the American Board of Family Medicine exam.

m. The mechanisms available for making up time, or extending or delaying training should be verified.

n. It should be verified if the extended training or make-up time will be paid.

o. The expectant or adoptive parent(s) should notify the program director and covering residents when labor and/or FMLA time begins.

Patient Care, Concurrent

See also

- Comprehensive Care, Definition of
- Disease Management
- Care Management Fees
- Hospitalists Trained in Family Medicine

As noted in Current Procedural Terminology (CPT), concurrent care is the provision of similar services (e.g., hospital visits) to the same patient by more than one physician or other qualified health care professional on the same day. In many instances, concurrent care is medically necessary and essential to the best care of the patient, including problem solving, coordination, management of services and/or emotional support. When concurrent care is medically necessary and essential to patient care, as documented by the physicians or other qualified health care professionals involved, it should be appropriately paid. (B1977) (2014 COD)
Patient-Centered Formularies

See also

- Physician's Rights Relative to Imposed Administrative Costs
- Managed Care Reform
- Disclosure of Corporate Ties Affecting Formulary Choices and Drug Substitution

Preamble

The American Academy of Family Physicians (AAFP):

- recognizes the critical role of proprietary pharmaceutical products in the prevention, treatment and cure of disease;
- values the role of pharmaceutical manufacturers in the research, development and distribution of new therapeutic agents and the education of physicians and others;
- recognizes the physician's responsibility for the appropriate use of pharmaceutical agents through the prescriptive powers vested in them by virtue of their medical license;
- supports assuring access to needed pharmaceutical products through their inclusion in benefit programs of public and private insurance products;
- recognizes the role of appropriately designed restrictive formularies used by providers of pharmacy benefits and third party insurers which have the goal of optimizing clinical outcomes while minimizing overall health care costs;
- recognizes that decisions about the inclusion of drugs on formularies must be made with a proper balance of cost, efficacy, quality, and ease of use to optimize individual outcomes in the context of resource conservation;
- realizes that "direct to consumer" advertising by pharmaceutical manufacturers has created an "induced demand" for these products which physicians must manage in the provision of patient care;
- has great concern about the extensive administrative time and expense required by family physicians to comply with multiple and conflicting restrictive formularies.

The AAFP is concerned that certain ownership and/or financial arrangements among pharmaceutical manufacturers, pharmacy benefit management (PBM) organizations, mail order companies, health plans, retail pharmacies, pharmacists and other provider groups could create “conflicts of interest” or financial incentives which may not be in patients’ best interests, e.g. manufacturer discounts and/or rebates for the utilization of certain drugs. They may also result in compromised quality of care, excessively high premium, and “out of pocket” costs.

Guidelines

The AAFP has developed the following set of “Principles for the Development and Management of Patient-Centered Formularies” for the consideration of, and use by, family physicians, other providers and the health plans with which they contract.

1. Formularies should be developed using a collaborative process involving physicians, pharmacists, patients, and others possessing information concerning the science and economics of pharmaceutical products.
2. Health plans should constitute Pharmacy and Therapeutics (P and T) committees with plan payers, members, and local practitioners who are credible and respected to review, revise as appropriate and approve formularies, including those provided to the health plan by contracted PBMs.
3. All P and T committee members should be required to disclose significant pharmaceutical company-related stock holdings.
4. Formulary design should be patient-centered, fiscally responsible, and evidence-based. Drug selection should be based on clinical outcomes, clinical comparability, safety, patient ease of use, and
bioequivalency with drug unit cost being a secondary consideration.

5. Patients stable on drugs should not be changed to a new product based solely on economic considerations.

6. Formularies should be designed to provide a physician- and patient-friendly option to prescribe and receive drugs not included on the formulary using patient-centered, clinically-based criteria.

7. Formularies should be designed to offer patients multiple levels of drug choice (from more to less restrictive) with accompanying patient cost sharing levels to account for variables including patient preferences (e.g., “direct marketing-induced” demand).

8. Health plans and PBMs should provide drug utilization and cost information to physicians in clear and understandable reports that are useful for physicians in affecting positive change in their prescribing behavior.

9. Sufficient information concerning the pharmacy benefit management design should be provided by health plans to physicians and patients in a clear and useful format. (Note: this includes information concerning generic drug and therapeutic substitution policies, deductibles and co-pays, appeal process for adverse decisions, formulary choices, product information, contractual arrangements with a PBM, etc.).

10. Formularies should restrict as few classes of therapeutic agents as possible, focusing on those classes of drugs that are the most frequently prescribed, the most expensive, or the most frequently “abused,” i.e., to seek value in selected therapeutic categories.

11. Formulary changes must be made known to physicians and pharmacies prior to implementation. Additionally, the insured patient should be allowed to continue with a previously approved drug until and unless a physician, in consultation with the patient, decides to change to another drug.

12. Before formulary changes are made, the total cost to the patient and physician must be considered including staff time and resources, unexpected adverse outcomes, additional office visits, and laboratory monitoring.

13. Formularies must be stable since frequent changes create confusion and frustration for patients and physicians leading to non-compliance, adverse reactions, increased costs, and erosion of patients’ confidence. This guideline is not meant to exclude newly FDA-approved drugs or indications.

14. Health plan financial incentives to physicians should be assessed in the aggregate across all prescription drugs and related to cost-effective practice and positive clinical outcomes rather than to formulary compliance or cost as the sole criterion. Additionally, physician drug utilization reviews (DUR) conducted by PBMs or health plans should focus on these same criteria.

15. Physicians should have access to reasonable due process for appeals of adverse decisions without concurrent concerns about institutional sanctions or economic penalties for cost over runs unless clearly related to evidenced-based clinical outcomes data.

16. The pharmaceutical industry, PBMs, health plans, and physicians should work collaboratively to conduct pharmacoeconomic research, publicly share the results and strive to bring as much uniformity and consistency to drug formularies as is possible within a competitive health care marketplace.

17. To help assure patient safety, any direct to consumer advertising for a medication should not occur until the medication has been on the market for a minimum of one year.

18. Physicians should be paid for services provided to patients in response to a request from a payer or third party administrator or in response to formulary changes that require a change in prescription medication, whether or not those services are provided in a face-to-face encounter.

19. Formularies should cover insulin pens at the same tier as vial and syringe insulin injections.

Patient Education

See also

- Fees for Patient Education
- Health Education
- Health Education in Schools
- Medical Waste Disposal in Non-Medical Settings
- Obesity and Overweight
- Patient Responsibility for Follow-up of Diagnosis and Treatment

Patient education is integral to the process that changes or enhances a patient’s knowledge, attitude or skills to maintain or improve health. Family physicians should take a leadership role in improving the health of the American public by providing accurate, evidence-based, culturally proficient, and meaningful patient education.

Patient Responsibility for Follow-Up of Diagnosis and Treatment

See also

- [Patient Education](#)
- [Patient Self-Referral](#)
- [Confidentiality, Patient/Physician](#)

Health care is a partnership in which the physician and the patient both have responsibilities. It is the physician's responsibility, in consultation with the patient, to arrive at a diagnosis, to inform the patient of that diagnosis in a manner that is understandable and culturally sensitive to the patient, to identify treatment options, to recommend a therapeutic plan, and to explain the importance of any recommended follow-up. It is the patient's responsibility to assist his or her physician in arriving at the diagnosis by providing a complete and accurate history and by undergoing appropriate and personally acceptable examinations, diagnostic testing, and follow-up visits. It is also the patient's responsibility to ask questions when he or she does not understand and to clearly communicate his or her perceptions of health and illness in the process. Once the diagnosis and course of treatment have been established and agreed upon collaboratively, it is the patient's responsibility to follow the agreed upon treatment plan and to return as advised for ongoing assessments of health, illness, and treatment outcomes.

In some jurisdictions, courts and government bodies have defined what constitutes adequate physician follow-up. Physicians should be aware of the specific requirements in their jurisdictions.

Patient Self-Referral

See also

- Patient Responsibility for Follow-Up of Diagnosis and Treatment
- Consultations and/or Policies on Referrals
- Patient Education

A patient should not be restricted from self-referral to the most appropriate provider for his or her needs. Every person should have a family physician for continuing, comprehensive, and personal care. The family physician, through a shared decision-making process with the patient, should guide consultations and referrals to other health care professionals. The patient is best served through informed decision-making with his/her family physician, along with input from family and care givers when appropriate. (1981) (2013 COD)
Pay-For-Performance

Both public and private payers have come to recognize the importance of experimentation with physician payment methodologies that incentivize medical practices to expand the provision of preventive services, improve clinical outcomes, and enhance patient safety and satisfaction. These incentive programs, known collectively as “pay for performance” programs, have the potential to increase physician use of health information technology, evidence-based clinical guidelines, and administrative and clinical “best practices.” They may also increase access to appropriate and timely care.

The American Academy of Family Physicians (AAFP) recognizes the need to reform physician payment, including pay for performance as one approach. However, there are a multitude of organizational, technical, legal, and ethical challenges to designing and implementing pay for performance programs. The AAFP also recognizes that there are both advantages (increased payment, improved efficiency and quality) and disadvantages (cost of acquiring information technology, multiple programs and guidelines, data collection) to such programs as they are currently designed and implemented. Payers' physician measurement processes used to rate/designate family physicians should be transparent and adhere to the AAFP policies on Performance Measures Criteria, Physician Profiling, Data Stewardship, and Transparency.

The AAFP supports pay for performance (PFP) programs that adhere to these principles:

1. Focus on improved quality of care
2. Performance measures harmonized
3. Support the physician/patient relationship
4. Utilize performance measures based on evidence-based clinical guidelines
5. Involve practicing physicians in program design
6. Use reliable, accurate, and scientifically valid data
7. Provide positive physician incentives
8. Offer voluntary physician participation

The AAFP will use its influence to support and encourage experimentation using the following guidelines:

1. PFP programs should provide incentives to physician practices for:
   1. Adopting and using health information technologies;
   2. Implementing systems to improve the quality of patient care and patient safety;
   3. Adhering to evidence-based clinical guidelines;
   4. Improving performance and meeting performance targets;
   5. Improving patient access to appropriate and timely care; and
   6. Measuring and attempting to improve patient acceptance and satisfaction with their care
2. PFP programs should be consolidated across payers to make the payment meaningful and the program more manageable for physician practices.
3. PFP programs should be funded by using a portion of the projected total system savings. There should
be no reduction in existing fees for service paid to physicians as a result of implementing a PFP program.

4. The financial rewards to physician practices in PFP programs should cover the additional administrative costs to participate in the programs (data collection and measurement) and provide significant incentive.

5. PFP programs should not create incentives that place physicians at odds with their patients, e.g., incentives to fragment care or deselect certain patients. Case-mix and other appropriate adjustments, including known clinical and socioeconomic factors, should be employed to allow fair comparisons of different practices.

6. PFP programs should minimize administrative, financial, and technological barriers to participation.

7. The payer with a PFP program should notify the patients affected, provide related self-care information, and reinforce patient responsibilities in achieving the desired health outcomes.

8. PFP programs should acknowledge that physician judgment, patient preference, and the costs associated with various options may be the best measures of the appropriateness of a given intervention for PFP purposes when evidence is lacking regarding the value of a particular diagnostic or therapeutic intervention.

9. PFP programs should remove patient cases from the performance measure(s) being assessed ("denominator exclusion") when a physician can demonstrate that:
   a. he or she has attempted to provide patients with the support needed to follow recommended care and the patient has subsequently not followed such recommendations,
   b. the recommendations are inappropriate for the patient due to other clinical or socioeconomic considerations, or
   c. the patient is unable to comply.

10. PFP programs should be designed to include practices of all sizes.

Payment for Non Face-to-Face Physician Services

See also

- Telemedicine
- Medicare Payment
- Physician's Rights Relative to Imposed Administrative Costs
- Pay-For-Performance
- Payment, Physician
- Coding and Payment
- e-visits

The AAFP believes that physicians should receive payment for services that are reasonable and necessary, safe and effective, medically appropriate, and provided in accordance with accepted standards of medical practice. The technology used to deliver the services should not be a consideration, only whether the service is medically reasonable and necessary. Therefore, AAFP supports payment for electronic communication and evaluations that physicians provide for the medical management of their established patients as a separate service unrelated to an evaluation and management (E/M) service. (2004) (2015 COD)
Payment, Non-Physician Providers

See also

- Team-Based Care
- Coding and Payment
- Medicare Payment
- Payment, Physician
- Guidelines on Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants
- Non-Physician Providers, Family Physician Training With
- Nurse Midwives, Certified
- Nurse Practitioners
- Physician Assistants
- Physician’s Right Relative to Imposed Administrative Costs

Services delegated to, and provided by, non-physician providers under physician supervision must be provided with the same quality and should be reimbursed at the same level as services directly provided by a physician. (1998) (2015 COD)
Payment, Physician

See also

- Coding and Payment
- Medicare Payment
- Pay-For-Performance
- Direct Primary Care
- Payment for Non Face-to-Face Physician Services
- Immunizations
- Data Stewardship
- Performance Measures Criteria
- Physician Profiling, Guiding Principles
- Tiered and Narrowed Physician Networks
- Transparency
- Physician Performance Reporting, Guiding Principles
- Payment, Non-Physician Providers
- Physician's Right Relative to Imposed Administrative Costs
- Independent Physician Associations (IPAs) Definition

It is the position of the AAFP that every reasonable effort should be made to devise a reliable payment system that addresses the following principles:

1. Quality care, access to care and positive health outcomes must be the primary goals of any payment system.
2. The unique partnership embodied in the doctor/patient relationship must be preserved.
3. A payment system must be based on continuing, comprehensive care and should encourage treatment on an ambulatory basis rather than in a costly institutional setting.
4. There must be recognition of the value of prevention, health maintenance, early diagnosis and early treatment, with appropriate incentives to the patient and to the physician.
5. Increased emphasis must be placed on appropriate payment for the cognitive portion of physician services, recognizing that this will likely result in lower payment for other services.
6. Physicians should only be paid to perform services for which they have documented training and/or experience, demonstrated abilities and current competence.
7. Certain factors (e.g., medical resources, locales, etc.) that diminish access to needed and quality medical care exist and may arise in the future. In these instances, national policies that provide appropriate payment incentives may be given to physicians who will serve these underserved needs or areas.
8. There must be substantial physician involvement in determining appropriate values to be assigned to payment for various physician services.
9. Sufficient flexibility must be built into the payment system to recognize individual variation inherent in medical encounters, including the site of service, number of patients present, patient's health status or special circumstances, complications which may arise, severity of illness and other reasons.
10. Individual physicians in independent practice must retain the right to set their own charges and the option to have those charges differ from the amounts scheduled for payment. In determining their charges, physicians' considerations should include, but not be limited to:
   1. The amount of skill and/or special training required;
   2. The amount of time spent providing the service;
   3. The risk involved in supplying the service;
   4. Special economic considerations for the financially disadvantaged;
   5. Supplies and equipment used;
6. The use of ancillary personnel in providing the service; and
7. Costs of maintaining an appropriate facility for providing the service;
8. The complexity of their patients.

11. Assurance of quality and appropriate utilization of services through peer review mechanisms shall remain the responsibility of the medical profession at the local level, with sufficient opportunity for involvement by all specialties.

12. Any payment system must include provisions for annual reevaluation to keep the system current, so it reflects changing economic factors affecting the cost of delivering services.

13. Any payment system which utilizes or contracts for care management services should pay appropriately for these services as necessary to the provision of continuous comprehensive patient care.

14. To the extent that payment for services is established according to Resource-Based Relative Value Scale, it should take into account the unique practice expenses and professional liability costs of primary care physicians and uses a single conversion factor for all physician services.

15. The value of family physicians’ role in diagnosing, managing, and coordinating the delivery of mental health services should be recognized by adequate payment by all payors responsible for mental health coverage. The role and payment of family physicians in the delivery of mental health services should not be limited by plan design.

16. Periodic preventive services should be paid by all public and private insurers when performed in the same anniversary month as they were last performed.

17. Physicians should be paid for non-face-to-face electronic communication, consultations, and care management services that they provide for the medical management of their established patients as a separate service unrelated to a face-to-face evaluation and management (E/M). This would include services relevant to the care of the patient that are currently Non-Covered Services by Medicare. (see Payment for Non Face-to-Face Physician Services and Care Management).

18. There should be "equal pay for equal work" and no discrimination in physician payment in any form, including but not limited to, that on the basis of actual or perceived race, color, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, economic status, body habitus, or national origin of the physician.

Peer Review

See also

- Peer Review, Confidentiality
- Clinical Proctoring
- Medicaid Services

The American Academy of Family Physicians supports effective peer review as an essential part of improving the quality of health care delivery. The membership is encouraged to actively participate in peer review programs to assure the use of high quality, patient-oriented evidence and sensitivity to community needs and practices. In addition, family physician participation will allow appropriate peer review for other family physicians.

In order for meaningful peer review to take place, adherence to the following concepts is essential:

1. The primary goal of peer review should reflect enhancing the quality of care for patients. Nonetheless, peer review will increasingly address issues of value driven care. Physicians should be the leader of these conversations.
2. Clinical policies for patient care should be established by practicing physicians based upon the best patient-oriented evidence available balanced with sensitivity to local needs and expectations.
3. Physician departure from clinical policies (e.g. clinical guidelines) should not be interpreted as a prior breach of good medical practice. Patient preference, the availability of services, and the weighing of individual risks and benefits may substantially influence management. Physicians should have access to the full rationale of peer decisions and opportunity for rebuttal if a negative conclusion is reached.
4. Peer review should assess the quality of care rendered. Peer review should be performed by a physician with similar qualifications to those of the physician being reviewed.
5. Criteria for care (e.g., hospital admission, transfer, or alternative care site delivery) should reflect severity of illness, social factors, caregiver burden, access to services and the particular circumstances of each patient.
6. Utilization review provided by a physician should be considered the most valid determiner of the correct diagnostic category. Physician peers should determine the appropriateness of care recognizing the many factors influencing decision-making.
7. The end product of peer review should be improvement of patient care through physician education and health system improvement. The conduct and process of peer review should seek to identify potential systematic improvements that the organization could implement to reduce the chances of mistakes or adverse events in the future.
8. In the public interest, peer review by medical staffs, medical societies, medical groups, health plans, and other entities should be confidential, protected, and not subject to disclosure or discovery, but the evidence and clinical decision making used in developing peer review decisions should be transparent and open to scrutiny. There should be the opportunity to provide further information and rebuttal to peer review outcomes. (1988) (2016 COD)
Peer Review, Confidentiality

See also

- Peer Review
- Clinical Proctoring

In the public interest, peer review by medical staffs, medical societies, medical groups, health plans, and other entities should be confidential, protected, and not subject to disclosure or discovery. The AAFP supports legislation intended to maximize protection from discovery and to restore peer review protections taken away by the courts. (1998) (2014 COD)
Performance Measures Criteria

See also

- Data Stewardship
- Physician Profiling, Guiding Principles
- Pay-For-Performance
- Payment, Physician
- Family Medicine, Quality Health Care in
- Tiered and Narrowed Physician Networks
- Transparency
- Physician Performance Reporting, Guiding Principles
- Health Care Costs, Methods for Reducing

Physician level clinical performance measures may be used for local improvement efforts, public reporting, accountability, or pay for performance programs. The American Academy of Family Physicians (AAFP) participates in the Physician Consortium for Performance Improvement (PCPI) sponsored by the American Medical Association and works closely with other medical specialty societies, the National Quality Forum (NQF(www.qualityforum.org)), and the National Committee on Quality Assurance (NCQA(www.ncqa.org)), all of which are involved in performance measurement development, endorsement, harmonization, or implementation.

The AAFP encourages the utilization of performance measures that are consistent with the criteria described below for evaluating and improving patient care.

Statement of Principles

The AAFP is committed to promoting quality, cost-effective health care. The AAFP supports health care quality improvement endeavors, including the development and application of performance measures (whether single or in aggregate) which have the following attributes:

- Focused on improving important processes and outcomes of care in terms that matter to patients;
- Responsive to informed patients' cultures, values, and preferences;
- Based on best evidence and reflect variations in care consistent with appropriate professional judgment;
- Are practical given variations of systems and resources available across practice settings;
- Do not separately evaluate cost of care from quality and appropriateness;
- Take into account the burden of data collection, particularly in the aggregation of multiple measures;
- Provide transparency for methodology used;
- Assess patient well-being, satisfaction, access to care, disparities, and health status;
- Are updated regularly or when new evidence is developed; and
- Are harmonized across all payers.

The spirit in which performance measures are developed and applied should be one of continuous improvement. The primary purpose of performance measurement should be to identify opportunities to improve patient care. Some measures will have usefulness for accountability, public reporting, or pay for performance programs. Efficiency of care measures, associated with a specified level of quality of care, is increasingly being incorporated into performance measurement sets. The PCPI Position Statement, The Linkage of Quality of Care Assessment to Cost of Care Assessment, describes "efficiency of care" as the relationship of the cost of care associated with a specific level of performance measured with respect to the
other five Institute of Medicine (IOM) aims of quality.

Only the most evidence-based, widely accepted, and important measures should be used for accountability, pay for performance or other significant decisions. When comparisons are made, they should be risk-adjusted, consider differences in denominator populations and account for variations in patient preferences, values, access, and availability of services. The AAFP policy statement on pay for performance programs can be found at: AAFP Policies.

The value of the application of performance measures should also be assessed in the context of physician, practice, and health system burden, economic costs and savings, and impact on patient-oriented outcomes that matter.

The AAFP participates in the development, endorsement, and harmonization of performance measures by nominating family physicians to represent the membership on workgroups pertinent to family medicine. This work is accomplished primarily through the PCPI and the NQF. The PCPI has developed Physician Performance Measurement Sets which offer clinical performance tools to support physicians in their efforts to enhance quality of patient care. Using physicians and other stakeholders, the NQF convenes steering committees and technical advisory panels to review, update, harmonize, and endorse performance measures.

The following criteria shall be used by the AAFP to evaluate the need, quality and acceptability of a performance measure.

**Importance**

**Grounded in science.** The measure should be evidence-based, explicit, and reflect the degree of scientific certainty. The aim of the measure should be to improve outcomes that are meaningful to patients. When intermediate processes of care are assessed, the causal pathway to improved patient-oriented outcomes should be strong.

**Substantial potential for improvement.** A significant gap should exist between optimal and current clinical practice. The gap should be amenable to substantial improvement by means of feasible interventions.

**Severity and prevalence.** The condition and its prevalence in the population should be significant enough to justify targeting the condition for improvement.

**Substantial impact.** The measure should be patient-centered, hold the potential for substantial impact on the health status, health outcomes, and satisfaction of individual patients and be capable of maintaining and/or improving the health of a community or population of patients.

**Relevant.** The measure should be important to physicians and their patients and should be amenable to evaluation.

**Improve value.** Measures should have the potential to improve value of health services for patients, plans, and purchasers of health care.

**Measurability**

**Accurate and reliable.** The measure should be clearly defined, reliable, and consistent across different practice settings.

**Valid.** The measure is scientifically valid and based on high quality evidence of efficacy and effectiveness. There is face validity, indicating obvious appropriateness or agreement by experts; and, construct validity, indicating a comprehensive picture of the care being provided. Comparisons should be statistically valid, risk-adjusted, and account for differences in denominator populations or patient settings. The translation of
best evidence of effectiveness into practice should be demonstrated.

**Precisely defined and specified.** The measure specifications should include:

- The rationale or intent of the measure;
- A description of the performance measure population;
- A well-defined denominator with explicit inclusion and exclusion criteria;
- Defined sampling procedures, when applicable;
- Defined data elements and data sources;
- Instructions for collecting data for the measure; and
- Data elements that can be verified by the practice/physicians that is being assessed.

**Easily interpreted.** The measure can be interpreted consistently by those using the information.

**Risk adjusted.** If the measure is intended for meaningful comparison with the performance of others, it should be risk adjusted, if possible and appropriate. Consideration should be given to variations given differences in practice settings, patient preferences, cultural and social factors, and appropriate physician-patient decision-making. While adjustment should consider characteristics that impact health outcomes among different populations, including those beyond a health system's control, it is important to retain accountability for developing systems and processes that strive for continuous quality improvement.

**Achievability**

**Improvement attainable.** The health outcome goal of the measure can be achieved, or an improvement can be accomplished, in the settings in which it is applied.

**Reasonable cost.** The measure should not impose an inappropriate financial burden on those collecting the data. The cost of collecting the data and affecting improvements should be justified by impact on patient-oriented outcomes. There should be alignment between the cost of data measurement and performance improvement and funds dedicated to these processes.

**Feasible.** The measure should be feasible for a physician to meet. For example,

- Data for the measures are readily available;
- Patient confidentiality must be maintained;
- The number of required measures is reasonable;
- Realistic time frames are allowed for data collection;
- To the extent possible, measures and specifications should remain consistent over a period of time long enough to achieve improvement;
- Instructive materials should accompany performance measures;
- Consideration is given to variation given differences in practice settings, patient preferences, cultural and social factors, and appropriate physician-patient decision-making;
- Performance improvement can be implemented and maintained with reasonable effort; and,
- The measurement is current and cost-effective.

Pharmacists Dispensing Drugs - AAFP

Legislative Stance

See also

- Pharmacists (Position Paper)
- Drugs, Prescribing
- Pharmacists' Right of Conscientious Objection

The AAFP encourages state chapters to oppose state legislation allowing pharmacists to dispense medication beyond the expiration of the original prescription for other than emergency purposes. (2002) (2013 COD)
Pharmacists (Position Paper)

See also

- Pharmacists Dispensing Drugs - AAFP Legislative Stance
- Pharmacists' Right of Conscientious Objection
- Drugs, Prescribing

Introduction

The AAFP recognizes the evolving complexity and proliferation of pharmaceutical agents and the important role pharmacists play in the delivery of high-quality health care. The pharmacy professional and physician can and should work collaboratively so that their combined expertise is used to optimize the therapeutic effect of pharmaceutical agents in patient care. It is the intent of this document to define the nature of that relationship.

Background

The increased complexity of pharmaceutical applications is at least partially reflected in the pharmacy profession's decision to upgrade its educational standards. Until July 1, 2000, an individual who wished to become a pharmacist could enroll in a program of study that would lead to either a bachelor of science degree or a doctor of pharmacy degree. As of July 1, 2000, the doctor of pharmacy became the only degree accredited by the American Council for Pharmaceutical Education (ACPE). PharmD programs take six years to complete and usually involve two years of preprofessional coursework and four years of professional education. For the purposes of this document, the terms pharmacist, PharmD, and pharmacy professional are interchangeable.

Expanded Scope of Practice

Like other health professionals, pharmacists are seeking to expand their influence and scope of practice. Expanded roles for pharmacists have been promoted via legislative and regulatory action. Currently, 46 states have collaborative drug therapy management (CDTM) legislation or regulations. These laws allow physicians and pharmacists to enter into voluntary written agreements to manage the drug therapy of a patient or group of patients. The American Pharmacists Association outlined the activities that CDTM may include:

- Initiating, modifying, and monitoring a patient's drug therapy
- Ordering and performing laboratory and related tests
- Assessing patient response to therapy
- Counseling and educating patients about their medications
- Administering medications

Benefits of Collaborative Arrangements

At the core of integrated care models such as the patient-centered medical home (PCMH) and the accountable care organization is the concept of coordinated and team-based care. There is a growing body of evidence that medication management programs can make positive contributions to patient health. In many of these studies, pharmacists lead the medication management programs.

Additionally, pharmacists have an important role in providing direction to patients seeking advice on over-the-counter medications. For the patient seeking nonprescription medication, the pharmacist is positioned to determine the presence of allergies, as well as adverse reactions between prescription and over-the-counter...
medications. However, the AAFP recommends that vaccine administration be provided in the medical home setting. When vaccines are administered elsewhere, the information should be transmitted back to the patient’s primary care physician and their state registry when one exists so that there is a complete vaccination record.

**Relationship with Physicians**

Fragmentation of care is one of the challenges in the American health care system. The PCMH and other such efforts to improve collaboration and team-based care models should be encouraged, whereas the development of islands of health care service or further fragmentation of care should be discouraged. In a collaborative environment, the pharmacist is a logical member of a team and is qualified to deal with issues of medication use, medication efficacy, and patterns of medication use. Although the AAFP supports health professionals working together, current policy says that "...interests of patients are best served when their care is provided by a physician or through an integrated practice supervised directly by a physician." This defines the family physician as the coordinator and the pharmacy professional as a member of an integrated team.

"The AAFP believes that only licensed doctors of medicine, osteopathy, dentistry, and podiatry should have the statutory authority to prescribe drugs for human consumption." The pharmacy professional is in the position to dispense the prescription written by the physician.

**Conclusion**

The AAFP supports arrangements where the pharmacist is part of an integrated, team-based approach to care. The AAFP believes that independent prescription authority for pharmacists will further fragment the American health care system and will undermine the national goals of integrated, accountable care and models such as the PCMH.

**References**

4. The American Academy of Family Physicians, "Drugs, Prescribing" Policy.

Pharmacists' Right of Conscientious Objection

See also

- Pharmacists (Position Paper)
- Drugs, Prescribing
- Pharmacists Dispensing Drugs - AAFP Legislative Stance

The American Academy of Family Physicians (AAFP) believes that pharmacists’ right of conscientious objection should be reasonably accommodated, but to safeguard the patient-physician relationship, governmental policies must be in place to protect patients’ rights to obtain legally prescribed and medically indicated treatments in a timely manner. Thus, the pharmacist’s refusal to fill a prescription must be discussed with the physician (or his/her representative) and the patient, and the prescription must be returned to its source. (2005) (2013 COD)
Physical Activity in Children

See also

- Sports Medicine, Health and Fitness
- Health Care Costs, Methods for Reducing
- Obesity and Overweight
- Ultimate Fighting and Disabling Competitions
- Athletic Performance Enhancing Drugs

The AAFP recommends that all children participate in physical activity for at least an average of 30-60 minutes a day and encourages parents and schools to make physical activity a priority. Prolonged periods of physical inactivity should also be discouraged in both the home and school. (2006) (2011 COD)
Physician and Patient Relationships, Professional Responsibility

See also

- Confidentiality, Patient/Physician
- Reproductive Decisions

Good medical care requires a mutually trusting and satisfactory relationship between physician and patient. No physician shall be compelled to prescribe any treatment or perform any act which violates his/her good judgment or personally held moral principles. In these circumstances, the physician may withdraw from the case so long as adequate notice is given to enable the patient to engage the services of another physician. (1987) (2014 COD)
The AAFP position is that the term "physician assistant" or "PA" should only be used to designate a graduate of an accredited PA program who has passed the Physician Assistant National Certification Exam administered by the National Commission on Certification of Physician Assistants.

The AAFP position is that physician assistants should practice in integrated practice arrangements with practicing, licensed physicians. In no instance may duties be delegated to a physician assistant for which the supervising physician does not have the appropriate educational training, and current competence.

The AAFP supports the concept of patient and third-party payment for services of physician assistants. PAs and physicians deliver care in integrated practice arrangements with payment for the PA's services being provided to the employer of the PA. (1984) (2014 COD)
Introduction
The American Academy of Family Physicians (AAFP) is concerned about the high rates of professional burnout among physicians in the United States. This subject is of importance to the AAFP because primary care physicians suffer from significantly higher rates of burnout than physicians in other specialties.1 Burnout can negatively impact the quality of patient care and result in physicians leaving practice, thus contributing to the primary care workforce shortage.

The State of Physician Burnout
Physician burnout has been a significant area of concern and investigation for decades. A broad body of literature addresses both the causes of physician burnout and potential interventions to prevent or alleviate it. In addition, this issue has been covered in popular media.2-3 The literature shows that there is a high risk of physician burnout in the United States. A recent broad-based study reported that 45.8% of physicians are considered to be experiencing at least one symptom of burnout.4 The same study found that there is currently a 35.2% overall burnout rate among U.S. physicians. Further, the study found that physicians are almost twice as likely as the general U.S. population to report being dissatisfied with their work-life balance. These striking findings bear out across medical specialties, career phases, and demographics.5

Definition of Burnout
Definitions of burnout include the following:

- “A syndrome characterized by a loss of enthusiasm for work (emotional exhaustion), feeling of cynicism (depersonalization), and a low sense of personal accomplishment.”6
- “An emotional condition marked by tiredness, loss of interest, or frustration that interferes with job performance. Burnout is usually regarded as the result of prolonged stress.”7

Common Drivers of Burnout
The importance of identifying and addressing the root causes of physician burnout cannot be overemphasized. Despite much research, a lack of definitive data on causes of physician burnout still exists.8 Studies indicate that common drivers of family physician burnout include the following: paperwork; feeling undervalued; frustrations with referral networks; difficult patients; medicolegal issues; and challenges in finding work-life balance.9,10 These factors have varying impact at different stages of a physician’s career, with inability to resolve work-life conflict having the greatest impact for physicians early in their careers.11 Long hours, frequent call, frustration with administrative burden, and reimbursement issues strongly impact physicians in the middle of their careers.12

Effects of Burnout
There is growing understanding of how physician burnout directly affects patient health outcomes. New research shows that symptoms of physician burnout can be connected with increased rates of medical errors, riskier prescribing patterns, and lower patient adherence to chronic disease management plans.13,14 Middle-career physicians report long hours and frequent call, resulting in greater burnout and dissatisfaction among these physicians compared with physicians in other career stages and making them more likely to leave clinical practice.15 This is a notable concern because the middle of a physician’s career typically is the most productive phase in terms of providing patient care, serving as a leader and mentor, and assuming important administrative roles. The fact that burnout causes some physicians to leave practice early may explain why reported levels of satisfaction are highest among older physicians.

The U.S. health care system needs physicians to lead the transition to new methods of health care delivery and to sustain effective participation. However, almost half of U.S. physicians report symptoms of burnout, which compromises their ability to be effective in leading and sustaining change.16,17 Reducing physician burnout is critical to achieving the goals of redesigning the health care system and improving the health of patients, families, and communities in the United States.

Interventions to Reduce Burnout and Increase Satisfaction
Understanding the drivers of physician burnout informs the ongoing development of intervention models to prevent burnout and support services to help physicians cope with the symptoms. Historically, most programs to address burnout focused on the treatment of individual physicians (e.g., counseling services). Studies have found that self-awareness and mindfulness training can reduce physician burnout and increase both physician well-being and patient-centered qualities.18 There is a growing trend among health systems and other employers of physicians to adopt more system-level interventions, such as implementing institutional success metrics that include physician satisfaction and well-being, and developing practice models that preserve the decision-making autonomy of physicians.19

Conclusion
Burnout impacts physicians across all specialties. The AAFP believes that physician burnout is an important issue that must be dealt with openly and proactively because it affects both patient safety and physician well-being. In addition, burnout affects physicians’ decisions about remaining in clinical practice and their ability to lead changes at the practice and health care system levels.

Physician burnout is a system problem, not just an individual concern. The AAFP is committed to help individual family physicians learn personal resilience skills, as well as taking a systems-based approach to identifying and combating root causes of physician burnout.

References

(2014 COD)
Physician Dispensing of Drug Samples

See also

- Drugs - Identification
- Drugs, Physician Dispensing
- Drugs, Prescribing
- Drugs, Therapeutic Substitution

The American Academy of Family Physicians supports the practice of physicians providing sample medications at no charge to patients based on physician discretion. The AAFP further encourages its members to consider the cost effectiveness of any sample provided. (1986) (2014 COD)
Physician Expert Witness in Medical Liability Suits

See also

- [Professional Medical Liability](#)
- [Professional Medical Liability, Lawsuits](#)
- [Professional Medical Liability, Insurance Stipulations](#)
- [Clinical Outcomes, Disclosing Unanticipated: A Resource Guide for Family Physicians (Position Paper)](#)
- [Confidentiality, Patient/Physician](#)

Under this nation's system of jurisprudence, it is recognized that an essential element of proving medical negligence is establishing that the defendant has breached a standard of care owed to the plaintiff. The courts have relied on the testimony of expert witnesses to establish what the standard of care is in a given situation and whether that standard of care has been met. The American Academy of Family Physicians recognizes and supports the concept that physicians have an ethical responsibility to assist in the administration of justice and that it is in the best interest of the public that expert medical testimony, which is objective and impartial, be readily available. It is the opinion of the American Academy of Family Physicians that the probability of achieving equitable outcomes in medical liability suits will be enhanced if the following guidelines concerning expert witnesses are observed:

1. It is the responsibility of the physician expert witness in a medical liability case to present complete and unbiased information with which the trier of fact can ascertain whether the defendant was medically negligent and whether, as a result, the plaintiff suffered compensable injury and/or damages. The physician expert witness should be aware that transcripts of depositions and courtroom testimony are public records.
2. The physician expert witness should not become an advocate or a partisan during the trial and, to the extent possible, the testimony presented should reflect the generally accepted standards within the specialty or area of practice about which the expert witness is testifying. When there is no generally accepted standard of practice or when the expert witness presents testimony that is contrary to the generally accepted standard, the expert witness should clearly identify that fact, as well as the basis for the opinions expressed. Ideally, both the defense and the plaintiff should have at least one witness in the same specialty as the defendant physician.
3. Prior to testifying, the physician expert witness should become familiar with the facts of the case and the medical standard at issue and should review and understand both the current concepts and practices related to that standard as well as the concepts and practices related to that standard at the time of the occurrence which led to the lawsuit.
4. Compensation to physicians who testify as expert witnesses should be reasonable and commensurate with the time and effort involved in fulfilling the physician's responsibilities as an expert witness. The acceptance of fees that are disproportionately high relative to the time and effort involved may be interpreted as influencing testimony and should be avoided. Under no circumstances should a physician accept compensation for serving as an expert witness when payment of the compensation or the amount of the compensation are contingent upon the outcome of the case.

In order to ensure the highest possible quality of testimony by the physician expert witness and thereby promote just and equitable verdicts, the Academy believes that all physician expert witnesses should meet certain minimum qualifications. Recognizing that legislative bodies in the various jurisdictions have the authority to establish such qualifications, the Academy supports the enactment of legislation that requires the following:

1. The physician expert witness must have a current, unrestricted license to practice. The physician expert witness should be fully trained in the medical specialty or area of practice about which he or she is testifying.
2. The physician expert witness must have current clinical experience in the medical specialty or area of
practice about which he or she is testifying and during the two-year period immediately preceding the occurrence which led to the lawsuit, such person must have been actively engaged in clinical practice in the medical specialty or area of medicine about which he or she is testifying.

3. At least one physician expert witness for the plaintiff and one physician expert for the defendant should be in the same clinical specialty as the defendant physician. (1989) (2014 COD)
Physician Performance Reporting, Guiding Principles

The American Academy of Family Physicians (AAFP) believes the primary purpose of performance measurement and sharing of results should be to identify opportunities to improve patient care. Payers' physician measurement programs should lead to better informed physicians and/or consumers and align with existing relevant AAFP policies on Physician Profiling Principles and Performance Measures. The benefit of measurement is the knowledge gained, so the improvement process can begin and be monitored over time. Ideally, any Physician Performance Reporting should:

1. Support the physician/patient relationship.
2. Provide physician performance reports/ratings to assessed physician within meaningful time periods and be compared against both peers and performance targets prior to being made public.
3. Be transparent in all facets of physician measurement analysis, including:
   1. origin and definitions of data sources
   2. number of cases assessed per measure
   3. performance measures utilized and their source
   4. margin of error assumed in calculations
   5. basis of evaluation - the individual physician or physician group level
   6. clear communication of the validity, accuracy, reliability and limitations of data utilized, which may include:
      1. defining the peer group against which individual physician performance is being measured/compared;
      2. detailing steps taken to ensure data accuracy and disclose data limitations, e.g., the impact of an "open access" product in which the primary care physician may have little or no control over resource utilization;
      3. describing the attribution of patient populations to either individual physicians or physician groupings;
      4. including appropriate risk adjustment and case mix measures; and
      5. using meaningful time periods for data comparisons.
4. Identify physicians that meet quality standards separately from their cost assessment
5. Utilize appropriate and easy to understand designations for physicians who:
   1. Have statistically insufficient data or payer claims to assess physician performance;
   2. Have data currently under review with pending results;
   3. Have declined to display their designation;
   4. Practice in a specialty that is not evaluated under the program;
   5. Practice in a market where the payer’s program is not available; or
   6. Have not met payers’ criteria for a designation.
6. Provide a minimum of 90 days for physicians to review, validate, and appeal their payer’s...
7. Immediately adjust physicians’ performance rating/designation(s) based upon a successful reconsideration or discovery of errors in the payer’s data analysis.

8. Provide consumers adequate guidance about how to use the physician performance information and explicitly describe any limitations in the data.

(2009 COD) (2014 COD)
Physician Profiling, Guiding Principles

Preamble

The AAFP defines physician profiling as an analytic tool that uses epidemiological methods to compare physician practice patterns across various quality of care dimensions (process and clinical outcomes). Cost, service and resource utilization data are dimensions of measuring quality, but should not be used as independent measures of quality care. The ultimate goal is to deliver high quality, evidence-based care to improve clinical outcomes.

It is important to recognize that physician profiling is not intended to be used to address issues of physician competency, including the dimensions of medical knowledge, skills and competence. Such issues should be addressed by the appropriate public and private credentialing bodies that exist for these purposes.

AAFP believes that transparency in health care cost and quality information to physicians, patients, and employers is important and supports such efforts provided that the data aggregation and analysis is consistent with the AAFP Performance Measures Criteria policy. These criteria encompass the framework in which physician profiling data is collected, analyzed, and utilized.

Family physicians must have an opportunity to review payer performance profiles prior to them being publicly reported. Payers must establish and communicate a reasonable, formalized reconsideration process in which physicians can appeal their performance rating/designation(s).

Guidelines

Ideally, any physician profiling system/program should:

1. Have as its purpose to assess and improve the quality of patient care and clinical outcomes.
2. Clearly define what is being measured.
3. Select measurement goals which are actionable so that physicians can easily interpret and act as needed to achieve the stated measurement goal.
4. Involve physicians in the development of performance measures, feedback process, and appeals process.
5. Explicitly describe the data sources on which measurement is based, e.g., administrative/claims, medical records, surveys, etc.
6. Clearly report on the validity, accuracy, reliability and limitations of data utilized when reporting profiling results and when providing physician feedback. This may include:
   1. detailing the steps taken to ensure data accuracy and fair physician attribution of costs of care,
   2. clearly defining the peer group against which individual physician performance is being
measured/compared,
3. disclosing data limitations, e.g., the impact of an "open access" product in which the primary care physician may have little or no control over resource utilization,
4. describing the assignment of patient populations to either individual or physician groupings,
5. using an appropriate sample size to assure validity,
6. including appropriate risk adjustment and case mix measures, and
7. establishing and reporting data using meaningful time periods for data collection.
7. Utilize criteria for comparison purposes that are based on valid peer groups, evidence-based statistical norms and/or evidence-based clinical policies.
8. Identify individual patients who are not receiving indicated clinical interventions and provide interventions to improve physician performance relative to stated measurement goals.

Physician Reentry

Physician reentry is a return to clinical practice in the discipline in which one has been previously trained or certified, following an extended period of clinical inactivity not resulting from discipline or impairment.

As family physicians frequently experience professional opportunities that may take them away from the practice of family medicine for a period of time, and as those physicians are important contributors to the family physician workforce, efforts must be made to identify the processes physicians must complete to obtain appropriate licensure, credentials and privileges to resume practice.

The process for physician reentry should: (1) be transparent for physicians and the public, (2) integrate into current licensure and maintenance of certification procedures, and (3) focus on helping physicians to deliver effective, efficient and high-quality patient care. (2010 COD) (2015 COD)
Physician's Medical Records

The AAFP opposes any attempt by hospitals, HMOs, managed care companies, and other entities that contract with physicians to provide patient care, to require access to a physician's personal medical records as a criterion for participation. (2003) (2014 COD)
Physician's Right Relative to Imposed Administrative Costs

See also

- Pay-for-Performance
- Payment, Physician
- Payment, Non-Physician Providers
- Patient-Centered Formularies
- Payment for Non Face-to-Face Physician Services

Physicians should be able to charge and receive payment for administrative requirements imposed by any public or private health plan, or by any regulatory authority, employer, or other entity, unless such charges are prohibited by contract or regulation. This would include, but not be limited to, the costs associated with changes of individual prescriptions made solely for formulary compliance or completion of Family Medical Leave Act (FMLA) and other forms not directly related to patient care. The physician's office should be transparent with both patients and entities imposing administrative requirements regarding the office's charges associated with completing such requirements. (2003) (2015 COD)
Political Action

See also

- [Legislative Activities](#)

The AAFP recommends and urges individual members and constituent chapters to devise ways to remain in effective contact with legislators at the state and federal levels, including supporting FamMedPAC and state and territorial family medicine PACs.

The Academy will continue to work with political parties and candidates to help them to recognize the importance primary care and the fundamental role of the family physician in the health care delivery system and the need to increase the number of family physicians. (1972) (2013 COD)
Population Health

“Population health” is a term frequently used in both healthcare and public health. It has been used to mean different things, depending on context and perspective. In order to assist AAFP members to understand population health, this definition defines population health from the perspective of the family physician.

Population health is “the health outcomes of a group of individuals, including the distribution of such outcomes within the group” (Kindig and Stoddart, 2003). The population being considered may vary based on an individual’s perspective and goals. For the family physician, the most obvious “group of individuals” is their patient panel. This is where most AAFP members focus their energies and where they often have the greatest impact. Population health also includes the health status and outcomes of the larger communities to which the physician and patient belong. It is essential when caring for their patients that family physicians consider the factors beyond the walls of their practice that influence their patients’ health. The family physician must consider the social and physical environments in which their patients live and work in order to effectively improve health outcomes.

As the healthcare system works to integrate primary care and public health, family physicians and the patient centered medical home will have more opportunities to partner with community resources and advocate for policies and interventions in these communities aimed at influencing social determinants of health and improving health outcomes.

(2015 COD)
Poverty and Health - The Family Medicine Perspective (Position Paper)

See Also

- Population Health
- Health Literacy
- Social Determinants of Health

Executive Summary

The vision of the American Academy of Family Physicians (AAFP) is to transform health care to achieve optimal health for everyone. In today’s era of population health management, the AAFP’s vision is especially relevant, focused, and clear. Implementing mechanisms to measure and improve the health of diverse populations is a goal that is not just “the right thing to do.” It is essential for improving the health status of all patients and is becoming standard work as the nation moves toward pay-for-value reimbursement. Success in this new era means achieving better outcomes by transforming health care to overcome obstacles to population health improvement, such as poverty.

As family physicians, we have a unique perspective on the health challenges of local populations because we serve generations of families and follow individual patients through different life stages. We are privileged to share the complex stories of individuals and families in both sickness and health over long periods of time and across different care settings. Rather than viewing a single snapshot of a patient during an episode of illness, we know the patient’s whole story. We know about the environmental and patient-/family-specific factors that led to the illness and what the patient needs in order to manage the illness effectively. As lifelong collaborators in care, family physicians are well positioned to understand each patient’s individual obstacles to health and help overcome them.

Poverty is one obstacle that can affect our patients’ health. It is an insidious, self-perpetuating problem that affects generations of families. Beginning in utero and continuing throughout an individual’s life, poverty affects health via complex mechanisms. Life expectancy, learning abilities, health behaviors, and risks for developing disease are affected by poverty, as are educational, work, and lifestyle opportunities. The degree to which an individual’s health outcome is affected is filtered by his or her level of “host resistance” to poverty. Poverty does not automatically determine an individual’s health status, although it can significantly influence it. This distinction opens a door of opportunity at both the individual and population levels. Society can intervene to increase host resistance and mitigate poverty’s negative effects on individual and population health by expanding access to health care, providing infrastructure that supports healthy habits, and promoting strategies to reduce poverty.

At the practice level, family physicians are well positioned to mitigate the effects of poverty on health by understanding each patient’s unique challenges and coping strategies, and knowing what community resources are available. We do not need to act in isolation. In the era of population health management, diverse private and public resources are recognizing each other and aligning to improve health outcomes. Health and social service resources can connect patients and physicians directly to solutions that mitigate poverty’s effect on health.

Caring for a patient of limited material means requires sensitivity to and understanding of the patient’s specific challenging circumstances in order to design a treatment plan that is achievable and sustainable. Such an approach requires a culturally proficient medical home and a well resourced medical neighborhood that supplies readily accessible solutions. When these solutions are incorporated seamlessly into everyday practice workflows, family physicians and care teams can be true to the AAFP’s vision by achieving positive change for individuals, families, and communities and improving population health.
Understanding Poverty and Low-Income Status

To understand poverty, we must first define it. The Centers for Disease Control and Prevention (CDC) defines poverty simply as a condition in which “a person or group of people lack human needs because they cannot afford them.”¹ In the United States, the federal poverty line is expressed as an annual pre-tax income level indexed by size of household and age of household members. For example, in 2014, the federal poverty line was $12,316 for an individual younger than 65 years of age and $24,418 for a family of four.² The American Community Survey revealed that 14.5% of all U.S. citizens fell below the poverty line in 2013 and that youth, racial and ethnic minorities, those without a high school diploma, and the unemployed had the highest rates of poverty.³

The term “low-income status” describes individuals and families whose annual income is less than 200% of the federal poverty level. Nearly 40% of the U.S. population meets this criterion.³

Poverty and low-income status are associated with a variety of adverse health outcomes, including shorter life expectancy, higher rates of infant mortality, and higher death rates for the 14 leading causes of death.⁴ ⁵ These effects are mediated through individual- and community-level mechanisms.⁶ For individuals, poverty restricts the resources used to avoid risks and adopt healthy behaviors.⁷ Poverty also affects the built environment (i.e., the human-made physical parts of the places where people live, work, and play, including buildings, open spaces, and infrastructure), services, culture, and reputation of communities, all of which have independent effects on health outcomes.⁸ Location matters, and there are often dramatic differences in health care delivery and health outcomes between communities that are only a few miles apart. For example, the Robert Wood Johnson Foundation (RWJF) found that there is a 25-year difference in average life expectancy between inner city and suburban neighborhoods for babies born in New Orleans, LA, and there is a 14-year difference in average life expectancy between two Kansas City, MO, neighborhoods that are roughly three miles apart.⁹

A recent study by The Commonwealth Fund assessed 30 indicators of access, prevention, quality, potentially avoidable hospital use, and health outcomes. The study found that low-income status populations suffer disparities in every state. However, it also identified significant differences among states’ performances. In fact, in top-performing states, many health care measures for low-income populations were better than average and better than those for higher income or more educated individuals in lagging states. These findings point out that low-income status does not have to determine poor health or poor care experience. Interventions seen in top-performing states, such as expanded insurance coverage, access, and coordination of social and medical services, can help mitigate poverty’s effects on health.¹⁰

The Complex Ways that Poverty Affects Health

Societal resources (e.g., social institutions, built environments, political structures, economic systems, technology) sustain health. Prosperity provides individuals with resources that can be used to avoid or buffer exposure to health risks (e.g., knowledge, power, prestige).¹¹ By contrast, poverty affects health by limiting access to proper nutrition; shelter; safe neighborhoods in which to learn, live, and work; clean air and water; utilities; and other elements that define an individual’s standard of living. Individuals who live in impoverished neighborhoods are likely to experience poor health due to a combination of factors that present obstacles to health maintenance.¹² Violence is prevalent where there is poverty. From 2008 to 2013, individuals in households at or below the poverty level had more than double the rate of violent victimization of individuals in high-income households, according to the National Crime Victimization Survey.¹³ This pattern was seen in both urban and rural areas. Victimization of violent behavior is experienced by both the family of the victim and the family of the perpetrator (through incarceration), which can create a cycle of stress, helplessness, and despair.

Life expectancy is significantly affected by poverty due to multiple factors, some of which are more obvious (e.g., violence) than others (e.g., lack of educational opportunities). Education and its socioeconomic status
correlates of income and wealth have powerful associations with life expectancy for both sexes and all races, at all ages. It is notable that students from low-income families are five times more likely to drop out of high school than students from high-income families. In 2008, the life expectancy among U.S. adult men and women with fewer than 12 years of education was not much better than the life expectancy among all adults in the 1950s and 1960s.

Poverty affects individuals insidiously in other ways that we are just beginning to understand. Mental illness and substance misuse are more prevalent in low-income populations; the argument about whether poverty is a cause or effect of this higher prevalence is ongoing. Poor nutrition, toxic exposures (e.g., lead), and elevated levels of the stress hormone cortisol are factors associated with poverty that may have lasting effects on children beginning in utero and continuing after birth. These effects, which can influence cognitive development and the development of chronic disease, are dose dependent (i.e., the duration of exposure matters). For example, the greater the number of years a child spends living in poverty, the more elevated the child’s overnight cortisol level is and the more dysregulated the child’s cardiovascular response to acute stressors is. Impaired development of the nervous system affects cognitive and socioemotional development, and increases the risk of behavioral challenges, adverse health behaviors, and poor school performance. These insidious biological effects of poverty contribute to its self-perpetuating cycle: low educational achievement leads to limited occupational options which leads to continued poverty.

However, the effects of poverty are not predictably uniform. Longitudinal studies of health behavior describe positive (e.g., tobacco use cessation) and negative (e.g., decrease in physical activity) health behavior trends in both lower and higher socioeconomic populations. However, there is a socioeconomic gradient in health improvement; in other words, lower socioeconomic populations lag behind higher socioeconomic populations in positive gains from health behavior trends. Health behaviors are important in that they account for differences in mortality. The fact that positive changes in health behaviors are possible in spite of the challenges of poverty points to the importance of developing and implementing interventions that promote healthy behaviors in low-income populations.

**Understanding the Health Effects of Poverty Opens the Door for Intervention**

Poverty affects health in many different ways through complex mechanisms that we are just beginning to understand and describe. It is important to note, again, that an individual’s poverty does not necessarily predetermine poor health. Poverty will not “cause” a disease. Rather, poverty affects both the likelihood that an individual will have risk factors for disease, and his or her ability and opportunity to prevent and manage disease. An individual’s health outcomes (a physiologic expression) ultimately will be influenced by genetic and environmental factors, as well as health behaviors, all of which may be influenced by poverty. The material conditions; discriminatory practices; neighborhood conditions; behavioral norms; work conditions; and laws, policies, and regulations associated with poverty make it a “risk regulator.” This means that poverty functions as a control parameter at a system level to influence the probability of exposure to key risk factors (e.g., behaviors, environmental risks) that lead to disease (Figure 1).

**Figure 1: An Illustration of Risk Regulators in Social and Biological Context**
Thinking of poverty as a risk regulator rather than a rigid determinant of health allows family physicians to relinquish the feeling of helplessness when we provide medical care to low-income families and individuals. We can devise solutions to mitigate both the development of risk factors that lead to disease and the conditions unique to low-income populations that interfere with effective disease prevention and management. We can boost an individual's or family's “host resistance” to the health effects of poverty. We can tap into a growing array of aligned resources that provide patients and families with tangible solutions so that health maintenance can be a realistic goal.

**Practical Approaches to Mitigating the Health Effects of Poverty: What Family Physicians Can Do**
Provide a patient-centered medical home (PCMH)

Strong primary care teams are critical in the care of low-income patients. These populations often have higher rates of chronic disease and difficulty navigating health care systems. They benefit from care coordination and team-based care that addresses medical and socioeconomic needs.

Across the United States, there is a move toward increased payment from government and commercial payers to offset the cost of providing needed care that is coordinated and team-based. Some payment models provide shared savings and/or per patient/per month care coordination payments in addition to traditional fee-for-service reimbursement. The rationale behind alternative payment models, particularly regarding the care of lower socioeconomic populations, is that significant cost savings can be realized when care moves toward prevention and self-management in a patient’s medical home and away from crisis-driven, fragmented care provided in the emergency department or a hospital setting. By recognizing and treating disease earlier, family physicians can help prevent costly, avoidable complications and reduce the total cost of care. We should be compensated appropriately for this valuable contribution to population health management.

Practice cultural proficiency

PCMH team members can have a positive effect on the health of low-income individuals by creating a welcoming, nonjudgmental environment that supports a long-standing therapeutic relationship built on trust. Familiarity with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (available online at www.thinkculturalhealth.hhs.gov/content/clas.asp) can prepare practices and institutions to provide care in a manner that promotes health equity.

Low-income patients may be unintentionally shamed by the care team when their behaviors are seen as evidence of being “noncompliant” (e.g., missing appointments, not adhering to a medical regimen, not getting tests done). These patients may not be comfortable sharing information about the challenges that lead to their “noncompliant” behaviors. For example, a low-income individual may arrive 15 minutes late to an appointment because he or she has to rely on someone else for transportation. A patient may not take a prescribed medication because it is too expensive. A patient may not get tests done because his or her employer will not allow time off from work. A patient may not understand printed care instructions because he or she has low literacy skills. Such patients may be turned away by staff because their tardiness disrupts the schedule, or they may even be dismissed them from the practice altogether because of repeated noncompliance. PCMH team members can tease out the “why” behind noncompliance and promote an atmosphere of tolerance and adaptation.

Patients in lower socioeconomic groups and other marginalized populations rarely respond well to dictation from health care professionals. Instead, interventions that rely on peer-to-peer storytelling or coaching are more effective in overcoming cognitive resistance to making positive changes in health behavior. PCMH team members can identify local groups that provide peer-to-peer support. Such activities are typically hosted by local hospitals, faith-based organizations, health departments, or senior centers.

Screen for socioeconomic challenges

Family physicians screen regularly for risk factors for disease; screening to identify patients’ socioeconomic challenges should also be incorporated into the practice. Once socioeconomic challenges are identified, we can work with our patients to design achievable, sustainable treatment plans. The simple question, “Do you (ever) have difficulty making ends meet at the end of the month?” has a sensitivity of 98% and specificity of 60% in predicting poverty. A casual inquiry about the cost of a patient’s medications is another way to start a conversation about socioeconomic obstacles to care.

A patient’s housing also has an effect on his or her health. The care team should ask the patient whether he or she has a home that is adequate to support healthy behaviors. For example, crowding, infestations, and lack of utilities are all risk factors for disease. Knowing that a patient is homeless or has poor quality, inadequate housing will help guide his or her care.

Set priorities and make a realistic plan of action
As family physicians, we direct the therapeutic process by working with the patient and care team to identify priorities so that treatment goals are clear and achievable. In many cases, we may need to suspend a “fix everything right now” agenda in favor of a treatment plan of small steps that incorporate shared decision making. It is likely that a low-income patient will not have the resources (e.g., on-demand transportation, a forgiving work schedule, available child care) to comply with an ideal treatment plan. Formulating a treatment plan that makes sense in the context of the patient’s life circumstances is vital to success.

For example, for a patient of limited material means who has a multiple chronic conditions, including hypertension (blood pressure of 240/120 mm Hg) and diabetes (A1c of 12%), it is important to start by addressing the elevated blood pressure and A1c. Colon cancer screening or a discussion about starting statin therapy can come later. It may be easier for this patient to adhere to an insulin regimen involving vials and syringes instead of insulin pens, which are much more expensive. The “best” medication for a low-income patient is the one that the patient can afford and self-administer reliably. We can celebrate success with each small step (e.g., self-administering one dose of insulin a day rather than no insulin) that takes a patient closer to disease control and improved self-management.

Help newly insured patients navigate the health care system
In many states, the expansion of Medicaid has allowed low-income individuals and families to become insured, perhaps for the first time. A newly insured low-income individual will not necessarily know how or when to make/keep/reschedule an appointment, develop a relationship with a family physician, manage medication refills, or obtain referrals. He or she may be embarrassed to reveal this lack of knowledge to the care team. PCMH team members can help by providing orientation to newly insured patients within the practice. For example, PCMH team members can ensure that all patients in the practice know where to pick up medication, how to take it and why, when to return for a follow-up visit and why, and how to follow their treatment plan from one appointment to the next. Without this type of compassionate intervention, patients may revert to an old pattern of seeking crisis-driven care, which is often provided by the emergency department of a local hospital.

Provide material support to low-income families
Resources that are available to make it easier for busy clinicians to provide support to low-income families include the following:

- Reach Out and Read ([http://www.reachoutandread.org](http://www.reachoutandread.org)) is a program that helps clinicians provide books for parents to take home to read to their children. Studies have shown that Reach Out and Read improves children’s language skills.

- 2-1-1 ([www.211.org](http://www.211.org)) is a free, confidential service that patients or staff can access 24 hours a day by phone. 2-1-1 is staffed by community resource specialists who can connect patients to resources such as food, clothing, shelter, utility bill relief, social services, and even employment opportunities. Follow-up calls are made to ensure clients connect successfully with the resource referrals.

- The National Domestic Violence Hotline ([www.thehotline.org](http://www.thehotline.org)) is staffed 24 hours a day by trained advocates who are equipped to provide confidential help and information to patients who are experiencing domestic violence.

Local hospitals, health departments, and faith-based organizations often are connected to community health resources that offer services such as installing safety equipment in homes; providing food resources; facilitating behavioral health evaluation and treatment; and providing transportation, vaccinations, and other benefits to low-income individuals and families.

Practices can make a resource folder of information about local community services that can be easily accessed when taking care of patients in need. This simple measure incorporates community resources into the everyday workflow of patient care, thus empowering the care team.

Participate in research that produces relevant evidence
Much of the research that exists about the effects of poverty on health is limited to identifying health disparities. This is insufficient. Research that evaluates specific interventions is needed to gain insight into
what effectively alleviates poverty’s effects on health care delivery and outcomes. Family physicians can serve a critical role in this research because we have close relationships with patients of low-income status.26

Advocate on behalf of low-income neighborhoods and communities

Family physicians are community leaders, so we can advocate effectively for initiatives that improve the quality of life in low-income neighborhoods. Some forms of advocacy, such as promoting a state’s expansion of Medicaid, are obvious. Other efforts may be specific to the community served. For example, a vacant lot can be converted to a basketball court or soccer field. A community center can expand programs that involve peer-to-peer health coaching. A walking program can be started among residents in a public housing unit. Collaboration with local law enforcement agencies can foster the community’s trust and avoid the potential for oppression.27

Family physicians have local partners in advocacy, so we do not have to act in isolation. As a result of the Patient Protection and Affordable Care Act (ACA), nonprofit hospitals regularly report community needs assessments and work with local health departments to establish action plans that address identified needs. A Community Health Needs Assessment (CHNA) reflects a specific community’s perception of need, and each action plan outlines multi-sectoral solutions to meet local health needs. Local CHNAs are typically available online, as are the associated action plans. Family physicians can use information in the CHNA to access local health care leadership and join aligned forces to achieve optimal health for everyone in the communities we serve, thereby supporting the vision of the AAFP.

Principal Authors:
Patricia Czapp, MD
Kevin Kovach, MSc, CHES

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Melanie D. Bird, PhD
Melody Goller, BSHA, CMP
Bellinda K. Schoof, MHA, CPHQ
Nicole Williams, MPH

REFERENCES


Pre- and Post-Operative Care

See also

- Surgery, Office-Based

Family physicians are professionally prepared to participate in pre- and post-operative care based on their education and training. Pre- and post-operative care should be a coordinated agreement between the family physician and the primary surgeon. These care coordination services play a pivotal role in ensuring continuity of care for patients, enhancing health care access, improving quality, and controlling costs. (1979) (2013 COD)
Preconception Care (Position Paper)

Introduction

As providers of preventive health and chronic disease care for men and women during their reproductive years, family physicians are well-positioned to proactively care for women, men, and families prior to, during, and after pregnancy. Preconception care is defined as individualized care for men and women that is focused on reducing maternal and fetal morbidity and mortality, increasing the chances of conception when pregnancy is desired, and providing contraceptive counseling to help prevent unintended pregnancies. The term “interconception care” is used when referring specifically to care provided between pregnancies. Details and risk factors associated with previous pregnancies are integral to interconception care. Because preconception care and interconception care address the same risk factors, the term “preconception care” is used throughout this position paper to include issues related to interconception care, unless a distinction is required.

National attention to preconception care interventions dates back to 1980 when the inaugural Healthy People initiative included a focus on the reduction of unintended pregnancies. The health objectives set forth in this initiative were designed to address the disparities in unintended pregnancy rates related to age and racial/ethnic group. These disparities were often associated with maternal risk factors and subsequent adverse reproductive outcomes. Preconception health care remains a strategic objective of Healthy People 2020. Despite reductions in the number of maternal deaths worldwide, maternal deaths in the United States have increased and birth outcomes in the United States are worse than many other high-income and even some low-income countries. In 2006, the CDC released Recommendations to Improve Preconception Health and Health Care - United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. This report was published in an effort to improve reproductive health outcomes. However, in spite of these national and international efforts, there continue to be barriers to incorporating preconception counseling into routine primary care.

To deliver on the promise to provide comprehensive care to patients, family physicians must possess the knowledge, ability, and skills to provide preconception care. This position paper discusses the critical role family physicians play in preconception care and provides evidence-based recommendations addressing reproductive health care, which is essential to the promotion of healthy families.

Benefits of Preconception Care

Infant mortality is often used as a key indicator of the overall health of the nation. The U.S. infant mortality rate is higher than the majority of other high-income countries and has remained relatively unchanged in the past decade. Prematurity and birth defects account for the majority of infant deaths in the United States, and interventions aimed at improving prenatal care have not been able to substantially improve these outcomes. To make matters worse, U.S. women ages 18 to 44 have numerous preconception risk factors that can negatively impact maternal and infant health; approximately 50% of these women are considered overweight or obese, 19% are current smokers, 10% have hypertension, and 3% have diabetes. The maternal mortality rate is also high in the United States. A woman is 10 times more likely...
to die from childbirth related complications in the United States than in countries such as Austria or Poland and significant racial and ethnic disparities persist within the United States.\textsuperscript{17}

Many of the potentially modifiable risk factors that affect future pregnancy outcomes occur prior to pregnancy. Preconception care offers family physicians and their patients an opportunity to discuss these risk factors so they can be minimized. There are clinical practice guidelines based on good quality evidence for interventions that improve outcomes; this fact, strengthens the case for a more robust delivery of preconception services in routine primary care. Yet, the delivery of preconception care has been less than satisfactory due to numerous barriers.

**Barriers to Delivery of Preconception Care**

Traditionally, preconception care has focused on those patients planning a pregnancy and has primarily been delivered at the well-woman/preventive care visit. However, since 50% of U.S. pregnancies are currently reported as unintended at the time of conception, the timing of addressing preconception risks poses a challenge.\textsuperscript{2} Additionally, until they are pregnant, many women of child bearing age do not seek care for themselves or may not have access to care.\textsuperscript{18} There are also barriers to achieving goals of interconception care; these goals include educating women about avoiding unintended rapid repeat pregnancy, following up on health risks identified during pregnancy, and transitioning into appropriate primary care. The postpartum visit provides one opportunity for interconception care; however, patient attendance is not guaranteed. Some women may lose insurance coverage in the early postpartum period, which makes it difficult for them to get access to appropriate follow up care.\textsuperscript{16, 18}

In 1990, Jack and Culpepper identified seven barriers to preconception care\textsuperscript{19}:

1. Women most in need of preconception care are the least likely to receive counseling
2. Fragmented health care service delivery system
3. Lack of treatment services for high-risk behaviors
4. Inadequate physician reimbursement providing counseling services
5. Lack of efficacy of counseling provided to unmotivated patients and their partner
6. Limited number of conditions with evidence-based preconception interventions
7. Lack of emphasis on risk assessment/health promotion in training programs.\textsuperscript{19}

Unfortunately, most of these barriers still exist. In a 2006 study, more than 95% of women surveyed recognized both the need to achieve optimal health prior to conception and the benefit of receiving information prior to conception.\textsuperscript{20} However, a majority of women did not recall receiving any preconception counseling.\textsuperscript{20} In addition, while the majority of preconception counseling is important,\textsuperscript{21} most neither provide nor recommend counseling for their patients of childbearing age.\textsuperscript{22} Another study showed that in 2015, the number of women receiving preconception care services during ambulatory care visits (OB-GYN or FP) is only 14%.\textsuperscript{23}

Changes in the current healthcare landscape are removing some of these barriers through expanded health insurance coverage, improved reimbursement for preventive services, and public health initiatives. In addition, clinical practice guidelines based on good-quality evidence have been developed for preconception interventions that improve maternal and fetal outcomes.\textsuperscript{24} Family physicians have a unique opportunity to make an impact by improving maternal and fetal outcomes in the United States.

**Call to Action: Why Family Medicine Should Lead this Process**

Family physicians are ideally suited to lead healthcare system change related to preconception care. They are the most frequent provider of ambulatory primary care services to women aged 18-44.\textsuperscript{25, 26} They also play a major role in providing ambulatory primary care services to children and men.\textsuperscript{25} Family physicians have an outstanding opportunity to address health issues (e.g. preconception risk reduction and chronic
disease management) with women in multiple settings. For example, mothers are present at over 98% of well-child visits for children from birth to 2 years of age. If a woman missed her postpartum care visit, her family physician would likely have an opportunity to address maternal risks during her child’s routine health care visit.

**Key Concept**

Providing quality preconception care is the responsibility of all primary care providers, not just those who provide maternity care or handle a high volume of women’s health. Innovative strategies that incorporate preconception care into routine primary care visits are needed. Transforming the way preconception care is delivered is critical to success. In order to successfully deliver preconception care, family physicians must understand the risk factors for- and the realities of-unintended pregnancy; recognize the value of reproductive planning in reducing these risks, and assess preconception health risks during chronic disease management visits and acute care visits that are not specifically focused on women’s health or maternity issues. Preconception care is primary care and it should be a priority for primary care providers in all settings. The majority of preconception health topics are important whether a woman desires a future pregnancy or not, so providing quality preconception care is essentially providing quality women’s health care. The American Academy of Family Physicians (AAFP) outlines the following evidence-based recommendations for preconception care provided by family physicians.

**Preconception Interventions for Women**

During routine care for women, family physicians should identify patients’ childbearing goals, screen for risk factors that can impact future pregnancies, and provide indicated interventions to help women enter pregnancy in optimal health. The following are key interventions focused on addressing women’s contraceptive needs and preconception risk factors.

A woman’s personal childbearing goals (i.e., her reproductive plan) should be considered for discussion at each visit, regardless of her reason for the visit because her plans may change on the basis of changing life circumstances. Reproductive plan discussions with women who want to become pregnant or who may become pregnant should include assessment of risks due to age, maternal or paternal conditions, obstetric history, and family history.

If a woman is sexually active and wants to prevent or delay pregnancy, comprehensive contraceptive services should be offered. All women who wish to delay or prevent pregnancy should be offered the following:

- A full range of U.S. Food and Drug Administration (FDA)-approved contraceptive methods
- An assessment to identify safe methods using the U.S. medical eligibility criteria,
- Counseling to help choose a contraceptive method
- Prompt provision of the contraceptive method selected by the patient (preferably on site; - by referral-if necessary).

Family physicians should use a tiered approach to present information on reversible contraceptive methods; information about the most effective methods should be presented first, followed by information on less effective methods. Counseling should include an explanation that long-acting reversible contraception (LARC) is safe and effective for most women, including adolescents and women who have never given birth. Family physicians should use shared decision making and tailor information about contraceptive methods to focus on the patient’s preferences; for some patients, efficacy may not be the highest priority. Routine counselling about emergency contraceptive methods and provision of emergency contraception when needed should also be components of comprehensive family planning services.

Due to the association of short interpregnancy levels with an increased risk of adverse perinatal outcomes,
birth spacing should be discussed with patients. A meta-analysis on birth spacing and perinatal outcomes found that an interpregnancy interval of 18 to 24 months was associated with the lower risks of poor outcomes than intervals shorter than 6 months. Longer interpregnancy intervals (over 59 months) were also associated with poor outcomes. This interval is consistent with the WHO’s birth interval recommendation and the recommendation from the United Nations Children Fund (UNICEF) that breastfeeding for two years or more is optimal. The evidence on optimal birth spacing following spontaneous or induced abortion is currently insufficient. Counseling on birth spacing should be individualized on the basis of a woman’s reproductive plan. The family physician should take into account the health risks and benefits of the timing of the subsequent pregnancy and should discuss effective contraceptive options.

All women of reproductive age should be advised to take a daily supplement (prenatal or multivitamin) of 400 to 800 mcg of folic acid daily and to consume a balanced, healthy diet of folate-rich foods. Folic acid supplementation starting prior to conception and continuing through 12 weeks of pregnancy reduces the risk of neural tube defects (NTDs) such as anencephaly, spina bifida, and encephalocoele. A higher dose of preconception folic acid (4 mg starting one month prior to attempting pregnancy and continuing through the first three months of pregnancy) is recommended for women at high risk for a pregnancy complicated by a NTD, and women who had a prior pregnancy complicated by a NTD, and women who have a personal or family history of NTD, insulin-dependent diabetes, or a seizure disorder (especially if it is treated with valproic acid or carbamazepine).

Management of overall health and chronic conditions is crucial for proper preconception care. Thirty-six percent of women aged 20 years and older are obese (body mass index [BMI] greater than or equal to 30 kg/m²). It is essential to counsel women on obtaining a healthy weight prior to pregnancy because being obese increases the risk of pregnancy complications that include gestational diabetes, hypertension, macrosomia, birth trauma, and cesarean section, as well as increasing the risk of induced and spontaneous preterm birth. Compared with mothers who have a BMI in normal range, obese mothers have a higher likelihood of pregnancies affected by congenital anomalies, including NTDs, cardiovascular anomalies, and cleft palate. Women who have a BMI less than 18.5 kg/m² are at increased risk for infertility, first trimester miscarriage, and preterm birth, and they are more likely to have an infant who has low birth weight. All women who have a BMI greater than 30 kg/m² or less than 18.5 kg/m² should be counseled about the risks their weight status poses to their own health and to future pregnancies; these patients should be offered specific strategies to improve the balance and quality of their diet and physical activity level.

Chronic hypertension can increase maternal and fetal morbidity and mortality during pregnancy. All women of reproductive age should have their blood pressure checked during routine care. Family physicians should provide counseling on lifestyle changes and appropriate medication adjustments for women who are diagnosed with hypertension. Women who have chronic hypertension should be counseled about preeclampsia and undergo a preconception assessment for ventricular hypertrophy, retinopathy, and renal disease to prevent end organ damage. Women who could become pregnant while taking angiotensin-converting enzyme (ACE) inhibitors or angiotensin II receptor blockers should be counseled about the adverse fetal effects of these medications and offered contraception. Women taking these medications who are planning a pregnancy or are not using an effective contraceptive method should strongly consider switching to a medication that is compatible with a healthy pregnancy.

Current data shows that 3% of women of reproductive age are affected by diabetes. Poor glycemic control in the first trimester—before some women know they are pregnant—is associated with an increased risk of spontaneous abortion and congenital defects. Other risks related to poor glycemic control include fetal macrosomia and associated birth trauma, stillbirth, and newborn hypoglycemia. If blood glucose remains uncontrolled during pregnancy, women with diabetes may have progression of any underlying retinopathy and/or nephropathy. Women who have diabetes also have an increased risk of high blood pressure and/or preeclampsia during pregnancy. Optimal glycemic control can reduce, but not
eliminate, risks. All women of reproductive of childbearing age who have diabetes should be counseled about the importance of glycemic control before pregnancy. Women who have suboptimal diabetes control should be encouraged to use an effective contraceptive method. Assisting women who have diabetes and other chronic conditions with reproductive planning and optimal timing of pregnancy is an essential component of quality preconception care.

Counseling on medication usage is an important part of preconception care. Approximately 10% to 15% of congenital anomalies in the United States are attributed to prescription medication use during pregnancy. Since the late 1970s, the use of prescription medications in the earliest weeks of pregnancy has increased by more than 60%. One study found that in 2006 to 2008, 82% of women reported taking at least one prescription or over-the-counter (OTC) medication in the first trimester. Many commonly prescribed medications are considered unsafe in pregnancy. Examples include ACE inhibitors, angiotensin receptor blockers (ARBs), warfarin, valproic acid, lithium, statins, and methotrexate. All women of childbearing age should be screened for the use of teratogenic medications and should be counseled about the potential impact of medications for chronic health conditions on pregnancy and fetal outcomes. When possible, known teratogenic medications should be switched to safer medications before conception. Women who have a chronic condition that poses a risk of serious morbidity to mother and infant, should be counseled to take the minimum number and the lowest dosages of medications that are essential to control the condition. For women who do not desire pregnancy, a plan for effective contraception should be discussed and initiated.

Preconception care should also include counseling on immunizations. All women of reproductive age should have their immunization status for tetanus-diphtheria-pertussis (Tdap); measles-mumps-rubella (MMR); and varicella reviewed annually and updated as indicated. In addition all women should be assessed annually to determine the need for vaccines that are recommended for those who have medical, occupational, or lifestyle risk factors for other infections.

Mental health assessment should be included in preconception care. Mood and anxiety disorders are highly prevalent among women of reproductive age, and there is a high prevalence of new psychiatric illness or relapse of a preexisting illness during pregnancy. Controlling depression and anxiety disorders prior to pregnancy may help prevent negative outcomes for a woman’s pregnancy and her family; women of childbearing age should be screened for these disorders. If a woman who has depression or anxiety disorder could become pregnant or is planning a pregnancy, her family physician should inform her about the potential risk of untreated illness during pregnancy. She should also be informed about the risks and benefits of treatment options for depression and anxiety disorders during pregnancy. If necessary, medications should be adjusted prior to conception. This timing decreases the exposure of the fetus to multiple medications and allows the medication dose to be tapered in order to minimize the risk of withdrawal symptoms. Treatment for depression and anxiety disorders during pregnancy should be individualized.

Another important part of preconception counseling is addressing lifestyle risks—including alcohol, tobacco, and substance use—and providing resources and support for lifestyle modifications. Alcohol use in pregnancy is the cause of fetal alcohol spectrum disorders (FASDs), a range of effects that include physical problems and behavioral and intellectual disabilities, and can have lifelong implications. All women of childbearing age should be screened for alcohol consumption and drug misuse. Family physicians should provide brief interventions that include describing the effects of drinking during pregnancy and warning that there are no safe levels of alcohol consumption during pregnancy.

Tobacco smoking in pregnancy is associated with numerous pregnancy complications including spontaneous abortion, stillbirth, low birthweight, preterm birth, placenta previa, placental abruption, and cleft lip/palate as well as an increased risk of sudden infant death syndrome (SIDS). Family physicians should screen all women of childbearing age for tobacco use. Patients who use tobacco should be provided with brief interventions that focus on the importance of reducing smoking—and ideally, completely stopping smoking—prior to pregnancy; interventions should also include discussing tobacco cessation medications and
referring patients for intensive services. Similarly, family physicians should screen women of childbearing age for misuse of other drugs (recreational and prescription) and should provide brief interventions with referral to a treatment center or higher level care, as indicated. Preconception care should also address occupational hazards and exposures, sexually transmitted infections (STIs), and physical and emotional abuse. For all women of childbearing age and their partners, family physicians should regularly assess STI risks, provide counseling and immunizations as indicated to prevent acquisition of STIs, and provide indicated STI testing and treatment. Expedited Partner Therapy significantly reduces the risk of persistent infection. All women of reproductive age should be asked whether physical, sexual, or emotional violence from any source is happening currently or happened in the recent past, or during childhood. If a woman is being abused or has been abused in the recent past, the family physician should express concern and willingness to assist by giving support and referring the patient to appropriate organizations for help. Appropriate evaluation, counseling, and treatment for physical injuries, STIs, unintended pregnancy, and psychological trauma should be offered—including emergency contraception—if appropriate. For counseling, legal advice, and other services, women should be offered information about community agencies that specialize in cases of abuse.

Table 1 General Recommendations for Preconception Interventions for Women

<table>
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<tr>
<th>Questions/Care Considerations:</th>
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<td>Reproductive Planning</td>
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<td>Folic Acid</td>
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<td>Social and Behavioral History</td>
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<td>Immunizations</td>
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<td>STIs</td>
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<tr>
<td>Physical/Sexual/Emotional abuse</td>
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</table>

BMI = body mass index; NTDs = neural tube defects; STI = sexually transmitted infection

### Preconception Interventions for Men

Most family planning and preconception care programs, research, and clinical practice guidelines have focused almost exclusively on women. Both the CDC and the U.S. Department of Health and Human Services (HHS) have called for improvements in meeting men's reproductive health needs. Survey data have shown that the majority of men are in need of family planning or preconception care. In spite of this perceived need, a man's reproductive health before a partner's pregnancy, and the effect of his health status on conception and pregnancy outcomes generally receive little attention, unless fertility issues arise.

The goals of men's preconception health are similar in many ways to those women's goals. The overall objective is to ensure optimal and positive outcomes of their reproductive and sexual behaviors, while minimizing the potential negative consequences of unhealthy lifestyle choices and unprotected sex. In addition, preconception care for a man should include counseling on the timing of pregnancy and on fathering children when he and his partner choose to do so; on overcoming fertility issues; and on ensuring healthy pregnancy for his partner and optimal post-partum outcomes for both his partner and their child or children.

### Effects on Fertility and Conception

Researchers have studied various substances, anatomical variations, behaviors and environmental issues that may affect a man's ability to contribute to a successful conception. Studies of factors that affect sperm quality, quantity, concentration, and motility have identified the following:

- Health conditions such as diabetes, erectile dysfunction, and testicular conditions (e.g. varicocele, history of testicular trauma, undisceded testes, hypogonadism, retrograde ejaculation), may affect fertility to a certain degree.
- Numerous medications (e.g. nifedipine, steroids, testosterone, colchicine, selective serotonin reuptake inhibitors [SSRIs], cimetidine, tetracyclines, allopurinol, opiates, ketoconazole) may alter the hypothalamic-pituitary-gonadal axis, and may reduce male libido, contribute to erectile dysfunction, and have toxic effects on sperm.
- Tobacco, alcohol and certain drugs (e.g. marijuana, cocaine) can affect spermatogenesis.
- Exposure to environmental hazards, radiation, heat, pollutants, lead, mercury and other occupational chemicals has been shown to affect sperm quality.
- Chemicals associated with woodworking, painting, making pottery and stained glass, and gun cleaning...
May affect sperm production.
- Stress has been shown to negatively impact sperm morphology and concentration.
- According to some studies, every 20 pounds above a man’s ideal body weight can lead to a 10% increase in the risk of infertility.  
- A number of genetic disorders, (e.g. cystic fibrosis, Klinefelter syndrome, Kartagener syndrome, and polycystic kidney disease), may impair fertility and affect sperm quality.

### Effects on Maternal and Fetal Outcomes

A man’s lifestyle factors can have a direct impact on his partner’s pregnancy. These factors include tobacco smoking, which exposes the expectant mother to secondhand smoke and, potentially, leads to negative effects such as low birth weight, intra-uterine growth restriction (IUGR), and preterm birth as well as increasing the risk of SIDS. A man who has HIV or another STI directly puts his pregnant partner and the fetus at risk for pregnancy complications and maternal and fetal morbidity. In addition, a growing body of literature suggests that a father’s involvement during pregnancy and delivery can have a positive effect on health outcomes for himself, his partner and their child or children. During wellness visits with men and adolescent boys, family physicians should consider discussing intimate partner violence, and coercive relationships, and promote respectful and consensual sexual relationships.

Paternal factors including genetics and age have been shown to have an effect on fetal outcomes. Screening for genetic conditions should be discussed and offered when appropriate. Recent studies have pointed to a relationship between advanced paternal age and conditions such as autism, and schizophrenia and other mental health disorders. Schizophrenia was found to be two times more likely in the child whose father was older than 45 years of age at conception and three times as likely if the father was older than 50 years of age. Similarly, a diagnosis of autism in the child is almost six times more likely in a child whose father was older than 40 years of age.

### Table 2 - General Recommendations for Preconception Interventions for Men

| Reproductive Planning | Male reproductive health issues should be an integral part of every wellness visit. Assess the man’s understanding of reproduction and his reproductive plan. When a partner’s pregnancy is desired, discuss medications, conditions, and activities that may affect fertility Conduct a physical examination looking for signs or conditions that may affect fertility |
| Contraception | When a partner’s pregnancy is not desired, discuss effective contraceptive methods |
| Family and Genetic History | Assess family history and genetic susceptibility |
| Social and Behavioral History | Assess social history, lifestyle risk factors (including smoking, substance abuse, and unsafe sex), and behavioral issues Assess for occupational hazards that may affect fertility |
| STIs | Assess STI risk, provide counseling, and immunizations as indicated to prevent acquisition of STIs, and provide STI testing and treatment |
| Physical/Sexual/Emotional Abuse | Beginning in adolescence, consider screening for and counseling to avoid intimate partner violence and coercive relationships and promote respectful and consensual sexual relationships |
STI = sexually transmitted infection

Summary

Preconception care is primary care, and providing quality preconception care is the responsibility of all primary care providers. Successful implementation requires transforming care delivery and making preconception care based on the best available evidence routine. The AAFP encourages members to follow these evidence-based recommendations to incorporate preconception care into all routine primary care visits and supports members’ efforts to improve maternal and fetal outcomes.

References


74. McGrath, J.J., et al., A comprehensive assessment of parental age and psychiatric disorders. *JAMA*
Pre-payments and Post-payment Audits

See also

- Coding and Payment

The AAFP advocates that pre-payment and post-payment audits should be infrequent, highly selective, supported by analysis showing definite abuse of the code in question, and demonstrate clear reasoning why the problem is not remediable by less onerous mechanisms. In lieu of broad pre-payment or post-payment audits, payers should use focused medical review of outliers based on reviews of patterns of services, using an independent medical peer review process, where physicians practicing in the same specialty, review their peers. The AAFP believes that broad use of pre-payment and post-payment audits is a significant business disruption for the physician office and creates an inappropriate culture of mistrust. (2014 COD)
Pre-Medical Student Shadowing

The AAFP promotes the workforce expansion needed to ensure that all Americans have access to a primary care patient-centered medical home, and recognizes that student shadowing opportunities in both academic and community family medicine practices can provide early exposure and mentorship that can lead to career choices to enhance this goal. The AAFP supports shadowing opportunities for students in middle and high school, college, and medical school. The AAFP supports the availability of resources to familiarize all family physicians with student-oriented career information and HIPAA-related professional education that emphasizes the critical importance of patient confidentiality. The AAFP also recognizes the right of the patient to decline a student shadow in the patient encounter.

(July 2011 BOD) (2016 COD)
Preceptorships

See also

- Residents and Students, AAFP
- Student Choice of Family Medicine, Incentives for Increasing
- Medical Schools, Minority and Women Representation in Medicine
- Teaching, Physician Responsibility
- Family Medicine Department, Definition
- Family Medicine Clerkship
- Family Medicine Interest Group

The American Academy of Family Physicians encourages its members to participate in preceptorships involving both medical students and premedical students. The AAFP strongly supports family medicine preclinical preceptorships for all medical students and will continue to serve as a resource for students interested in information about such preceptorships. (1980) (2013 COD)
Preferred Unit of Measurement for Liquid Medications

The AAFP supports a standardized approach for the use of milliliters (mL) as the preferred unit of measurement for liquid medications, in order to prevent unintended medication overdoses in children.

(Board Chair-September 21, 2011) (2016 COD)
Prevention and Control of Sexually Transmitted and Blood Borne Infections

See also

- Adolescent Health Care - Sexuality and Contraception
- Treatment of Survivors of Sexual Assault
- Health Education
- Child Abuse
- Adolescents, Protecting: Ensuring Access to Care and Reporting Sexual Activity and Abuse

In view of the epidemic of HIV, sexually transmitted infections (STIs), and blood borne infections sweeping the globe, the AAFP recognizes the need for intense and ongoing public and professional education. AAFP's goals for this educational outreach are to: increase awareness of these infections, encourage effective prevention; enable proper diagnosis; ensure proper treatment; and follow public health protocols for prompt reporting and outbreak investigation. All of these pieces are critical in order to stem the tide of these infections.

The AAFP endorses and encourages the following HIV, STIs and blood borne infections prevention strategies:

1. Effective ways to prevent sexual transmission of infections are abstinence and the maintenance of a life-long mutually monogamous relationship with one uninfected partner. For individuals who are sexually active with more than one partner, the following strategies are generally effective for reduced infections transmitted through bodily fluids:
   - Have intercourse with one uninfected partner;
   - Use condoms (or other effective devices such as dental dams) in a suitable manner for the entire episode of sexual activity.

2. Prevent blood-borne infection by:
   - Having appropriate up-to-date immunizations;
   - Monitoring safe blood banking protocols, transfusion services and organ donor services.
   - Deferring donations by persons at risk for or with blood borne infections;
   - Avoiding accidental inoculation and/or exposures by the use of universal precautions
   - Avoiding use of contaminated needles;
   - Reducing the amount of used needles in circulation by the development of regulated needle exchange programs;
   - Providing access to treatment when considered curative or effective in reducing transmission.

3. Reduce the number of of congenital and perinatal infections by appropriate testing, diagnosis, and treatment of infected individuals and their partners.
   - Providers should be aware of local law and community standards regarding expedited partner therapy (EPT) and patient-delivered partner therapy (PDPT) for STIs. With EPT and PDPT, clinicians prescribe treatment to partners of individuals known to be infected without providing direct medical evaluation and counseling to the partner.
   - Providers should be advising against breastfeeding when risk of transmitting and infection to the infant exceeds the benefits of breastfeeding.

4. Pre-exposure Prophylaxis for HIV: Pre-exposure prophylaxis, or PrEP, is an effective method for preventing HIV infection in people who are HIV-negative but at substantial risk of contracting it. PrEP adds prophylactic antiretroviral medication to other prevention strategies including consistent condom/barrier use.
Family physicians should counsel and when appropriate prescribe PrEP as a routine part of STI prevention.

The AAFP believes that any program for the diagnosis and treatment of HIV, STIs and blood borne infections should emphasize family medicine and the role of primary care physicians. (1971) (2016 COD)
Prevention of Gun Violence

See also

- Firearms and Safety Issues
- Violence (Position Paper)
- Violence as a Public Health Concern

The federal requirement for an on-site background check should ensure that those who have been convicted of a violent criminal offense and those who have been involuntarily committed to a mental institution or otherwise adjudicated to be suffering a severe mental condition posing a danger to others or themselves are not able to purchase firearms. Therefore, this background-check requirement should be expanded to include the sale of firearms at gun shows, over the Internet and in classified ads. Reasonable exceptions from the background check requirement should be allowed for sales between immediate family members if the seller does not know or have reasonable cause to believe that the purchaser is prohibited from receiving or possessing a firearm under federal, state, or local law. (2013 COD)
Preventive Medicine

Health promotion and prevention of disease are critical and foundational components of primary care and family medicine. The American Academy of Family Physicians (AAFP) strongly encourages practicing physicians, family medicine residents and medical students to practice evidence-based, cost-effective preventive medicine in the delivery of health care. In support of its members, the AAFP advocates for policies and payment that advance, stimulate, and facilitate preventive services. (1978) (2016 December BOD)
In defining primary care, it is necessary to describe the nature of services provided to patients, as well as to identify who are the primary care providers. The domain of primary care includes the primary care physician, other physicians who include some primary care services in their practices, and some non-physician providers. However, central to the concept of primary care is the patient. Therefore, such definitions are incomplete without including a description of the primary care practice.

The following five definitions relating to primary care should be taken together. They describe the care provided to the patient, the system of providing such care, the types of physicians whose role in the system is to provide primary care, and the role of other physicians, and non-physicians, in providing such care. Taken together they form a framework within which patients will have access to efficient and effective primary care services of the highest quality.

Definition #1 - Primary Care

Primary care is that care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undiifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.

Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care is performed and managed by a personal physician often collaborating with other health professionals, and utilizing consultation or referral as appropriate. Primary care provides patient advocacy in the health care system to
accomplish cost-effective care by coordination of health care services. Primary care promotes effective communication with patients and encourages the role of the patient as a partner in health care.

Definition #2 - Primary Care Practice

A primary care practice serves as the patient's first point of entry into the health care system and as the continuing focal point for all needed health care services. Primary care practices provide patients with ready access to their own personal physician, or to an established back-up physician when the primary physician is not available.

Primary care practices provide health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.).

Primary care practices are organized to meet the needs of patients with undifferentiated problems, with the vast majority of patient concerns and needs being cared for in the primary care practice itself. Primary care practices are generally located in the community of the patients, thereby facilitating access to health care while maintaining a wide variety of specialty and institutional consultative and referral relationships for specific care needs. The structure of the primary care practice may include a team of physicians and non-physician health professionals.

Definition #3 - Primary Care Physician

A primary care physician is a specialist in Family Medicine, Internal Medicine or Pediatrics who provides definitive care to the undifferentiated patient at the point of first contact, and takes continuing responsibility for providing the patient's comprehensive care. This care may include chronic, preventive and acute care in both inpatient and outpatient settings. Such a physician must be specifically trained to provide comprehensive primary care services through residency or fellowship training in acute and chronic care settings.

Primary care physicians devote the majority of their practice to providing primary care services to a defined population of patients. The style of primary care practice is such that the personal primary care physician serves as the entry point for substantially all of the patient's medical and health care needs - not limited by problem origin, organ system, or diagnosis. Primary care physicians are advocates for the patient in coordinating the use of the entire health care system to benefit the patient.

Definition #4 - Non-Primary Care Physicians Providing Primary Care Services

Physicians who are not trained in the primary care specialties of family medicine, general internal medicine, or general pediatrics may sometimes provide patient care services that are usually delivered by primary care physicians. These physicians may focus on specific patient care needs related to prevention, health maintenance, acute care, chronic care or rehabilitation. These physicians, however, do not offer these services within the context of comprehensive, first contact and continuing care.
The contributions of physicians who deliver some services usually found within the scope of primary care practice may be important to specific patient needs. However, the absence of a full scope of training in primary care requires that these individuals work in close consultation with fully-trained, primary care physicians. An effective system of primary care may utilize these physicians as members of the health care team with a primary care physician maintaining responsibility for the function of the health care team and the comprehensive, ongoing health care of the patient.

**Definition #5 - Non-Physician Primary Care Providers**

There are providers of health care other than physicians who render some primary care services. Such providers may include nurse practitioners, physician assistants and some other health care providers. These providers of primary care may meet the needs of specific patients. They should provide these services in collaborative teams in which the ultimate responsibility for the patient resides with the primary care physician. (1975) (2006)

*In this document, the term physician refers only to doctors of medicine (M.D.) and osteopathy (D.O.).

**Use of Term**

The AAFP recognizes the term "primary care" and that family physicians provide services commonly recognized as primary care. However, the terms, "primary care" and "family medicine" are not interchangeable. "Primary care" does not fully describe the activities of family physicians nor the practice of family medicine. Similarly, primary care departments do not replace the form or function of family medicine departments. (1977) (2016 COD)
Primary Care Physician, Generic

See also

- Primary Care
- Family Physician, Definition
- Role Definition of Family Medicine

The American Academy of Family Physicians affirms that the family physician is the ideal primary care physician and opposes any and all efforts to create a specialty or designation of "generic" primary care physician. (1987) (2015 COD)
Principles for Physician Payment Reform to Support the Patient-Centered Medical Home
(Position Paper)

A physician payment system should:

1. Recognize the value of whole-person care delivered in a patient-centered medical home (PCMH) including physician and non-physician work for:
   a. face-to-face services
   b. patient care management that falls outside of face-to-face encounters, consistent with AAFP policy on "Care Management Fees"

2. Reward PCMH activities that improve patient outcomes, enhance population health, improve the professional satisfaction of health care providers, and reduce total health care spending through incentives that:
   a. allow physicians to share in savings from reduced total health care spending
   b. reward measurable and continuous quality improvements
   c. support physicians in engaging patients as partners through shared decision-making and the development of strong, enduring, healing relationships
   d. support the efficiencies of team-based care
   e. support the use of evidence to guide clinical decision making
   f. prioritize the provision of comprehensive primary care services

3. Compensate for the physician practice’s investment in technology, infrastructure, and services that enhance patient access and improve care coordination, including:
   a. improved patient care communication (e.g. a secure, Web-based patient portal that supports synchronous or asynchronous e-mail and virtual visits and telephone consultation)
   b. use of health information technologies (e.g. patient registry systems, evidence-based clinical decision support, electronic health records, etc)
   c. practice transformation and innovation (e.g. staff training, work flow redesign and practice recognition requirements)

4. Include a transparent process that ensures the payment model accurately accounts for the cost of operating an efficient practice, including but not limited to, inflation, patient demographics (e.g. socioeconomic status, age, and gender), practice setting (e.g. rural/urban), and disease severity/case mix.

5. Promote accountability for achieving better results by linking a portion of payment to reporting on appropriate evidence-based measures of care, including structural, process, and outcomes measures. Performance measures included in payment and reporting systems must be valid, meaningful to all stakeholders, and harmonized across all payers. Payment must exceed the additional costs of reporting.

6. Include standardized administrative and reporting requirements and business rules across all payers including, but not limited to, interfaces for eligibility, benefits, deductibles, and real time claim submission/payment.

7. Allow for blended approaches to payment to counter-balance unintended consequences associated with using any single approach to payment.

8. Achieve an appropriate balance in income between primary care and sub-specialty physicians as a means to help ensure that there are sufficient primary care physicians.

(2010 COD) (2016 COD)
Privilege Assignment in Departmentalized Hospitals

See also

- AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Privileges
- Privileges at Competing Hospitals
- Privileges, Documentation of Training and Experience
- Privileges, Electrocardiogram Interpretation
- Privileges, Emergency Care Services
- Privileges, Family Medicine Departments and
- Privileges and Training for New Procedures
- Privileges Independent of Department Structure
- Privilege Support Protocol
- Privileging Policy Statements
- Privileges, Special/Critical Care Unit
- Privileges, Surgical Assistant
- Hospital Medical Staff, Board Certification for Membership

Privileges for family physicians must be recommended by the department of family medicine in departmentalized hospitals. (1982) (2013 COD)
Privilege Support Protocol

See also

- AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Privileges
- Privilege Assignment in Departmentalized Hospitals
- Privileges at Competing Hospitals
- Privileges, Documentation of Training and Experience
- Privileges, Electrocardiogram Interpretation
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- Privileges, Family Medicine Departments and
- Privileges and Training for New Procedures
- Privileges Independent of Department Structure
- Privileging Policy Statements
- Privileges, Special/Critical Care Unit
- Privileges, Surgical Assistant Privileges
- EGD, Training and Credentialing of Family Physicians In (Position Paper)
- Hospital Medical Staff, Board Certification for Membership

The American Academy of Family Physicians supports unequivocally the concept that all physicians should obtain privileges in accordance with their individual, documented training and/or experience, demonstrated abilities, and current competence.

The criteria necessary before the AAFP accepts cases for legal support in the area of hospital privileges include:

1. Strict following of the AAFP Protocol for Handling Hospital Privilege Problems.
2. Impact on the specialty of family medicine.
3. Evidence of discrimination based on physician specialty rather than individual qualifications. (In accordance with the legal principle of "inurement," a tax exempt organization may not expend funds for the benefit of an individual.)

All physicians on the medical staff should have the opportunity to practice medicine in their health care organizations, and should be granted clinical privileges commensurate with their documented training and/or experience, demonstrated abilities, and current competence. (1964) (2013 COD)
Many new procedures and techniques are being developed to aid in the care of patients, and many of these procedures/techniques are pertinent to the practice of family medicine. The American Academy of Family Physicians (AAFP) unequivocally holds that the granting of privileges for new procedures and techniques for all physicians should be made on the basis of each physician's documented training and/or experience, demonstrated abilities and current competence.

Further, educational opportunities for physicians to learn new procedures and techniques should be available to all physicians, regardless of specialty. Since many of the new procedures and techniques are very important to the practice of family medicine, the AAFP will work to ensure that such courses will be made available to family physicians.

All hospitals should have a standing protocol for establishing the privileging criteria for a procedure new to that institution and for which no privileging criteria currently exist. The purpose for establishing such a process is to assure that the eligibility to exercise a new procedure is determined fairly, rigorously and with regard to ascertaining competence, rather than promoting or limiting access to any particular specialty. (1983) (2015 COD)
Privileges at Competing Hospitals

See also

- AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Privileges
- Privilege Assignment in Departmentalized Hospitals
- Privileges, Documentation of Training and Experience
- Privileges, Electrocardiogram Interpretation
- Privileges, Emergency Care Services
- Privileges, Family Medicine Departments and
- Privileges and Training for New Procedures
- Privileges Independent of Department Structure
- Privilege Support Protocol
- Privileging Policy Statements
- Privileges, Special/Critical Care Unit
- Privileges, Surgical Assistant

The AAFP opposes the limitation of medical staff participation and privileges by a hospital or health system based on a physician (or a partner, family member, associate or employee of the physician) having privileges at, a position of leadership or influence at, or a financial relationship with a second or competing hospital or health system. (2001) (2016 September BOD)
Privileges, Documentation of Training and Experience

See also

- Privileges
- Health Workforce Credentialing
- Family Medicine Faculty Training
- Hospital Medical Staff, Board Certification for Membership
- Privilege Assignment in Departmentalized Hospitals
- Privilege Support Protocol
- Privileges at Competing Hospitals

The American Academy of Family Physicians believes that documentation of training and experience is of utmost importance, not only for residents preparing for their first application for hospital privileges, but also for practicing physicians.

The AAFP recommends that family physicians document all significant training and experience so that it is recorded and can be reported in an organized fashion. Such documentation should include at a minimum all procedural skills, intensive/critical care experiences, treatment of major illnesses, and other significant training and experiences. (1989) (2016 September BOD)
Privileges, Electrocardiogram Interpretation

See also

- Electrocardiograms, Family Physician Interpretation of
- AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Privileges
- Privilege Assignment in Departmentalized Hospitals
- Privileges at Competing Hospitals
- Privileges, Documentation of Training and Experience
- Privileges, Emergency Care Services
- Privileges, Family Medicine Departments and
- Privileges and Training for New Procedures
- Privileges Independent of Department Structure
- Privilege Support Protocol
- Privileging Policy Statements
- Privileges, Special/Critical Care Unit
- Privileges, Surgical Assistant

The American Academy of Family Physicians (AAFP) unequivocally holds that all physicians should obtain privileges in accordance with their individual, documented training and/or experience, demonstrated abilities, and current competence. On the basis of their training in Family Medicine, family physicians should have the education, training and experience to read electrocardiograms and should therefore be eligible for privileges to interpret electrocardiograms. Where local tests are utilized to establish current competency, the use of such tests should apply equally to all physicians regardless of specialty. (1982) (2015 COD)
Privileges, Emergency Care Services

See also

- AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Privileges
- Privilege Assignment in Departmentalized Hospitals
- Privileges at Competing Hospitals
- Privileges, Documentation of Training and Experience
- Privileges, Electrocardiogram Interpretation
- Privileges, Family Medicine Departments and
- Privileges and Training for New Procedures
- Privileges Independent of Department Structure
- Privilege Support Protocol
- Privileging Policy Statements
- Privileges, Special/Critical Care Unit
- Privileges, Surgical Assistant
- Emergency Department Call for Family Physicians (Position Statement)
- Emergency Medical Care

Family physicians, through training and experience, are qualified to provide emergency care services. The American Academy of Family Physicians believes that privileges to practice in the emergency department should be based on the individual physician's documented training and/or experience, demonstrated abilities, and current competence and not solely on the physician's specialty. (1995) (2016 September BOD)
Privileges, Family Medicine Departments and

See also

- AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Privileges
- Privilege Assignment in Departmentalized Hospitals
- Privileges at Competing Hospitals
- Privileges, Documentation of Training and Experience
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- Privileging Policy Statements
- Privileges, Special/Critical Care Unit
- Privileges, Surgical Assistant
- Family Medicine Department, Definition

Hospitals departmentalized by specialty should establish departments of family medicine. The department of family medicine should have all the rights, duties, and responsibilities comparable to other specialty departments of the medical staff. It should have the right to recommend directly to the appropriate committee, typically the credentials committee, those privileges that fall within the scope of family medicine. The assent or approval of any other department should not be required. The ultimate responsibility for the granting of privileges remains with the hospital governing body.

Family medicine encompasses continuous, comprehensive, quality care, emphasizing patient advocacy. Family physicians should have access to their patients in all areas of a healthcare facility, including areas of high technological care, through appropriate privileging. Patients should have access to family physicians in all these areas. All medical staff members should recognize that overlap occurs between many specialties and that no one department "owns" or has exclusive rights to any particular privileges. (See AAFP Policy on Privileges Independent of Department Structure.)

The family medicine department should determine the criteria for and recommend privileges commensurate with the core curriculum and training offered in a family medicine residency program.

The department of family medicine should establish and use a core privileging process based on criteria developed by the department. Core privileges within the department of family medicine should reflect the core curriculum and training offered in accredited family medicine residency programs. Criteria for privileges outside of the core should be pre-established by the department of family medicine in consultation with other appropriate clinical departments. Recommendations for privileges outside the family medicine core may then be considered by the department of family medicine according to the criteria jointly established by the relevant clinical departments. In all cases, clinical review of a physician should be done in the department where the privilege originated.

As with any specialty department, individual members of the department of family medicine may have different degrees of experience, and clinical interests, and would not all be eligible, per se, for the same privileges just by virtue of being members of the family medicine department. Privileges in the department of family medicine should be based on documented current licensure, training and/or experience, demonstrated abilities, and current competence. (1997) (2014 COD)
Privileges Independent of Department Structure

See also

- AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Privileges
- Privilege Assignment in Departmentalized Hospitals
- Privileges at Competing Hospitals
- Privileges, Documentation of Training and Experience
- Privileges, Electrocardiogram Interpretation
- Privileges, Emergency Care Services
- Privileges, Family Medicine Departments and
- Privileges and Training for New Procedures
- Privilege Support Protocol
- Privileging Policy Statements
- Privileges, Special/Critical Care Unit Privileges
- Privileges, Surgical Assistant

Family medicine encompasses continuous, and comprehensive quality care, emphasizing patient advocacy. Family physicians should have access to their patients in all areas of a health care facility, including areas of high technological care, through appropriate privileging. Patients should have access to family physicians throughout the entire hospital. All medical staff members should recognize that overlap occurs between many specialties and that no one department "owns" or has exclusive rights to any particular privileges. (2002) (2013 COD)
Privileges, Special/ Critical Care Unit

See also

- AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Privileges
- Privilege Assignment in Departmentalized Hospitals
- Privileges at Competing Hospitals
- Privileges, Documentation of Training and Experience
- Privileges, Electrocardiogram Interpretation
- Privileges, Emergency Care Services
- Privileges, Family Medicine Departments and
- Privileges and Training for New Procedures
- Privileges Independent of Department Structure
- Privilege Support Protocol
- Privileging Policy Statements
- Privileges, Surgical Assistant Privileges

The AAFP believes that qualified physicians should be granted privileges in special/critical care units based on documented training and/or experience, demonstrated abilities and current competence. (1981) (2016 September BOD)
Privileges, Surgical Assistant

See also

- AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Privileges
- Privilege Assignment in Departmentalized Hospitals
- Privileges at Competing Hospitals
- Privileges, Documentation of Training and Experience
- Privileges, Electrocardiogram Interpretation
- Privileges, Emergency Care Services
- Privileges, Family Medicine Departments and Privileges and Training for New Procedures
- Privileges Independent of Department Structure
- Privilege Support Protocol
- Privileging Policy Statements
- Privileges, Special/Critical Care Unit

As the patient's advocate, when the family physician's patients require surgical care not provided by the family physician, the family physician will exercise his/her best professional judgment in recommending the most appropriate consultant.

The "Program Requirements for Residency Education in Family Practice" mandate that all family medicine residents must receive training in pre- and postoperative care, basic surgical principles, asepsis, handling of tissue and technical skills to assist the surgeon in the operating room. Based on their education, training, and/or experience, family physicians are well qualified to assist at surgery. In addition to providing skilled technical assistance, a family physician assisting at surgery will:

1. ensure comprehensive and continuous care of the individual patient,
2. provide the important psychological support and safety necessary,
3. provide clinical correlation with surgical findings at the time of the operation,
4. provide or assist in provision of pre- and postoperative care, including technical and psychological components,
5. coordinate and support in communication and rapport between the consultants/surgeons, the patient and the patient's family, and act as the patient's advocate in obtaining appropriate, comprehensive, and coordinated care. Physician assistance at surgery, which is clinically necessary for improved patient outcome, should be fairly compensated by all payers of health care.

As a member of the medical staff and the patient's attending physician, the exercise of a family physician's privilege to assist at surgery shall not be superseded by a surgical residency program's rules or regulations regarding surgical assistance.

When hospital rules require surgical assistance on cases, nonphysician surgical assisting should be acceptable only in individual cases where appropriate family physician or other physician assistance is unavailable. (1988) (2013 COD)
Privileging Policy Statements

See also

- AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Privileges
- Privilege Assignment in Departmentalized Hospitals
- Privileges at Competing Hospitals
- Privileges, Documentation of Training and Experience
- Privileges, Electrocardiogram Interpretation
- Privileges, Emergency Care Services
- Privileges, Family Medicine Departments and
- Privileges and Training for New Procedures
- Privileges Independent of Department Structure
- Privilege Support Protocol
- Privileges, Special/Critical Care Unit
- Privileges, Surgical Assistant

The American Academy of Family Physicians (AAFP) believes that each specialty society should maintain responsibility for recommending, implementing, maintaining and evaluating privileging policies for its members. The AAFP also believes that privileging should be based on documented training and/or experience, demonstrated abilities and current competence, and, whenever possible, be evidence based. Physician privileging should allow for any and all combinations of competencies in adult, pediatric, and obstetric care in both the inpatient and outpatient setting.

Recognizing that on rare occasions minimum quotas (or numbers) may be required in specific privileging instances where insufficient data exists, the AAFP believes that a consensus opinion of experts from within the specialty may be necessary until such time as an evidence-based recommendation is available. (1995) (2014 COD)
Procedural Skills, Interspecialty Support in Clinical Procedures

See also

- Procedural Skills, Preceptor/Proctor Readiness Course
- Procedural Skills Training, Residency Criteria
- Procedural Skills, Scope of Training in Family Medicine Residencies

The AAFP should seek to work collaboratively with other specialty societies, when appropriate, concerning issues of procedure skills, including but not limited to: training, privileging and credentialing, and joint political action. (1994) (2016 COD)
Procedural Skills, Preceptor/ Proctor Readiness Course

See also

- Procedural Skills, Interspecialty Support in Clinical Procedures
- Procedural Skills Training, Residency Criteria
- Procedural Skills, Scope of Training in Family Medicine Residencies

The AAFP sponsors certain procedural skills' courses which by design, scope and/or duration include both cognitive and skills testing. Physicians performing satisfactorily on the cognitive and skills testing will be awarded a certificate indicating readiness to be preceptored/proctored.

The AAFP recommends that hospitals and health care organizations assign preceptors/proctors to family physicians who have been granted an AAFP preceptoring/ proctoring readiness certificate. These preceptors/proctors should, if possible, be family physicians with clinical privileges in the procedure(s) being sought. (1994) (2016 COD)
Procedural Skills, Scope of Training in Family Medicine Residencies

See also

- Procedural Skills, Interspecialty Support in Clinical Procedures
- Procedural Skills, Preceptor/Proctor Readiness Course
- Procedural Skills Training, Residency Criteria

Family medicine residencies should strive to teach residents all procedures within the scope of family medicine. They should, at a minimum, teach residents those procedures done by a substantial number of practicing family physicians both in the ambulatory and inpatient settings. Whenever possible, family physician faculty should teach these procedures.

Procedures and skills associated with maternity care and hospital care remains essential parts of family medicine residency training and clinical practice. Each family medicine residency must have faculty, board certified in family medicine, who actively teach, have clinical privileges and practice maternity care. As the scope of family medicine changes, family medicine residencies should strive to teach new or emerging procedures or techniques that are within the scope of family medicine. (1994) (2014 COD)
Procedural Skills Training, Residency Criteria

See also

- Procedural Skills, Interspecialty Support in Clinical
- Procedural Skills, Preceptor/Proctor Readiness Course
- Procedural Skills, Scope of Training in Family Medicine Residencies

In order to provide an appropriate protocol for procedures training in the family medicine residency, the following components should be included in training:

1. Background
2. Indications for the Procedure
3. Contraindications for the Procedures
4. Alternatives to the Procedure
5. Complications
6. Informed Consent/Patient Counseling
7. Patient Preparation
8. Adherence to Joint Commission Standards as Applicable (e.g. Universal Protocol)
9. Anesthesia, Analgesia, Sedation (as appropriate)
10. Equipment
   1. Selection
   2. Knowledge of Use
   3. Care, Cleansing, and Maintenance
11. Patient Positioning
12. Technique
   1. Descriptions of Procedure Steps
   2. Observation of Technique
   3. Performance Under Supervision
   4. Practice of Procedural Skills
13. Chart Documentation and Procedure Tracking
14. Pathology Recognition
15. Management of Complications
16. Practice Management Aspects
17. Financial Implications and Stewardship of Resources
18. Patient Monitoring/resuscitation
19. Outcome Evaluation
   1. Faculty Evaluation
   2. Self-Evaluation
   3. Reflective Learning
   4. Coaching

The instructor(s) in the residency must have significant personal experience in performing the procedure(s) that are being taught. Family medicine residents should be credentialed to perform procedures in which they have received cognitive instruction, documented experience and demonstrated competency. (March Board 2001) (2016 December BOD)
Professional Competence Evaluation

See also

- Certification/Maintenance of Recertification, Definitions
- Licensure
- Licensure/Relicensure, Definitions

Evaluation of competence in the discipline of family medicine and other specialty disciplines, including periodic recertification, should continue to be under the purview of the individual specialty boards of that discipline, and medical licensure should continue to be the province of the state boards of medical examiners. (1974) (2013 COD)
Professional Medical Liability

See also

- Professional Medical Liability, Insurance Stipulations
- Professional Medical Liability, Lawsuits
- Physician Expert Witness in Medical Liability Suits

Academy Goals and Methods

As one of its highest priorities, the Academy will continue to work on the professional medical liability problem. The professional liability insurance problem continues to have a negative impact on patients’ access to care. No responsible party in the medical profession denies the existence of malpractice and the right of a fair recovery to the negligently injured patient.

The goals of the AAFP in this area are:

1. To be an advocate for the patient and help them obtain relief from costs related to professional medical liability insurance and to support solutions that more equitably and quickly compensate those truly injured in the course of medical care.
2. To be an advocate for family physicians regarding any mechanism for: (1) affordable premiums; (2) differential premiums for beginning and part time physicians; and (3) equitable premium differentials for family physicians who provide obstetrical and surgical services based on sound actuarial evidence and standards of care.
3. To encourage and support in depth study and implementation of non legislative solutions to the professional liability problem.
4. To encourage and support state and national legislative solutions to aid physicians providing medical care (including obstetrics) in underserved areas. Such relief could be in the form of tax relief, partial payment of professional liability insurance premium and/or loan forgiveness.
5. To support chapters by serving as a resource center to provide information of evolving solutions in other areas. (1976) (2004)

The American Academy of Family Physicians supports the following federal liability reforms:

1. A limit on payments on "non-economic damages,"
2. Reducing awards by the amount of compensation from collateral sources,
3. Allowing periodic payment of future damages at a defined award limit,
4. Limiting attorneys' contingency fees,
5. Replacing joint and several liability with proportionate liability among the defendants in a case,
6. Reduce statute of limitations for commencing professional liability actions to one to three years after injury, with an absolute limit of six years for minors,
7. Incentives for states to establish Alternative Dispute Resolution Systems, and
8. An expert affidavit that must be provided by a specialist who possesses knowledge and expertise and practices in the same medical specialty as the defendant.

Other methods that the Academy believes will be helpful in stabilizing unacceptably high liability premiums and aid in abating the medical liability problem are:

1. Secure state legislation requiring joint underwriting associations (JUAs), consisting of all casualty insurance carriers in the state, to provide professional liability coverage on a collective basis.
2. Redefine, by legislation, medical negligence and liability, including specific designations concerning implied warranty and informed consent.
3. Legislate limits on awards including, but not limited to, limits on awards for total damages, non economic damages, damages for dependent care, wrongful death benefits and limited punitive
damage awards.
4. Mandate catastrophic insurance coverage.
5. Make information concerning collateral sources of income, and the tax status of awards, admissible in evidence.
6. Increase disciplinary authority of state boards of medical examiners.
7. Require 60 days advance notice of intention to sue.
8. Affirm a physician's right to recover from plaintiff reasonable legal costs and attorney's fees in successful defense of professional liability suits.
9. Eliminate the ad damnum clause in the filing of lawsuits.
10. Require that accompanying the filing of a claim is an affidavit from a physician stating the physician's opinion that the claim has merit.
11. Require that expert witnesses meet specific requirements (see Academy's policy regarding expert witnesses).
12. Required that insurance companies provide information regarding economic versus non-economic damages and settled versus verdict cases to state and national regulators.
13. Raising the evidentiary standard in medical liability cases to require "clear and convincing" evidence. (1975) (2012 COD)
Professional Medical Liability, Insurance Stipulations

See also

- Professional Medical Liability
- Professional Medical Liability, Lawsuits
- Physician Expert Witness in Medical Liability Suits

The American Academy of Family Physicians recognizes that professional liability carriers may find it necessary to create contractual stipulations (endorsements) that oblige a physician to a particular course of action when treating certain conditions or providing certain types of medical care. However, the Academy believes that such stipulations should not be based solely on one's specialty. Rather, such stipulations should be reflective of the individual physician-insured's training, experience and demonstrated ability, as well as his or her access to medical technology and health manpower resources. (1986) (2014 COD)
The American Academy of Family Physicians denounces the use of medical liability lawsuits as a means to pursue social and ethical policy.

Promoting Early Literacy Development

SEE ALSO

- Health Literacy

SEE ALSO

- Health Literacy

Family physicians should promote early literacy development as an important intervention at health supervision visits for children from six months through six years of age by effective methods that include:

1. Advising parents and caregivers about the importance of reading aloud to young children;
2. Counseling parents and caregivers about specific age- and developmentally-appropriate reading activities; and
3. Participating in early literacy programs. (2014 COD)
Protective Equipment for Recreational and Competitive Sports Activities

See also

- Athletic Trainers for High School Athletes
- Collision Sports
- Motor Vehicle Occupant Protection
- Motorcycle and Bicycle Helmet Laws
- Motorized Recreational Vehicle Safety
- Residential Pool Safety
- Sports Medicine, Persons with Disabilities: Participation in Sports and Physical Activities

The AAFP recommends that family physicians counsel patients to use appropriate protective equipment for recreational and competitive sports activities, but should be aware of the proliferation of protective equipment, add-ons, or accessories, that may not have been rigorously tested, may not actually reduce the risk of injury, or may fundamentally alter the purpose or function of existing protective equipment. This equipment may include, but is not limited to, certified flotation devices, eye protection, helmets, mouth guards, knee and elbow pads, wrist protection and other equipment as needed to protect against injury. Whenever practical, family physicians should direct patients (or their parents) to look for National Operating Committee on Standards for Athletic Equipment (NOCSAE) certification on protective equipment.

The AAFP also recommends that facilities or groups offering recreational or competitive sports activities for youth make available low-cost protective equipment.

Provider, Use of Term

See Also

- Provider, Use of Term (Position Paper)

The American Academy of Family Physicians opposes the use of the term "provider" when referring to physicians. Third party payers should never use the term "provider" as an inclusive term that lumps physicians with non-physician professionals, institutional providers and other service suppliers. The Academy supports the use of terms such as "physician" or "primary care physician" to distinguish physicians from other health care professionals. The term "physician" should be reserved for an MD or DO. (2008) (2013 COD)
Provider, Use of Term (Position Paper)

See Also

- Provider, Use of Term
- Non-Physician Provider, Family Physicians Training With Nurse Practitioners
- Physician Assistants

The term "provider" levels distinctions and implies a uniformity of expertise and knowledge among health care professionals. The term diminishes those distinctions worthy of differentiation such as education, scope and range of ability. Generic terminology implies an interchangeability of skills that is inappropriate and erroneous, as well as conferring legitimacy on the provision of health services by non-physician providers that are best performed by, or under the supervision of, physicians.

The term "provider" is one of bureaucratic origin and has no significance or relevance beyond that created by regulators and insurers. The effect of the term is to create confusion among individuals seeking care, especially those seeking care within a managed care environment. The implication is that "providers" are interchangeable and patients can expect to receive the same level of care from any "provider." Use of the term is especially inappropriate if it is employed as a tactic to confuse and thereby encourage use of health care professionals of less cost to the insurer.

Patients should be free to make personal decisions concerning their selection of health care professionals, including their personal physician. This right is restricted by the use of the term "provider" which, as indicated, implies uniformity of skills and conceals by failing to differentiate. Although the AAFP recognizes that non-physician personnel are valuable resources and may be able to assist in providing many aspects of patient care, the AAFP continues to support a patient's right to have a personal physician. That right is eroded when the several categories of health care professionals are aggregated into a generic cluster.

Academy policy clearly delineates different organizational roles for physicians and non-physician providers. Academy policy states that non-physician providers, "...should always function under the direction and responsible supervision of a practicing, licensed physician."¹ Accordingly, any attempt to imply an interchangeability of expertise is derogatory to the profession, misleading to the consumer, and usurps the legitimate role and responsibility of the physician to oversee the activities of non-physician providers.

Academy policy also states that nurse practitioners and physician assistants, "...should only function in a collaborative practice environment under the direction and responsible supervision of a practicing, licensed physician."²³ AAFP policy also states that payment for the services of non-physician professionals should be limited to those environments "...where services are provided in a collaborative practice arrangement."²

The term "provider" implies that the relationship between the patient and physician is a commercial transaction. The underlying premise of the "provider" based environment is that health care delivery is essentially a market-based enterprise based on a market ethic. This contradicts the Academy's position that the core of the family medicine specialty lies in "...the patient-physician relationship with the patient viewed in the context of the family." The Academy further maintains that the degree to which this relationship is developed and fostered is what distinguishes family medicine from other physician specialties.

References

Radiology (Position Paper)

See also

- Imaging Personnel

Family Physician Interpretation of Outpatient Radiographs

Overview and Justification

Diagnostic radiography is an integral part of the evaluation and management of acute and chronic illnesses. Offering radiography in the family medicine practice reduces access issues and decreases the time to diagnosis and treatment. Specific radiologic services provided are at the discretion of an individual practice. According to the American Academy of Family Physicians (AAFP) Member Census (as of June 30, 2015), 26.1 percent of AAFP members offer x-ray services in their practices, 7.4 percent offer obstetric (OB) ultrasound imaging, 5.6 percent offer non-OB ultrasound imaging, and 4.3 percent offer echocardiography. Family medicine practices that offer in-office radiography typically do not have a radiologist on staff, particularly in rural settings. Because family physicians receive the necessary training in residency to interpret radiographs, it is common for them to order and read radiographs in their practices. A family physician is uniquely positioned to make a diagnosis and develop a treatment plan by integrating his or her interpretation of a patient’s radiograph with knowledge and understanding of the patient’s complete history, physical examination, and laboratory testing. In some cases, the family physician may choose to have a radiograph over-read by a radiologist. The patient’s care may be modified if there is a clinically significant discrepancy between the readings.

The PCMH model promotes increased patient access and same-day services; in-office diagnostic radiography supports these goals. It is a valuable service for patients, providing care at a local level and giving needed access to patients who would have difficulty traveling to another facility, especially patients who are elderly or have a disability. Diagnostic radiography provided in the family physician’s office reduces transitions of care, allowing patients to remain in their medical home for diagnosis and treatment (e.g., splinting or definitive care of fractures or sprains). It saves the health care system money because patients are not seen in the emergency department (ED) or an urgent care center. Diagnostic radiography provided in the family physician’s office reduces transitions of care, allowing patients to remain in their medical home for diagnosis and treatment (e.g., splinting or definitive care of fractures or sprains). It saves the health care system money because patients are not seen in the emergency department (ED) or an urgent care center. This also avoids the fragmentation of care that can occur when an urgent care or ED physician refers a patient out of the PCMH to another specialist following radiography.

Physicians billing for in-office radiography may bill for the technical component (taking the pictures) or the professional component (reading the images) or both. A family physician with on-site radiography equipment will typically bill for the technical component of the imaging service. In addition, if the family physician reads a radiograph and generates a separate written report, then the professional component would also be billed. If a radiograph is initially read by the family physician and then over-read by a radiologist who generates the written report, the radiologist would bill for the professional component. A 2015 study estimated that 53.8 percent of Medicare Physician Fee Schedule (MPFS) payments for medical imaging services in 2011 were made to nonradiologists. Nonradiologists received the following percentages of specific payment types for medical imaging:

- Professional-only payments: 20.6 percent
- Technical-only payments: 84.9 percent
- Global (both professional and technical) payments: 70.1 percent

MPFS medical imaging payments to nonradiologists differed from state to state, with percentages ranging from a low of 32 percent (Minnesota) to a high of 69.5 percent (South Carolina). In nearly 60 percent of states, the percentage of MPFS payments for medical imaging to nonradiologists exceeded payments to radiologists.

Between 2000 and 2005, medical imaging was one of the fastest growing categories of Medicare spending, with the number of imaging studies paid for under the MPFS (excluding imaging studies performed in hospital outpatient departments) growing more rapidly (61 percent growth) than the sum of all physician services (31 percent growth). In response to this rapid growth, Congress and the Centers for Medicare & Medicaid Services (CMS) took action to systematically reduce reimbursement for medical imaging, primarily focusing on reductions to the unit cost. One major action was the 2005 Deficit Reduction Act (DRA), which took effect on January 1, 2007; it reduced global and technical-only payments for in-office imaging to the outpatient hospital payment level. Other initiatives to address...
medical imaging costs included changes to payment methods for practice expense and equipment utilization, bundling of CPT codes, and discounting of Multiple Procedure Payment Reduction (MPPR).\textsuperscript{5,6}

Aggregate Medicare payments to physicians for diagnostic imaging began to decline in 2007; in 2010, these payments were 21 percent lower than they had been in 2006.\textsuperscript{6} The volume of medical imaging also declined during this time period.\textsuperscript{5} According to a report from the American College of Radiology (ACR), data from private payers on medical imaging use reflect the same general trends as Medicare data.\textsuperscript{6} In addition to the DRA and other payment-reduction initiatives, factors that have contributed to slowing the growth of medical imaging include changes in imaging technology and clinical practice, such as technological maturation; initiatives to reduce radiation exposure; increased use and promotion of evidence-based medicine, appropriateness criteria, and clinical utilization guidelines; increased attention to cost-effective care; and better electronic access to reports and images from previous examinations.\textsuperscript{4-6}

\textbf{Section I: Scope of Practice for Family Physicians}

It is the position of the AAFP that clinical privileges should be granted on the basis of each individual physician’s documented training and/or experience, demonstrated abilities, and current competence, not on specialty designation alone.\textsuperscript{7} This general policy applies to ordering and interpreting radiographs in the family medicine practice. Patient care is improved when a family physician is able to fully integrate the patient’s history and physical examination with contemporaneous interpretation of diagnostic imaging and other diagnostic studies. Patient convenience and satisfaction also are improved by the availability of on-site radiography.

The AAFP believes that family physicians—like other physicians who use diagnostic radiography to evaluate patients—are entitled to appropriate compensation for their services. This position is in keeping with the positions of other specialty organizations that represent physicians who are not radiologists but use diagnostic radiography to evaluate patients, such as orthopedic specialists and ED physicians. For example, according to a position statement of the American Academy of Orthopaedic Surgeons (AAOS) that was revised in February 2012, “The AAOS believes that orthopaedists are entitled to adequate compensation for the cost and work involved in providing [musculoskeletal radiographic studies] in their offices. Any policy that prohibits orthopaedists from performing and interpreting diagnostic imaging studies in their offices interferes with the patient’s ability to receive optimal care.”\textsuperscript{8} In February 2013, the American College of Emergency Physicians (ACEP) reaffirmed a policy statement that endorses the following principle: “The emergency physician providing contemporaneous interpretation of a diagnostic study is entitled to reimbursement for such interpretation even if the study is reviewed subsequently as part of the quality control process of the institution in which the physician practices.”\textsuperscript{9}

The American Medical Association’s (AMA’s) approved policy \textit{Freedom of Practice in Medical Imaging} states that the AMA will:

1. “Encourage and support collaborative specialty development and review of any appropriateness criteria, practice guidelines, technical standards, and accreditation programs, particularly as Congress, federal agencies and third-party payers consider their use as a condition of payment, and [use] the AMA Code of Ethics as the guiding code of ethics in the development of such policy;
2. Actively oppose efforts by private payers, hospitals, Congress, state legislatures, and the Administration to impose policies designed to control utilization and costs of medical services unless those policies can be proven to achieve cost savings and improve quality while not curtailing appropriate growth and without compromising patient access or quality of care;
3. Actively oppose efforts to require patients to receive imaging services at imaging centers that are mandated to require specific medical specialty supervision and support patients receiving imaging services at facilities where appropriately trained medical specialists can perform and interpret imaging services regardless of medical specialty; and
4. Actively oppose any attempts by federal and state legislators, regulatory bodies, hospitals, private and government payers, and others to restrict reimbursement for imaging procedures based on physician specialty, and continue to support the reimbursement of imaging procedures being performed and interpreted by physicians based on the proper indications for the procedure and the qualifications and training of the imaging specialists in that specific imaging technique regardless of their medical specialty.”\textsuperscript{10}

The CMS policy on Medicare Part B payment for the professional component of diagnostic radiography does not discriminate on the basis of specialty. Chapter 13, Section 20.1 of the \textit{Medicare Claims Processing Manual} states that Medicare administrative contractors (MACs) that process Medicare Part A and Medicare Part B claims for a defined
Section II: Clinical Indications

Diagnostic radiography is part of the evaluation of many clinical conditions that present in a family medicine practice. For example, well-accepted criteria for diagnostic radiography have been reported in the literature for acute knee and ankle injuries that are commonly evaluated and treated by family physicians. Initial radiologic evaluation of a variety of acute and chronic conditions is appropriately performed in the family physician's office, with referral to another facility for more extensive imaging, if necessary.

Physicians should be mindful of the risks of medical imaging (e.g., radiation exposure, overuse) and make judicious use of diagnostic radiography to reduce these risks. Diagnostic radiography should be performed when indicated after careful consideration of the patient's clinical presentation and the evidence related to various imaging modalities. For example, under the Choosing Wisely campaign—a national effort to reduce waste in the health care system and avoid unnecessary or harmful tests and treatment—the AAFP recommends that physicians should not do imaging for low back pain within the first six weeks unless red flags are present because “imaging of the lower spine before six weeks does not improve outcomes, but does increase costs.” There is also a Healthcare Effectiveness Data and Information Set (HEDIS) measure for the use of imaging studies for low back pain; it measures performance based on the percentage of adults 18 to 50 years of age with a primary diagnosis of low back pain who did not have a plain x-ray, magnetic resonance imaging (MRI), or computed tomography (CT) scan within 28 days of the diagnosis.

The use of evidence-based appropriateness criteria for various clinical scenarios may help physicians weigh risk versus benefit so that they use diagnostic radiography judiciously and avoid overuse. The ACR Committee on Appropriateness Criteria and its expert panels use literature review and a modified Delphi method to develop practice guidelines based on clinical indications for a large number of diagnostic imaging modalities. The criteria include recommendations and a summary of relevant literature, as well as a relative radiation level designation for each rated procedure. Representatives from 23 specialty organizations participate in the development of the ACR Appropriateness Criteria®, although no representatives from a family medicine organization are currently involved in this process. The criteria address a large variety of clinical conditions using a nine-point scale, with a rating of seven, eight, or nine indicating that a radiologic procedure is considered “usually appropriate” by expert consensus panels. Many indications for plain radiographs are acute and chronic conditions that frequently present in the family physician's office.

Section III: Training Methodology

Training in diagnostic radiography interpretation begins during clinical training in medical school, although the amount and intensity of the training experience at various medical schools can vary widely. The Accreditation Council for Graduate Medical Education’s (ACGME’s) Residency Review Committee, which accredits family medicine residency programs, developed a set of requirements that became effective July 1, 2014. The requirements state, “The curriculum should include diagnostic imaging interpretation and nuclear medicine therapy pertinent to family medicine.”

Extensive individualized training also occurs during acute and chronic patient care in the hospital, ED, and continuity practice experience during residency training. This training occurs during consultation with family physician and emergency medicine preceptors, and during formal and informal consultation with interpreting radiologists. Additional training occurs when patient care decisions based on a resident’s provisional reading are either reinforced or adjusted following review of a radiologist’s written report. For family physicians who use diagnostic radiography in their practices, training and feedback continue throughout their careers as they consult with practice colleagues and radiologists.
Section IV: Testing, Demonstrated Proficiency, and Documentation

To advance through their training, residents are expected to have an appropriate level of competence in ordering and interpreting diagnostic radiographs. Competence is judged by the supervising faculty. Deficiencies are addressed by more intense remedial training, as in any other educational category for family medicine.

Testing knowledge of indications for and interpretation of diagnostic radiographs is a part of the general testing for certification by the American Board of Family Medicine. Certification examinations include questions about diagnostic radiography and some radiographic images. Radiography is considered one of many general areas of medical knowledge tested. There are no specific rules for the number of interpretations of radiographs or questions about radiography on each primary certification or recertification examination.25

Section V: Credentialing and Privileges

Medicare covers imaging services that are “performed or supervised by a physician who is certified or eligible to be certified by the American Board of Radiology or for whom radiology services account for at least 50 percent of the total amount of charges made under Medicare.”26 Effective January 1, 2012, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required suppliers of the technical component of advanced diagnostic imaging (ADI) procedures to be accredited by a CMS-approved accrediting organization in order to receive Medicare reimbursement. The MIPPA defines ADI procedures as diagnostic MRI, CT, and nuclear medicine imaging procedures (e.g., positron emission tomography [PET]).27 X-ray, ultrasound, and fluoroscopy procedures are not included in this definition. Diagnostic and screening mammography, which is subject to oversight by the U.S. Food and Drug Administration (FDA), also are not included in the MIPPA’s definition of ADI procedures.28 CMS allows ADI accrediting organizations to establish their own individual quality standards, but states, “At a minimum, these standards must address, but are not limited to, the following areas: staff qualifications; equipment standards and safety; safety of patients, family and staff; medical records; and patient privacy.”28

The issue of hospital privileges is not relevant to outpatient radiograph interpretation. Managed care and health insurance organizations may request that participating physicians go through a credentialing process, either to meet internal standards or as a part of an application for National Committee for Quality Assurance (NCQA) accreditation. However, specific procedures or skills are not usually considered in the credentialing process.

Section VI: Miscellaneous Issues

A. Competence for interpretation of diagnostic radiographs

The literature on interpretation of diagnostic radiographs suggests that the error rates of family physicians are similar to the error rates of radiologists. A primary care physician is likely to have a more complete clinical history for the patient than a radiologist has, which may give the primary care physician an advantage in interpreting radiographs accurately. One systematic review reported that the majority of studies showed higher accuracy of radiograph readings when clinical information was provided, and none of the studies showed a decrease in accuracy.29

Several studies have evaluated the frequency of agreement between primary care physicians’ readings of office radiographs and radiologists’ readings. Concordance between readings by family physicians and radiologists was found in 72.5 percent to 92.4 percent of all radiographs.30-33 In addition, concordance between readings by internists and radiologists was found in 92 percent of all radiographs.34 Concordance rates for extremity films were higher, ranging from 79 percent to 96 percent.31-33,35 Concordance rates were lower for chest radiographs, ranging from 41.9 percent to 89.5 percent, which likely reflects a greater level of complexity.30-37 Results from different studies are not directly comparable because different criteria for concordance were used.

B. Over-reading of radiographs

A variety of studies have addressed the issue of whether over-reading by a radiologist improves clinical care. For example, a 2004 study evaluated 1,393 pairs of radiograph readings, with an initial reading performed by one of 86 primary care clinicians in nine ambulatory practices and an over-reading performed by one of 42 radiologists.30 In a subgroup of 553 pairs of radiographic readings—instances in which the primary care clinician would not have requested an over-read if it had not been required—researchers found that clinical care would only have been
different without the second reading for 2.5 percent of the 553 cases. Moreover, they found “zero substantial changes in care or episodes of averted patient harm.” Similarly, a 1989 study reported clinically significant discordance in only four of 508 radiographs and zero substantial changes in care.

Family physicians refer patients for specialty consultation for numerous reasons and are usually able to determine independently when such consultation is needed. Review of the literature does not support mandatory over-reading of all radiographs performed in family physicians’ offices. Instead, studies suggest that over-reading by a radiologist is not always necessary and that selective request for radiology consultation is appropriate. Allowing family physicians to decide which radiographs to send for consultation and over-reading frees radiologists’ time for interpretation of more complex radiographs and radiological interventions.

C. Formal relationships with other organizations

Cooperation should be encouraged between the AAFP, the ACR, the Intersocietal Accreditation Commission, and other relevant organizations in the development of quality improvement programs, radiography use guidelines, and CMS standards for in-office imaging.

D. Broader dissemination of ACR Appropriateness Criteria®

Broader use of the ACR Appropriateness Criteria® may have some beneficial impact by encouraging appropriate outpatient radiography use and discouraging unnecessary or inappropriate use. Studies of radiograph guideline dissemination methods have had mixed results. Studies reporting a decrease in inappropriate radiographs have shown only modest improvements.

E. Research agenda

The research agenda for interpretation of outpatient radiographs should focus on the following:

1. Quantifying whether a shift in billing for the professional component of radiology services, or in CMS standards for performing and interpreting outpatient radiographs would affect the financial model of the PCMH
2. Developing effective quality improvement programs that ensure acceptable image quality, reduce interpretation error rates, ensure patient safety, and provide guidance regarding which radiographs should be referred for consultation
3. Identifying effective methods to encourage appropriate outpatient radiography use and discourage unnecessary or inappropriate use
4. Defining the effect of on-site performance and interpretation of diagnostic radiographs by family physicians on patient-oriented clinical outcomes compared with the effect of referral to a radiologist for off-site imaging and interpretation, with particular attention to outcomes in rural areas and other underserved areas.

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Reasonable Choice

See also

- Health Care Delivery Systems
- AAFP Mission Statement

The American Academy of Family Physicians (AAFP) supports physicians and patients in making personal choices regarding their participation in the healthcare system as a fundamental principle.

Patients

Patients should have reasonable freedom to select their physicians and healthcare delivery system. Importantly, whenever making a choice, one must be well-informed on the options available and possible effects of, and responsibilities involved with, each option. To this end, all medical and pharmacy plans should, to the fullest extent possible, provide transparency regarding:

- coverage;
- network, including credentials and quality of care of participating providers;
- restrictions on patient access to services or goods; and
- price and patients’ financial responsibility (including premium, deductible, and copayments)

Special circumstances may render limitations on choice; however, such circumstances should be clearly explained and free from coercion (e.g., free clinics, Medicaid service limitations, drug formularies, etc.).

Physicians

Physicians should have reasonable freedom in the context of patient values, evidence-based care, quality, and value options, to determine where and how to provide ethical medical care. Similarly, physicians should be free to determine, assess, and collect reasonable and appropriate fees for their services. In making such determinations, physicians should be mindful of the ethical precepts of the profession and individual circumstances of their patients. In some instances, physicians may opt to provide charity or courtesy care.

Public Policy

The AAFP notes that although it is proven that a strong primary care-based health system yields both better outcomes and lower cost, the current U.S. healthcare system has serious obstacles to changing to a strong primary-care based system. A variety of public policy incentives should be developed to strengthen primary care’s long-term viability. Such incentives should be adequate to create reasonable freedom of choice for those entering medical careers. In addition, all insurance networks should actively recruit most of the local family physicians in any given community to preserve and protect ongoing patient-physician relationships and reasonable access to primary care services. Further, insurance networks should not restrict or limit, on an arbitrary basis, family physicians from applying to or participating in any health care plan, nor limit services offered by family physicians. (1985) (2014 COD)
Referral, Unsolicited Laboratory

See also

- Fees to Physicians for Referrals to Other Health Care Providers

Family physicians occasionally receive results of unsolicited clinical tests on patients with whom no patient-physician relationship exists, most commonly clinical laboratory and radiological studies.

When a family physician receives unsolicited clinical testing results in the absence of a patient-physician relationship, it is the policy of the American Academy of Family Physicians that the physician is not required to assume responsibility for patient notification and/or management of the results. (1992) (2015 COD)
Reparative Therapy

The American Academy of Family Physicians (AAFP) opposes the use of “reparative” or “conversion” therapy of lesbian, gay, bisexual or transsexual individuals. The AAFP recommends that parents, guardians, young people, and their families seek support and services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority persons of all ages.

Reporting on Residency Status of Patients

See also

- Criminalization of Medical Practice
- Health Care for All
- Medically Underserved
- Comprehensive Care, Access to
- Community and Migrant Health Centers
- Medical Schools, Service to Minority, Vulnerable and Underserved Populations

The American Academy of Family Physicians (AAFP) encourages all family physicians provide patient education on contraceptive options at every available opportunity to avoid unintended pregnancies. In the event of an unintended pregnancy, family physicians should educate patients about all options. If a patient desires termination of their pregnancy or adoption, family physicians should provide resources to facilitate those services. If a family physician's moral or ethical beliefs conflict with the ability to provide the requested resources or education, the family physician should ask a colleague to provide this information in a timely fashion rather than omit it. Additionally, the AAFP encourages family physicians to stay informed of all state and federal laws as they apply to reproductive health.
The American Academy of Family Physicians supports the concept that no physician or other health professional shall be required to perform any act which violates personally held moral principles.

The AAFP recommends that medical students and family medicine residents be trained in counseling and referral skills regarding all options available to pregnant women.

The AAFP supports provision of opportunities for residents to have access to supervised, expert training in management techniques and procedures pertaining to reproductive health and decisions commensurate with the scope of their anticipated future practices. (1995) (2015 COD)
Reproductive Health Services

See Also

- Reproductive Decisions

The American Academy of Family Physicians (AAFP) supports a woman's access to reproductive health services and opposes nonevidence-based restrictions on medical care and the provision of such services. (2014 COD)
The Academy endorses the principle of collaborative research between clinicians including practice-based research networks and researchers and encourages expansion of collaborative research at the national and state levels. (1971) (2013 COD)
Research - Ethical Participation by Family Physicians

Medical research is defined in this document as research to create new knowledge to improve patient care and associated activities. Members of the AAFP are encouraged to become involved in medical research. Research participation may provide benefits such as expanding medical knowledge, increasing job satisfaction, and improving patient care. Participation also carries responsibilities and potential pitfalls. The physician must be aware of the quality and purpose of the proposed research, including the sponsorship, scientific merit, possible conflicts of interest, and other ethical considerations.

The following are common standards for ethical research:

a. A peer-reviewed protocol reflecting a well-designed, scientific methodology should be available for all studies.

b. For all studies involving human subjects, there should be approval by an Institutional Review Board (IRB), in some cases, a waiver may be granted by the IRB, e.g., non-obtrusive survey work. The IRB should be based at a recognized institution, free from possible conflicts of interests.

c. The sponsoring and funding entities should be fully disclosed to the participating researchers. They should be recognized entities such as government agencies, academic departments of family medicine, practice-based research networks or pharmaceutical corporations' research divisions.

d. Participants in clinical studies should be selected from appropriate populations without regard to race, ethnicity, economic status, or gender. Women, children, and minorities should be included in clinical studies applicable to their health issues.

e. A clinical investigator should demonstrate the same concern for the safety and welfare of study participants as is required of a physician caring for patients in clinical practice.

f. Voluntary informed consent should be obtained in writing from all participants. When physicians are the subjects under study, informed consent should be obtained from them.

g. Physician and participant confidentiality should be assured unless specific rights have been waived. Safeguards must be undertaken to preserve such confidentiality and to limit scrutiny of the health information to aims directly related to the approved study.

The following are recommendations regarding conflicts of interest in medical research:

a. Studies sponsored by the marketing divisions of pharmaceutical firms should be critically appraised to ascertain whether medical research or marketing research is the aim of the study. While marketing research may be rigorously designed and employ high caliber research methods, the primary motive behind marketing research is improved sales, not improved patient care.

b. When the purpose of a research study is unclear, a full protocol, plans for publication and peer review, and proposed outcomes of the research should be discussed before a physician decides to participate.

c. When a physician is both the investigator and the physician caring for a patient who is eligible to enroll in a study, the informed consent process must differentiate between the two roles. Ideally, a third person
should obtain the consent. The sources of study funding and any financial incentives offered to the investigator must be disclosed.

d. Any financial compensation received from the trial sponsors must be commensurate with the efforts of the physician performing the research.

e. Honoraria, expense reimbursement, travel and other payments from industry (e.g. pharmaceutical or medical device companies) for research-related activities shall be in accordance with guidelines from the Code of Medical Ethics of the AMA: Ethical Guidelines for Gifts to Physicians from Industry:

1. If the physician is providing genuine services, reasonable compensation for time and travel expenses can be given. However, token advisory or consulting arrangements cannot be used to justify compensation.

2. Expenses may be paid for meetings that serve a genuine research purpose. One guide to their propriety would be whether the NIH conducts similar meetings when it sponsors multi-center clinical trials. When travel subsidies are acceptable, the guidelines emphasize that they be used to pay only for "reasonable" expenses. The reasonableness of expenses would depend on a number of considerations. For example, meetings are likely to be problematic, if overseas locations are used for exclusively domestic investigators. It would be inappropriate to pay for recreation or entertainment beyond the kind of modest hospitality such as meals or social events held as part of the conference.

3. Physicians may be compensation for time and travel expenses to participate in focus groups sponsored by industry as long as the focus groups serve a genuine and exclusive research purpose and are not used for promotional purposes.

These guidelines cannot cover every eventuality. Individual physicians should continue to use their good judgment and integrity in deciding to participate or decline working in a particular study. If a physician is in doubt as to the ethical nature of a study or advisability of participating, consultation is recommended with an uninvolved IRB, or a local ethics committee. (1992) (2014 COD)
Research, Family Medicine Journals

See also

- Research, Collaborative
- Research, Ethical Participation by Family Physicians

It is in the vital interest of our members and patients and consistent with the current research mission for the AAFP to ensure strong venues for publications of original research. Therefore, the AAFP will take a leadership role to assure the maintenance of at least one journal within the discipline, in print or other innovative media, that publishes original family medicine research.

The AAFP supports the inclusion of quantitative risk information such as absolute risk, incidence of adverse events, specific population information, number needed to treat (NNT) and number needed to harm (NNH) be published in medical literature along with evidence-based recommendations, when appropriate.

Residency Training Leading to Dual Board Certification

The preferred mode of training family physicians is through a three-year residency program leading to board certification in family medicine. Dual track residency programs leading to certification in family medicine and another specialty may meet the needs of a limited number of physicians who desire expertise in a specialty in addition to family medicine. In any combined family medicine residency program, the integrity of the specialty of family medicine must be upheld, and the requirements of family medicine residency training must not be reduced or compromised.

Combined residency programs with family medicine should be developed only in specialty areas where accredited fellowships are not available to graduates of family medicine residency programs. The second specialty should complement the tenets of family medicine, including comprehensive coordinated care throughout the life cycle. The Accreditation Council for Graduate Medical Education (ACGME) must accredit both participating residency programs.

Each proposed combined residency program should address a demonstrated social need, demonstrate its capacity to expand access to care; and/or enhance academic qualifications of its trainees, and describe the efforts the program will undertake to ensure that its graduates fulfill the intent of dual training.

Examples of potential need for dual training include training physicians for geographic areas without a population density to support a subspecialty practice, enhancing specific skills of physicians teaching in residency programs, and meeting the needs of special practice situations, such as public health departments, military or other public sector settings. Examples of compliance efforts to ensure that graduates are fulfilling the intent of the program include reporting requirements that focus on the practice location of graduates, the number of graduates serving specific and/or vulnerable populations, and the number of graduates who join the National Health Services Corps (NHSC).

In order to discourage financial incentives that would promote the unchecked growth of combined residency programs, full graduate medical education funding should support the training of individual residents for the minimum number of months necessary to meet the training requirements of only one certifying board, regardless of the number of months actually experienced by the resident during training.

Financial support for combined residency programs should not adversely affect family medicine residency training in individual programs or in the nation.

Combined residency programs should be wholly in compliance with the ACGME program requirements for residency training in family medicine.

The Academy should continue to monitor the development of combined programs and their impact on the training of family physicians for the nation. (1997) (2014 COD)
See also

- Discrimination, Family Practice Residency Graduates
- Discrimination, Physician
- Discrimination, Patient
- Minority Students, Family Physicians as Role Models for

The AAFP opposes all discrimination in any form, including but not limited to, that on the basis of actual or perceived race, color, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, economic status, body habitus, pregnancy, national origin, or geographic location of training. (1996) (2015 COD)
Resident Work Hours

a. The American Academy of Family Physicians opposes government regulation of resident work hours.

b. The AAFP opposes 24-hour work limits or any other consecutive time constraints as these can compromise patient care and residency education as well as limit flexibility of scheduling within individual residency programs.

c. The AAFP supports the concept that the time residents spend delivering patient care services of marginal or no educational value should be minimized.

d. The AAFP supports maintaining the Review Committee for Family Medicine (RC-FM) as the primary regulatory entity of the family medicine practice residency standards, including resident work hours. However, the AAFP calls on the RC-FM to institute more effective enforcement of these standards.

The development of further restrictions on work hours should consider the following:

1. Accrediting organizations will commission research studies to more closely examine the impact of duty hours on: patient safety/medical errors, preparedness of the resident for independent practice, and faculty and their availability for teaching.
2. Accrediting organizations will not support further duty hours restrictions without the economic support necessary to prevent program closures due to resulting fiscal insolvency.

Physicians have an ethical duty to their patients and profession to provide safe, compassionate, quality medical care. These duties depend on a safe and healthy working environment for resident physicians. To this end, resident assignments must be made in such a way as to prevent excessive patient care responsibilities, inappropriate intensity of service or case mix, and excessive length and frequency of call contributing to excessive fatigue and sleep deprivation.

Programs must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment. There also should be a structured and facilitated group designed for resident support that meets on a regular schedule.

Residency programs should have written guidelines governing resident duty hours and should inform all resident of these guidelines.

Residents should have the right to confidentially report work hour violations to the RC-FM and each residency program should inform residents of this right. (March BOD 2002) (2015 COD)
Residential Pool Safety

See also

- Sports Medicine, Health and Fitness
- Protective Equipment for Recreational and Competitive Sports Activities

The American Academy of Family Physicians supports residential pool safety measures including the following:

1. Permanent perimeter protection of pool by an approved safeguard to limit or delay access of children to the pool. Fencing or barriers that completely enclose pools without direct access to the house are preferred.
2. Training of household adults, older children and other adult supervisors in CPR.
3. Telephone access poolside including the use of cell phones with 911.
4. Constant adult supervision of young children at all times. Supervise children at "arm's length" for those less than 4 years of age at all times. Adults should avoid distracting activities while in or around the pool with young children, i.e. barbecuing, children's walkers, toys, etc.
5. Teaching children to swim when ready, usually at age 5. (Children younger than 4 years require longer instructional periods to learn skills and are limited by their neuromuscular capacity. Therefore, having children begin swimming lessons at an earlier age does not translate to a more rapid mastery of aquatic skills or a higher level of swimming proficiency compared with those taking lessons at a later age.) Reliance on a child's water safety/swimming classes or flotation device provides a false sense of security and is not a substitute for adult supervision. Swimming instruction does not guarantee protection against drowning in young children.
6. Public and private pools and hot tubs should have drains that prevent entrapment and/or release suction if entrapment occurs.

Residents and Students, AAFP

See also

- Residency Training Leading to Dual Board Certification
- Preceptorships

Family medicine residents and medical students have special needs in terms of education and specialty and career planning, and the AAFP works to provide them with the resources appropriate for their distinct needs. Leadership opportunities allow residents and students to play a vital role in shaping AAFP policy and the future of family medicine. Their unique voice and perspective are welcome additions to that of the overall membership.

There are several avenues for residents and students to become AAFP leaders. They can either be appointed by the AAFP directly, or they can be elected by their peers at the National Congress of Family Medicine Residents or the National Congress of Student Members held during the annual National Conference of Family Medicine Residents and Medical Students.

Residents and students serve on six of the seven commissions of the AAFP and have multiple leadership opportunities at the National Conference. Residents and students also have the opportunity to serve as representatives to other medical, educational, or humanitarian organizations. Since 1974, residents and students have been represented in the AAFP's Congress of Delegates by two elected delegates and two alternate delegates each. A resident and student were appointed as observers to the Board of Directors in 1984. In 1985, the Bylaws were changed to authorize full voting privileges for the resident board member. In 1991, the Bylaws were changed to authorize a vote for the student board member. (2012 COD) (2014 COD)
Retail Clinics

The American Academy of Family Physicians (AAFP) believes that patient-centered primary care delivered through the Patient-Centered Medical Home (PCMH) is foundational to a health care system that improves the quality and efficiency of care. The AAFP continues to monitor market-based developments in health care delivery that are evolving to meet the expanding needs of patients for timely, convenient, transparent, and consumer-centric health care.

The AAFP continues to engage and respond to the ongoing development of retail clinics in America. While retail clinics may provide a limited scope of health care services for patients, this can ultimately lead to fragmentation of the patient’s health care unless it is coordinated with the patient’s primary care physician’s office.

Furthermore, retail clinics are not the only source of convenient care available for patients today. The overwhelming majority of family physicians offer same-day scheduling in their practice and roughly half of all family physicians have extended office hours for patients to seek care.

RELATED LINKS

- [AAFP Characteristics for Retail Clinics](1 page PDF)

See Also

- [Electronic Health Records](http://www.aafp.org/about/policies/all/retail-clinics.content.pdflist.html)

This easy access, combined with the adoption of the principles of patient-centered care, allow family physicians to provide care that is highly convenient while avoiding overall fragmentation of care.

The AAFP opposes the expansion of the scope of services of retail clinics beyond minor acute illnesses and, in particular, opposes the management of chronic medical conditions in this setting. Protocol-based decision and diagnostic models are used in most non-physician led retail clinics, resulting in a missed opportunity to address more complex patient needs. These missed opportunities range from preventive care services to critically important diagnoses which may not be specifically covered in the pre-generated protocol decision program. The AAFP is committed to the development of a health care system based on strong, team-based patient-centered primary care – defined as first contact, comprehensive, coordinated, and continuing care for all persons.

Care delivered in retail clinics can be a component of patient-centered care, but must work in coordination with the patients’ primary care physician to ensure that care is not further fragmented. Fragmentation and unaccountable silos of care are in direct opposition to achieving continuous whole-person care with improved health outcomes for both the individual and society. While the AAFP recognizes the demand for the advancement of patient centered-ness in the American health care delivery system, it should not be at the expense of comprehensive coordinated longitudinal care. (2006 COD) (2014 COD)
Role Definition of Family Medicine

See also

- Family Medicine, Quality Health Care in
- Family Medicine, Specialist in
- Family Medicine Faculty Training
- Family Medicine, Undergraduate Training in
- Medical Home
- Family Physician, Definition
- Primary Care Physician, Generic
- Definition of Family Medicine

Family physicians are personal doctors for all people of all ages and health conditions. They are reliable first contact for health concerns and directly address most health care needs. Through enduring partnerships, family physicians help patients prevent, understand, and manage illness, navigate the health system and set health goals. Family physicians and their staff adapt their care to the unique needs of their patients and communities. They use data to monitor and manage their patient population, and use best science to prioritize services most likely to benefit health. They are ideal leaders of health care systems and partners for public health. (May 2016 BOD) (2016 COD)
Rural Health Care, Access to

See also

- Area Health Education Centers
- Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants
- Nurse Midwives, Certified
- Rural Health Care, "First Responder" Training
- Rural Health Care in Medical Education
- Maternal/Child Care (Obstetrics/Perinatal Care)
- Telemedicine
- Essential Community Provider

The American Academy of Family Physicians (AAFP) supports the position that inequities of payments to rural hospitals should be abolished, and the AAFP will make reasonable efforts to ensure that these inequities be discontinued to eliminate these disparities to access to quality care for all populations. (1987) (2015 COD)
Rural family physicians should advocate "first responder" training by encouraging community members to undergo training and by promoting the ongoing availability of "first responder" training programs in rural communities. (B1990) (2014 COD)
Rural Health Care in Medical Education

See also

- Area Health Education Centers
- Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants
- Nurse Midwives, Certified
- Rural Health Care, Access to
- Rural Health Care, “First Responder” Training
- Maternal/Child Care (Obstetrics/Perinatal Care)
- Telemedicine

The AAFP recommends the following:

- That medical education include curriculum and student experiences pertinent to careers in rural medicine.
- That federal and state funding incentives be altered to support medical schools with a track record of producing rural physicians.
- That graduate medical education funding be redesigned to give direct and increased support to rural-based residency training programs including teaching health centers.
- Increased flexibility in the design of curricula by the Accreditation Council on Graduate Medical Education (ACGME) to enhance training of physicians with the needed skills for all aspects of family medicine, including rural practice.

The AAFP supports partnerships between academic medical centers and rural communities to train rural physicians. These partnerships should be encouraged by financial incentives on the state and federal level. They should also be supported by the AAFP constituent chapters.

The AAFP recognizes that increasing the family physician supply will increase the rural physician supply, since family physicians are more likely than any others to enter rural practice. Thus, the AAFP supports legislative initiatives that support family medicine education, such as Title VII of the United States Public Service Act, Teaching Health Centers, and the Area Health Education Center (AHEC) system. Preferences and priorities for Title VII funding should specifically encourage the production of rural physicians.

The AAFP and National Rural Health Association have developed a joint statement that supports the above conclusions. (B1991) (2015 COD)
Rural Practice: Graduate Medical Education for (Position Paper)

See also
- Rural Practice, Keeping Physicians in Rural Residency
- Rural Health Care in Medical Education
- Area Health Education Centers
- Rural Health Care, Access to
- Medical Schools, Service to Minority, Vulnerable and Underserved Populations
- Medical Student Debt Relief

A joint statement of the National Rural Health Association and the American Academy of Family Physicians, revised and updated November 2013 from July 2008.

The Role of Distributed Rural Medical Education in Access to Quality Healthcare

In the century since the Flexner Report, medical education in the United States has become specialized, centralized and urban, embracing uniformly rigorous standards of patient care, education, and research. Despite an increased production of the total number of physicians, a persistent geographic maldistribution of physicians has characterized the past 70-80 years. While twenty percent of the US population lives in rural areas, only nine percent of physicians do. The opportunity for medical education in this century is to recapture the diversity and relevance of distributed training even as patient care, education and research is further improved. Distributed medical education that is uniquely adapted and responsive to the needs of rural underserved communities has the potential to reclaim medicine's social contract with the public.

Changes in technology continue to transform the ability of medical educators to offer a geographically distributed quality medical education through the use of information exchange and communication with faculty and peers. At the same time, technology is also influencing the delivery of healthcare services to rural areas. Concurrently, healthcare policy reform and anticipated changes in payment have placed a new emphasis on population and community oriented care. These policy changes in healthcare delivery are now becoming increasingly aligned with a community-focused and geographically distributed medical education format.

Examples of technology advances include use of telemedicine, information exchange through electronic medical records and databases, population health within a patient panel and patient centered medical home and rural community integration into regional delivery systems accountable to a population. Enhanced communications such as distant synchronous group learning models, asynchronous educational curricula, and access to resource libraries, even in very remote areas are particularly relevant to medical education. Practice based research networks are also reaching rural campus and practice locations.

Distributed medical education models such as rural tracks in both undergraduate and graduate medical education are therefore increasingly applicable and supported for the following reasons:

- ongoing transitions toward population-based, community centered healthcare delivery
- payment methodology reform for primary care delivery in medical homes
- team-based care delivery incorporating healthcare providers in the community
- increased and enhanced use of information technology and electronic communication
- growing evidence supporting rurally located education’s impact on rural workforce

The proceedings of meetings of rural medical educators demonstrate that challenges to rural medical education stubbornly persist. Of note is that rural physicians continue to demonstrate a satisfaction with
practice and a passion for service. Yet, after more than 30 years of policy initiatives, incentives, and rural-focused programs, the challenge of providing an adequate supply of physicians in rural practice remains virtually unchanged. Both the NRHA and the AAFP have long been advocates for the health of rural populations and continue to promote the development and funding of programs that will address this rural health provider shortage. Still, the scale of these current efforts does not appear to be alleviating the growing shortage.

More recently, however, policy makers, researchers and educators have made renewed and significant contributions to the literature and have initiated investments supporting and promoting successful models of rural track medical education. The intuitive propositions of those earlier rural health education leaders have now been borne out by a preponderance of evidence demonstrating:

1. Medical school programs intended to produce rural physicians have an impact to increase the rural physician supply,
2. A study of medical school rural tracks reveals the importance of the selection process for admissions and the extensive rural clinical experience provided and accompanied by financial support, and
3. Residency rural training track (RTT) programs produce physicians locating to rural areas with high proportions of graduates providing care in shortage areas and safety net provider settings.

Studies linking rural physician supply and demand, geographic mapping of physician workforce and educational institution outcomes are now available. These findings can be associated with workforce needs projections published in the literature incorporating anticipated healthcare policy reform such as the Affordable Care Act, better delineating future needs. Studies investigating factors influencing medical student and resident choice are accompanied by an understanding of the unequal geographic distribution of physicians.

Rural training tracks (RTT's) have demonstrated how a rigorous teaching program can thrive in rural communities. Although they account for only a small number of first year postgraduate positions presently available in family medicine, RTT’s are a demonstrated benefit for both recruitment of new physicians and retention of experienced rural faculty. Studies show that at least half of RTT graduates locate in rural areas after graduation, two to three times the proportion of family medicine residency graduates overall.

By linking data on rural workforce needs to the evidence regarding successful models of rurally located medical training, more attention has been drawn to the opportunity for expansion of undergraduate and graduate medical education, specifically in rural patient care settings.

The Rural Training Track Technical Assistance Program has identified and studied separately accredited 1-2 RTTs and identified tracks within larger programs in which the tracked residents meet their 24-month continuity requirement in a rurally located Family Medicine Practice. These programs complement the other ACGME and AOA residency programs providing some or all of their family medicine residency training in rural communities across the nation.

After reaching a peak of 36 such programs in 2001, and decreasing to 21 in 2012, separately accredited allopathic rural residency training tracks now number 26. While several programs closed in the past decade, RTTs are now increasing in number, especially if non-separately accredited rural tracks and osteopathic rural programs are included. Most allopathic programs follow the original “1-2” configuration, with one year in the usually urban sponsoring institution followed by two years in the more rural location. However, variations exist and may conform to the assets, opportunities, and needs of a particular program and community.

An "integrated RTT," a term in federal legislation since (BBRA 1999) was codified by CMS, in a Final Rule in 2003 which defined the term as any residency track that as part of a larger program placed residents in a rural location for more than 50% of their training. The term has also been defined since 2002 by the National Rural Health Association and the American Academy of Family Physicians to also include rural focused residency programs or tracks which are not separately accredited by the ACGME in the 1-2 format.
and that place residents in rural places for less than 50% of their training.

An integrated rural training track according to the NRHA and AAFP has the following required components:

- At least four (4) rural block months to include a rural public and community health experience. During a rural block rotation, the resident is in a rural area for a minimum of 4 weeks, or a month,
- A minimum of three (3) months of obstetrical training or an equivalent longitudinal experience,
- A minimum of four (4) months of pediatric training to include neonatal, ambulatory, inpatient and emergency experiences through rotations or an equivalent longitudinal experience,
- A minimum of two (2) months of emergency medicine rotations or an equivalent longitudinal experience.

Some RTT’s have grown in program size and even evolved into full-fledged rural "4-4-4" programs while others have closed, a subset of which have substantially contributed to the local rural physician workforce prior to the program ending.

It must be remembered that many residency programs not located in rural areas also have variously configured rural training streams or a rural training focus. Although the rural placement rates of these programs are typically lower than the RTT’s, they ultimately contribute the larger numbers of graduates to the population of rural doctors by virtue of their much larger size and total number.

Changes in accreditation and funding of educational programming have also altered the landscape of rural medical education. It should be noted as well that osteopathic and international medical graduates (IMGs) constitute a proportion of graduates locating in rural and persistent poverty locations. Examples of practice and training settings include Critical access hospitals, Federally-Qualified Health Clinics, and Rural Health Clinics. These entities provide new venues for patient care and education and a safety net for rural communities while ongoing innovation and adaptations for medical education in these environments include the Teaching Health Center (THCGME) pilot under the Affordable Care Act of 2010. Integrated residency strategies that align undergraduate and graduate medical education in a seamless manner have developed in some states such as the Targeting Rural Underserved Student Track (TRUST) developed in Montana.

Some programs were noted to have been granted an exemption to the National Residency Matching Program (NRMP).

Successful rural graduate medical education programs have also developed in specialties other than family medicine and osteopathic GME standards for rural track residencies now exist in both family medicine and pediatrics. Although it has been shown that the more specialized the physician, the less likely that physician will practice in a rural area, family medicine is not the only specialty integral to the health of rural communities. Rural-focused residency programs have been established in general surgery, emergency medicine, psychiatry and internal medicine varying configurations.

Rural education is by nature more inter-professional, with physicians, pharmacists, mental health providers, dentists, nurse practitioners, physician assistants, social workers, dieticians and other health professionals learning side by side. There is a growing body of evidence regarding the success of inter-professional training and education in rural communities, particularly in the setting of the Patient Centered Medical Home concept of primary care delivery and the growth of the Teaching Health Center model of residency education.

Finally, there is an increasing recognition for the value of context in training, career satisfaction and retention. Experiential place integration, an active developmental process based on three 'principles' - security, freedom and identity – first described by Cutchin, is a sound theoretical basis for place-based education and policy. The preparation and teaching for rural medical education is best anchored in the experience of rural places, complemented by facilitated reflection and intentional learning from that experience.

In the immediate future, rural residency programs will continue to face the challenges of (1) student recruitment in the face of historically low student interest in generalist careers, and in particular, rural...
practice, (2) faculty recruitment in the face of an aging and declining number of rural physicians with a wide range of skills accompanied by an interest in teaching, (3) the lack of sustainable funding inherent in the governmental and institutional policies supporting medical education.

To overcome these challenges, a more organic, coherent, sustainable and community-anchored distributed medical education approach is necessary\textsuperscript{xxi}. Programs centered on community context in medical education can prepare learners to be both competent and confident, matching skills to patient and community needs. Rural medical education must be readily adaptable to changing conditions, aligned with the interests of multiple stakeholders, and linked to desired outcomes and workforce needs. Rural program should be self-renewing and less dependent upon external funding as local environments can benefit from workforce "return on investment" from program service and graduate retention. Academic institutions and communities will mutually benefit from a medical education enterprise that is distributed, rooted, nourished and relevant in diverse underserved communities, is interprofessional in nature, and is adapted in scale and scope to the population it serves.

**Recommendations**

**Structure and content of postgraduate rural training:**

Learning in context is essential to training for rural practice. Although residents trained in urban environments may be equipped with the necessary knowledge and skills, there is no substitute for personal experience in rural medicine. The rural physician’s scope of practice cannot be rigidly proscribed and is best defined by the needs of the community. Therefore the following general curricular structure and content is warranted:

1. Cumulative rural training experience for all medical students and residents with an interest in rural practice should be at least six (6) months in duration\textsuperscript{xxii}.
2. Knowledge and skill acquisition with demonstrated competency in the following areas especially relevant to rural practice:
   1. Maternity care
   2. Pediatric and newborn care
   3. Orthopedics and sports medicine, including basic fracture care
   4. Surgical and procedural skills, including colposcopy, ultrasound and endoscopy
   5. Trauma and other emergency care and stabilization, including training in programs such as ACLS, ATLS, CALS, NRP, PALS, and ALSO
   6. Critical care in a rural setting
   7. Occupational health and safety, including recreation, agriculture, mining, and forestry
   8. Behavioral health and psychiatry, including access issues unique to rural practice
   9. Practice management in a small practice setting and system integration
   10. Telemedicine, the electronic health record, and other electronic tools and resources
   11. Public Health, including basic definitions, resources for rural health, access and barrier issues, funding and delivery of rural health care, interdisciplinary teams in rural health, health outcomes and disparities in rural populations, strategies for delivery of care, and cultural competence
   12. Community-oriented primary care

Rural residency programs and medical educators, in addition to specific content particularly relevant to rural practice, should elaborate, teach, and measure general competencies in rural medicine including:

1. Adaptability – how to shape one’s skill set to the needs of the rural community
2. Improvisation – how to deliver quality care within the resources and skills you have available in the moment
3. Life-long learning – how to continually acquire additional knowledge and skills as needed
4. Collaboration – how to get help from others and work together
5. Endurance – how to sustain oneself and others in rural practice and lifestyle
6. Resilience – how to continue to re-energize your practice in the context of changing personal and community needs

Medicare funding and definitions of rural training

CMS should deliver on congressional intent and, under the rural exemptions granted in the Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999, eliminate caps on GME funding for both new and existing rural programs in graduate medical education provided that these programs are rural training tracks as defined below or have a significant track record of placing a high proportion of graduates in rural practice.

The BBA (Public Law 105-33) placed a cap on the number of medical residents that are eligible for Medicare direct and indirect GME payments. This limitation has negatively impacted the availability of funding to support rural residency programs. In the BBRA (Public Law 106-113), an exemption for RTT’s was included that was intended to exempt both “1-2” rural and “integrated” RTT’s from the GME funding freeze. Subsequent reallocation of residency slots under the Medical Modernization Act of 2003 (Public Law 108-173) did not benefit rural programs as predicted.

NRHA supports the following definitions of residency programs training physicians for rural practice in any specialty:

1. A traditional rural training track, with at least 24 months practice experience in a rural setting
2. An integrated rural training track with the following required components:
   1. At least four (4) rural block months to include a rural public and community health experience. During a rural block rotation, the resident is in a rural area for a minimum of 4 weeks or a month
   2. A minimum of three (3) months of obstetrical training or an equivalent longitudinal experience
   3. A minimum of four (4) months of pediatric training to include neonatal, ambulatory, inpatient and emergency experiences through rotations or an equivalent longitudinal experience
   4. A minimum of two (2) months of emergency medicine rotations or an equivalent longitudinal experience

Although included in legislation (BBRA), the terminology “1-2 Rural Training Track” is no longer used by accrediting bodies, either the ACGME or the AOA. The NRHA has recently adopted an operational definition of a rural training track for the purposes of the RTT Technical Assistance Program as follows:

Continuing Definition of a “1-2 RTT” (for the purposes of the RTT TA program grant)

A residency training program that is either:

1. An alternative training track integrated with a larger more urban program and separately accredited as such, with a rural* location, a rural mission, or a major rural service area, in which the residents spend approximately two of three years in a place of practice separate and more rural or rurally focused than the larger program, or
2. An identified training track within a larger program, not separately accredited (i.e. without a separate accreditation program number), in which the tracked residents meet their 24-month continuity requirement** in a rurally located continuity clinic or Family Medicine Practice site (FMP).

The NRHA and AAFP further recommend that the waiver of a cap on GME positions for "rural" programs be extended by including in the definition of "rural" any allopathic or osteopathic residency program which can document that over 50% of its graduates in the last three years are practicing in rural areas. Although other arguably more appropriate definitions of "rural" exist, use of rural by Rural Urban Commuting Area (RUCA) codes of 4 or greater, except 4.1, 5.1, 7.1, 8.1, and 10.1, which are urban, may be a reasonable proxy and the easiest data to obtain from existing sources.

Congress and CMS should take the opportunity afforded by the relatively small number and size of rural programs to streamline RIS (interns and residents information system) reporting and simplify GME funding of actual resident FTE’s, recognizing that in addition to educational tasks, resident physicians devote at
least 40 hours to patient care weekly. They should provide such funding directly to rural programs, decreasing bureaucratic inefficiencies and affording an opportunity for increased accountability, linking funding to both outpatient and inpatient care and to training outcomes.

CMS should encourage and not discourage GME in rural locations and with safety net providers by allowing reimbursement of costs of residency education in settings including Critical Access Hospitals, Rural Health Clinics and Federally Qualified Health Centers (FQHC and FQHC-LA) in rural areas. Congress is urged to continue support of the THCGME program for Teaching Health Centers beyond its current expiration date set in 2015.

**Academic support and rural leadership**

The NRHA and the AAFP urge academic medical centers and clinical departments to financially support and fully integrate rural faculty who practice in communities remote from the academic institution. Strategies for accomplishing these goals include shared rural/urban governance, faculty exchanges, coverage provision for rural faculty by urban peers, and sustained funding of protected academic time.

Faculty living and working in rural places are core to the mission of rural medical education and as such should take the leadership role in advancing training in these settings. They should be recognized with faculty appointments commensurate with that role, encouraged and supported in the scholarship of practice, education and community engagement, and participate in key decisions and strategic planning within the academic enterprise. This should include access to technology in communication and electronic resources and teaching aids such as medical reference libraries and simulation labs. Visits to the rural location by academic leaders and reciprocal visits by rural faculty to urban centers are integral to building mutual respect, sharing understanding of the realities of both rural and urban contexts, and establishing relationships and trust. The challenges of time and distance can be addressed in part through telephone and videoconferences, but these can only complement and do not substitute for in-person meetings and activities.

Rural medical education leaders should have access to education and support in the areas of scholarly activity and presentations, research, curriculum development, program financing and demonstration of community benefit of medical education programs.

**Accreditation of rural programs**

The ACGME should continue to allow flexibility and innovation in the development and the required curricula of rural training programs in adapting to local resources while graduates of all rural programs should be expected to meet the accepted standards of all GME programs. In addition, since context is an important element of residency education, the ACGME should require the reporting of geographical data identifying the location of the continuity practices and hospitals of all residency programs, enabling the identification of rural training tracks and other programs that are located in rural and other underserved settings. An accurate listing of rural programs and rural training tracks should be readily accessible to medical students, researchers, and policy makers alike.

**Community investment in rural training**

Rural institutions, including Critical Access hospitals, Rural Health Clinics, and rural FQHC’s, should make sustained investments in health professions education. Rural practitioners should continue to support the training of students and residents in rural environments. Rural communities should support health professions education as an important driver of economic development and public health.

**Organizational Support**

The NRHA and the AAFP advocate and support collaboration of rural medical faculty with family physicians and other health care professionals in rural practice through organizational staff support, intentional
network development, funded innovation, advocacy and increased research in the area of rural training and retention in rural practice.

Summary

This paper has summarized the recent history of residency education to prepare physicians to practice in rural environments. It makes specific recommendations relating to the content and conduct of postgraduate training. Most importantly it outlines critical policy changes with regards to funding and definitions of rural training.

Medical education anchored in rural places, nourished and funded through significant federal, state and local community support, and meaningfully connected to both regional academic institutions and local physicians in practice has great potential to address both present and future needs for physicians who provide care to our rural populations.

The 2013 update to this position paper was prepared by David Schmitz, MD with assistance from Byron Crouse, MD, Ted Epperly, MD, Randall Longenecker MD, Thomas Rosenthal MD, and staff of the NRHA and AAFP. It was initially prepared and written in 2007 by Randall Longenecker, MD with editorial assistance from Tom Rosenthal MD, Jeff Stearns MD, and Michäel Woods MD

* For this document, rural is defined as Rural Urban Commuting Area (RUCA) code of 4 or greater, except 4.1, 5.1, 7.1, 8.1, and 10.1, which are urban.

**Continuity requirement as defined by the ACGME Family Medicine Review Committee and the American Board of Family Medicine.

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(http://depts.washington.edu/uwrucar/(depts.washington.edu)).

(B1999) (2014 COD)
Rural Practice, Keeping Physicians In (Position Paper)

See also

- Rural Health Care in Medical Education
- Medical Student Debt Relief
- National Health Service Corps

Overview

Access to high quality health care services for rural Americans continues to be dependent upon an adequate supply of rural physicians. While efforts to meet shortages in rural areas have improved the situation, there continues to be a shortage of physicians for rural areas. Although current data is not always available to assess the magnitude of the problem and variation exists based on differing definitions of “rural”, studies based on the demand to hire physicians by hospitals/physician groups or based on the number of individuals per physician in a rural area continue to indicate a need for additional physicians in rural areas. A balanced and cooperative effort among those involved in medical education is needed to promote rural practice. This includes increased recruitment of medical students from rural backgrounds actively teaching of skills needed in rural settings, both at the academic medical center and the community level, as well as providing necessary funding for rural medical education on the federal, state and private level. All need to work together to provide support for training future rural physicians.

Family physicians comprise just under 15 percent of the U.S. outpatient physician work force, yet they perform 23 percent of the visits that Americans make to their physicians each year. In rural areas, an even greater proportion, about 42 percent, of these visits are to family physician offices. Possessing a broad range of skills, family physicians provide comprehensive and irreplaceable care to small rural communities (Figure 1). A 2001 study from the Robert Graham Center for Policy Studies in Family Medicine and Primary Care indicated that, if family physicians were removed from the 1,548 rural U.S. counties that are not Primary Care Health Personnel Shortage Areas (PCHPSAs), 67.8 percent of those counties would become PCHPSAs. On the other hand, removing all general internists would make only 2.1 percent of the counties PCHPSAs, and only 0.5 percent would become PCHPSAs without pediatricians or without ob/gyns.

Despite the enormous contributions that family physicians make to rural populations, and despite a reported surplus of physicians in the United States, the country’s rural areas have been medically underserved for decades. While statistics on the exact number of rural Americans vary with the definition of “rural” and the data collection method used, the latest (2000) U.S. Census data has determined that about 21 percent of the U.S. population lives in rural areas. However, rural physicians comprise only about 10 percent of the total number of working physicians in the country. Using the new model of practice espoused by the Future of Family Medicine project, it is estimated that a reasonable physician to population ration is 1:1200. In the U.S. as a whole there is 1 Primary Care physician per 1300 persons while in rural areas the ratio is 1 Primary Care physician per 1910 persons and 1 Family Physician per 2940 persons. In the most rural counties, those with a community of at least 2500 people but no town over 20,000, close to 30,000 additional Family Physicians are needed to achieve the recommended 1:1200 ratio. Sparse population, extreme poverty, high proportions of racial and ethnic minorities, and lack of physical and cultural amenities characterize rural communities most likely to suffer from a shortage of physicians. This persistent, intractable shortage of physicians in rural communities means that many communities struggle continuously to recruit and retain physicians.

A particular area of concern for rural physicians is the provision of emergency services. The 2008 AAFP...
Board of Directors report part F addresses this issue in detail. According to the data used in this report, Family Physicians outnumber Emergency Physicians about 7 to 1 in rural areas. One of the major causes of this disparity is that rural communities do not have the population density to support a residency trained Emergency Physician. However, The breadth of training in family medicine makes the Family Physician a nearly ideal provider of emergency services in rural areas. It has long been believed that Family Physicians provide the bulk of emergency care for the rural population. An April 2008 publication generated by the Robert Graham Center traced emergency room attendants based on Medicare claims from 2003. Overall, 75 percent of the claims were for care by board certified Emergency Physicians. Most of the rest were seen by Family Physicians and General Internists. However, Emergency Physicians saw only 48 percent of the rural Medicare emergency patients. The more rural the location, the more likely the patient saw a Family Physician. In the most rural communities, the likelihood of seeing an Emergency Physician drops five fold, while the odds of seeing a Family Physician increases seven fold. The unique concern of rural emergency healthcare delivery must be considered in the training and recruitment of Family Physicians who will practice in these areas.

Although recruitment and retention of rural physicians are often discussed in tandem, the factors that make a physician likely to choose rural practice are actually quite different from those that make a physician likely to stay in such a practice setting. Even a successful recruitment effort may not result in the addition of a family physician because the physician may have such a hard time adjusting to rural life that he or she leaves soon after arriving. Thus, it is important to deal with each issue separately.

Recruitment

Two of the strongest predictors that a physician will choose rural practice are specialty and background: Family physicians are more likely than those with less general training to go into rural practice, and physicians with rural backgrounds are more likely to locate in rural areas than those with urban backgrounds. Other factors associated with increased likelihood that a physician will choose rural practice include the following:

- Training at a medical school with a mission to train rural physicians. Such schools are more likely to graduate students who go into rural practice than schools that do not have a rural mission. (There is, however, evidence that physicians who go into rural practice after having been trained at a school that does not have a rural mission tend to stay in rural practice longer.)
- Osteopathic training. Osteopathic medical schools have a long tradition in rural communities, and physicians who are trained in osteopathic medicine are more likely to select family medicine as a specialty than those trained in allopathic medicine (46 percent vs 11 percent) and to practice in rural areas (18.1 percent vs 11.5 percent).
- Training that includes rural components. Rural rotations and other rural curricular elements in medical school and residency training are critical to keeping students who have an interest in rural practice from looking elsewhere.
- Participation in the National Health Service Corps scholarship program.

Of course, many factors influence the resident’s initial choice of practice site, rural or otherwise. Table 1, from a 1996 study of 1,012 residents, suggests some of the most important ones. And while none of them intrinsically favor rural sites, some suggest possibilities for giving physicians incentives to choose rural practice.

Unfortunately, data from recent years show that medical student interest in both family medicine and rural practice is actually declining. And although many physicians clearly enjoy rural practice, most physicians show little or no interest. Some proposed reasons for this lack of interest include admission of fewer medical students from rural backgrounds, less institutional or school commitment to meeting the needs of their state or locality, the negative effect of a medical school’s vision as a research institution that creates physician-scientists of subspecialties, and a perception that Family medicine is a less “intellectual” pursuit. In addition, as students face higher debt loads, there is a belief that Family Medicine, especially in a rural practice will not be successful enough to resolve these debts in a reasonable time. Because of these
issues, some have suggested that the solution to the problem of rural recruitment is to expand pay-back programs such as the National Health Service Corps.\textsuperscript{25} Certainly, state and federal loan pay-back and scholarship programs provide much-needed physician manpower for many rural, isolated communities.\textsuperscript{26} However, more recent evidence also supports the need to target students from rural backgrounds in the medical school admission process. It also highlights success of nurturing and sustaining interest in rural practice by providing students and residents with early and frequent exposure to rural practice settings, and increasing rural training tracks in graduate medical education.\textsuperscript{27}

Finally, the recent increase in the number of women graduating from U.S. medical schools could further diminish the supply of rural physicians, since women have historically been much less likely to go into rural practice than men, although it does appear that a higher proportion of recent women family medicine residency graduates are going into rural practice.\textsuperscript{28} One explanation for the historically low percentage of women in rural practice is the difficulty of meeting the needs of male spouses of physicians in rural areas. It is possible that a higher percentage of two-physician and other nontraditional partnerships may account for the recent increase in rural female physicians,\textsuperscript{18} although two-physician couples can have difficulty fitting into small call groups in isolated areas because both prefer to be off-call at the same time. Women physicians may be particularly desirable to rural communities,\textsuperscript{29,30,31} making this a positive development in many ways.

**Retention**

Considerable research has been done regarding the reasons physicians stay in rural practice once they have started. While having a rural background may make a physician more likely to take up practice in a rural community, it does not seem to affect his or her decision to stay in such a community.

Research suggests that the ability to adapt to rural practice and, especially, rural life is the key determinant of retention. Pathman's prospective study of 456 randomly selected, non-obligated rural physicians\textsuperscript{31} found that those who indicated that they felt better prepared both medically and socially for practice in a rural area stayed longer than those who felt unprepared or who were initially unaware of the special characteristics of rural practice. Being prepared for rural life in the social sense seems more important in this regard than being medically trained for rural practice. Those who felt prepared for small-town living were over twice as likely as others to remain in a rural area for at least six years.

In 1997, Cutchin published a paper based on in-depth interviews of 17 rural physicians in Kentucky. This study underscores the importance of a sense of place for physicians who practice in a rural setting.\textsuperscript{33} Physicians attributed this feeling of "security, freedom and identity" to a number of factors, which are listed in Table 3. Cutchin's papers\textsuperscript{33,34} help flesh out the concepts validated by Pathman in his more quantitative studies.\textsuperscript{22,33,40}

Besides feeling that they "belong" to their rural community, family physicians who practice in remote and sparsely populated areas require special training in procedures, emergencies, obstetrical care and surgical care to feel confident in their abilities to handle situations without assistance. Fortunately, there are several rural-based and rural-track residency programs that offer this sort of training. It is less clear, however, whether medical schools and residencies are teaching the social skills family physicians need to succeed in rural practice. For example, the rural family physician may be called on to be a community leader and to represent the community's interest in public health emergencies. Additionally, the rural family physician tends to encounter his patients more often during the course of everyday life (e.g., at the grocery store). Being comfortable with this degree of closeness may or may not be part of the family physician's personality and social skill set. Medical school curricula that include classes on community development\textsuperscript{35} and even Community-Oriented Primary Care (COPC)\textsuperscript{36} can also have the eventual effect of promoting retention of family physicians who practice in rural areas. However, current medical school curricula, by the emphasis on tertiary care and lack of respect for generalists, may subvert successful adjustment to rural practice.\textsuperscript{36}
Programs that help rural family physicians become successful and stay satisfied with their choice have been developed. Ideally, rural-based family medicine residencies or departments with an emphasis on training physicians for rural practice could work with area health education cooperatives (AHECs) or other community-based groups to help communities develop such programs. Community physician preceptors can serve as role models for residents and as links to rural communities.

Finally, although a complete review of these issues is beyond the scope of this paper, continued welfare reform and changes in Medicare and Medicaid payment policies that result in more equitable payments to rural hospitals and physicians would likely have a positive effect on retention of family physicians.

Conclusions

Rural communities in America need more physicians. The best way to fill this need is to increase the number of students from rural areas and other students committed to rural and family medicine that are enrolled in medical schools. Physicians and community organizations from rural areas need to urge their state medical schools to give priority to students from rural backgrounds. Family medicine faculty members should be part of medical school admissions committees, so they can advocate for the admission of these students.

But increasing the number of rural-oriented students who enter medical school is not enough in itself, nor is simply increasing the number of physicians who begin rural practice. To support the students in their commitment and to promote retention of rural physicians, we need strong family medicine departments and rural-based curriculum elements in all medical schools. We need residency programs designed to teach the clinical, social, and interpersonal and management skills needed for successful rural practice.

These residency programs themselves also need support. Groups such as the Accreditation Council on Graduate Medical Education (ACGME) and the Residency Review Committee (RRC) need to make special accommodation for rural-based programs. Barriers to accreditation for rural programs persist in spite of the demonstrated success of these programs in getting physicians into rural practice.

More, rural health care services are still under-paid, threatening the viability of rural training programs as well as physician recruitment and retention. Government action is needed. Federal and state agencies that fund medical services could more actively support rural physicians and add to the attractiveness of rural practice in many ways (see Table 4).

Finally, family physicians should actively support the AAFP, the National Rural Health Association (NRHA), and other groups that advocate for rural physicians. Additionally, the AAFP will continue its ongoing support and outreach to rural family physicians such as the recent formation of a Workgroup on Rural Health issues and an online community through the AAFP website for networking and sharing between rural physicians. Additional services could include a mentorship program between established rural physicians and residents and new physicians considering or planning to practice in rural settings.

Figure 1

Patient Care Physicians Per 100,000 Population by Location and Specialty

Figure 2

Active Physicians Per 100,000 Population by Year and Location

Table 1:
Factors Important to Graduating Family Practice Residents in Choosing Their First Practice Site
<table>
<thead>
<tr>
<th>Factor</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor: Significant other’s wishes</td>
<td>Rank: 1</td>
</tr>
<tr>
<td>Factor: Medical community friendly to family physicians</td>
<td>Rank: 2</td>
</tr>
<tr>
<td>Factor: Recreation/culture</td>
<td>Rank: 3</td>
</tr>
<tr>
<td>Factor: Proximity to family/friends</td>
<td>Rank: 4</td>
</tr>
<tr>
<td>Factor: Significant other’s employment</td>
<td>Rank: 5</td>
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<tr>
<td>Factor: Schools for children</td>
<td>Rank: 6</td>
</tr>
<tr>
<td>Factor: Size of community</td>
<td>Rank: 7</td>
</tr>
<tr>
<td>Factor: Initial income guarantee</td>
<td>Rank: 8</td>
</tr>
<tr>
<td>Factor: Benefits plan</td>
<td>Rank: 9</td>
</tr>
<tr>
<td>Factor: Proximity to spouse’s family/friends</td>
<td>Rank: 10</td>
</tr>
<tr>
<td>Factor: Weather/geography</td>
<td>Rank: 11</td>
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<tr>
<td>Factor: Need for physicians</td>
<td>Rank: 12</td>
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<tr>
<td>Factor: Significant other’s school opportunities</td>
<td>Rank: 13</td>
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<tr>
<td>Factor: Maximum potential income</td>
<td>Rank: 14</td>
</tr>
<tr>
<td>Factor: Familiar with physicians in area</td>
<td>Rank: 15</td>
</tr>
<tr>
<td>Factor: Community service commitment</td>
<td>Rank: 16</td>
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<tr>
<td>Factor: Affordable housing</td>
<td>Rank: 17</td>
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<tr>
<td>Factor: Opportunity to teach</td>
<td>Rank: 18</td>
</tr>
<tr>
<td>Factor: Familiar with hospital</td>
<td>Rank: 19</td>
</tr>
<tr>
<td>Factor: Loan pay-back plan</td>
<td>Rank: 20</td>
</tr>
<tr>
<td>Factor: Signing bonus</td>
<td>Rank: 21</td>
</tr>
<tr>
<td>Factor: Residency nearby</td>
<td>Rank: 22</td>
</tr>
<tr>
<td>Factor: Medical school nearby</td>
<td>Rank: 23</td>
</tr>
<tr>
<td>Factor: Military service commitment</td>
<td>Rank: 24</td>
</tr>
</tbody>
</table>


Table 2: Factors that Influence Retention

Physicians who feel better prepared to handle emergencies, tough medical situations and busy outpatient practices without consultants or high-level technology are more likely to stay in rural practice.

Physicians who receive part of their residency training in rural areas stay longer in rural practice.

Physicians in rural communities are no more likely to leave their practices than are their urban counterparts.

Urban-raised physicians who enter rural practice stay in rural practice longer than physicians who were raised in rural areas.

Length of stay in rural practice is not associated with attending a public vs. private medical school or with training in a community-based vs. medical school-based residency.

Physicians whose spouses are from urban areas stay in practice as long as those whose spouses are from rural areas.

Physicians involved in teaching remain in rural practice longer than those who are not involved.

For obligated National Health Service Corps scholars, students from private schools are more likely to stay in a rural pay-back site after they have fulfilled their obligation period than are those from public medical schools.
Although many urban physicians assume otherwise, rural physicians do not necessarily view professional isolation and an inability to access medical information as drawbacks to rural practice.

Lack of quality of rural school systems, perceived or real, is related to length of stay for physicians in a rural practice.

### Table 3:
**Security, Freedom and Identity: How Rural Family Physicians Define These Concepts**

<table>
<thead>
<tr>
<th>Security</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security: Confidence in medical abilities.</td>
</tr>
<tr>
<td>Security: Commitment to goals.</td>
</tr>
<tr>
<td>Security: Ability to meet needs of family.</td>
</tr>
<tr>
<td>Security: Comfort with local medical community and hospital.</td>
</tr>
<tr>
<td>Security: Not too much call.</td>
</tr>
<tr>
<td>Security: Respect by community at large and by the medical community.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Freedom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freedom: Challenge and diversity in medical work.</td>
</tr>
<tr>
<td>Freedom: Ability to spend time with patients.</td>
</tr>
<tr>
<td>Freedom: Cooperation from medical community and larger community.</td>
</tr>
<tr>
<td>Freedom: Power in medical system.</td>
</tr>
<tr>
<td>Freedom: Ability to develop health care delivery system.</td>
</tr>
<tr>
<td>Freedom: Involvement in the community.</td>
</tr>
<tr>
<td>Freedom: Personal and family activities.</td>
</tr>
<tr>
<td>Freedom: Developed sense of self and place</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identity: Loss of anonymity.</td>
</tr>
<tr>
<td>Identity: Like-minded practice group.</td>
</tr>
<tr>
<td>Identity: Responsible role in hospital and community.</td>
</tr>
<tr>
<td>Identity: Respect.</td>
</tr>
<tr>
<td>Identity: Fulfilling aspirations for job.</td>
</tr>
<tr>
<td>Identity: Seeing self as belonging in the community.</td>
</tr>
<tr>
<td>Identity: Awareness of self in time and place.</td>
</tr>
<tr>
<td>Identity: Creation of future goals without needing to relocate.</td>
</tr>
</tbody>
</table>


### Table 4:
**Key Legislative and Governmental Issues**

| Expand the Medicare Incentive bonus program, which pays a bonus to physicians for services rendered to residents of designated shortage areas, to include practices in remote small towns regardless of HPSA designation. |

| Renew and expand Title 7 funding, which provides funds for family practice training, and link Title 7 funding to rural medical education. |
Reform Medicare regulation of graduate medical education to support rural-based medical education.

Revise Medicare regulations, including the Medicare Incentive bonus program and the Area Wage Index of the Medicare Inpatient Hospital Prospective Payment System.

Write legislation to support rural hospitals, which may include strengthening the Critical Access Hospital system and other special arrangements for rural health care funding.

Changes the Personal Responsibility and Work Opportunity Reconciliation Act, which may improve rural economies and improve government support for rural populations.

**Table 5:**
**Resources for Information About Rural Health**

<table>
<thead>
<tr>
<th>Web sites</th>
<th>Web site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web sites: American Academy of Family Physicians</td>
<td><a href="http://www.aafp.org">http://www.aafp.org</a></td>
</tr>
<tr>
<td>Web sites: Rural Policy Research Institute</td>
<td><a href="http://www.rupri.org">http://www.rupri.org</a></td>
</tr>
<tr>
<td>Web sites: Rural Medical Educators Home Page</td>
<td><a href="http://www.ruralhealthweb.org/go/left/networking-and-programs/rural-medical-educators/">http://www.ruralhealthweb.org/go/left/networking-and-programs/rural-medical-educators/</a></td>
</tr>
<tr>
<td>Web sites: National Rural Health Association</td>
<td><a href="http://www.ruralhealthweb.org">http://www.ruralhealthweb.org</a></td>
</tr>
<tr>
<td>Web sites: Federal Office of Rural Health Policy</td>
<td><a href="http://www.ruralhealth.hrsa.gov/">http://www.ruralhealth.hrsa.gov/</a></td>
</tr>
</tbody>
</table>

**Articles and Books**


Medicare Payment Advisory Commission: Report to the congress: Medicare in rural America. Medpac, Washington, DC. June 2001 (www.medpac.gov). (Note: this document has some useful information, although it has been criticized as being extremely timid in its conclusions).


**References**


Safe Prescribing Act - AAFP Legislative Stance

See also

- Maternal/Child Care (Obstetrics/Perinatal Care)
- Reproductive Decisions
- Women's Health Care

The AAFP opposes legislation that would make any substance containing hydrocodone a Schedule II drug. (July 2013 BOD)
The American Academy of Family Physicians strongly believes that all children and adolescents should have access to a medical home that provides high-quality health care services in a continuous and comprehensive fashion. The American Academy of Family Physicians supports the selective implementation of school-based health clinic programs in areas where the health care needs of the school-age population are not being met. School-based health clinic programs should cooperate and communicate with the medical home to assure consistent and quality care. Clinical services in school-based clinics should be provided by a professionally prepared school nurse or similarly qualified health professional and supervised by family physicians or other physicians trained in the care of children and adolescents. Written policy for school health services should be formulated by a health council consisting of school and community-based physicians, nurses, faculty, parents, and community leaders. This policy should include a carefully prepared, well-integrated health education curriculum emphasizing positive health practices. (1989) (2013 COD)
School Bus Safety

See also

- Motor Vehicle Occupant Protection

The Academy advocates legislative and educational efforts in the promotion of safe school bus transportation for the nation's children. These efforts may include, but are not limited to, research on seat belt use, safety education programs, specific regulations and standards for vehicles used for school transportation, and mandatory special licensing and physical examination requirements for school bus drivers. (1982) (2013 COD)
School Nutrition: Healthy Eating Options in Schools

See also

- Healthy Foods
- Healthy Nutrition in Health Care Facilities and Other Workplaces
- Obesity and Overweight
- Children's Health

The AAFP believes that sound nutrition is a cornerstone of health and should be reflected in all dietary offerings/options in schools, (e.g. food service, meals, vending, outside contractors, etc.). Items of little or no nutritional value should be replaced with healthy alternatives. (2005)

1. Students, parents, educators, family physicians, school nurses, and community leaders should be involved in assessing the schools’ eating environment, developing a shared vision and an action plan to achieve it.
2. Adequate funds should be provided by local, state and federal sources to ensure that the total school environment supports the development of healthy eating patterns.
3. Behavior-focused nutrition education should be integrated into the curriculum from pre-K through grade 12 and staff who provide nutrition education will have appropriate training.
4. Schools should be encouraged to incorporate school gardens and locally grown foods.
5. School meals should meet the USDA nutrition standards as well as provide sufficient choices, including new foods and food prepared in new ways, to meet the taste and cultural preferences of diverse student populations.
6. All students should have designated meal periods of sufficient length to enjoy healthy foods with friends and these lunch periods will be scheduled as near the middle of the school day as possible.
7. Schools should provide enough serving areas to ensure student access to school meals with a minimum of wait time.
8. Space that is adequate to accommodate all students and pleasant surroundings that reflect the value of the social aspects of eating should be provided.
9. Students, teachers and community volunteers who practice healthy eating should be encouraged to serve as role models in the dining areas.
10. If foods are sold in addition to National School Lunch Program meals, they should be from the five major food groups to foster healthy eating patterns.
11. Decisions regarding the sale of foods in addition to the National School Lunch Program meals should be based on nutrition goals, not on profit-making. (2004) (2015 COD)
Screening

See also

- Home Test Kits

The AAFP encourages patients to consult with their physician regarding selection, use, and interpretation of screening tests. (1980) (2013 COD)
Seal, AAFP

See also

- AAFP Mission Statement
- AAFP Promotions: Print Advertorials
- AAFP Public Statements
- Family Physicians' Creed
- Seal, AAFP, Use of

Each element of the AAFP seal helps tell the story of family medicine and its role in American health care. By building respect and awareness for family medicine, the AAFP aims to be a guiding light for all family physicians.

- The torch signifies enlightenment. Its flame is a guiding light that represents honor, valor, and victory.
- The serpent encircling the staff represents healing and the renewing power of life. (The staff encircled by the serpent is a symbol given to Apollo and his son, Aesculapius. It is the traditional symbol of medicine.)
- The tagline Strong Medicine for America demonstrates our belief that family physicians are the cornerstone of the American health care system. The AAFP is working to position family physicians as foundational to a primary care, physician-based health care system; and to ensure family physicians become tomorrow's respected providers of vital, quality health care delivered cost-effectively.

This Bold Champion seal was adopted by the AAFP Board of Directors in August 2007 in Beaver Creek, Colorado. The original seal was conceived in 1947, updated in 1956, and updated again in 1971 to reflect the AAFP's name change.

(March 2008) (2013 COD)
Seal, AAFP, Use of

See Also

- Seal, AAFP

The AAFP Seal is a registered service mark and may not be altered in any way without permission.

As the AAFP Seal signifies endorsement by or affiliation with the American Academy of Family Physicians, its use is strictly governed. Use of the Seal is limited to the AAFP national office, and its constituent and component chapters. The Seal is not intended for use by individual members.

AAFP Use - The Seal may be used by the AAFP on materials such as stationery, publications and communications; on technical and educational materials; and on resale and giveaway items which are in good taste. Uses may be in print, electronic or in such other manner as may be appropriate.

Constituent Chapter Use - Constituent Chapters may use the Seal on materials such as stationery, publications and communications; and on technical and educational materials. Uses may be in print, electronic or in such other manner as may be appropriate. All uses must be in accordance with visual standards and guidelines developed by the AAFP. Constituent Chapters may also use the Seal on resale and giveaway items which are in good taste, provided that such use is approved in advance by the AAFP.

External Use - No outside entity may use the Seal without written permission of the AAFP. All requests for use shall be submitted in writing to the executive vice president, who shall oversee review of such requests and, as necessary and appropriate, forward such requests for consideration by the AAFP Board of Directors.

(1962) (2014 COD)
The American Academy of Family Physicians (AAFP) supports a sexual assault survivor’s rights to protection from their perpetrator. This protection should include protection from re-victimization as it may relate to the use of custody or visitation lawsuits for offspring conceived during the illegal act. The AAFP supports a legal framework that codifies this protection. (2015 COD)
Shared Medical Appointments/ Group Visits

See Also

- e-Visits

A shared medical appointment, also known as a group visit, occurs when multiple patients are seen as a group for follow-up care or management of chronic conditions. These visits are voluntary for patients and provide a secure but interactive setting in which patients have improved access to their physicians, the benefit of counseling with additional members of a health care team (for example a behaviorist, nutritionist, or health educator), and can share experiences and advice with one another.

The American Academy of Family Physicians (AAFP) believes that group visits are a proven, effective method for enhancing a patient’s self-care of chronic conditions, increasing patient satisfaction, and improving outcomes.

Shared medical appointments should be documented in each participating patient’s medical record. That documentation should reflect the individual services provided to each patient as well as the services provided to the group as a whole at each encounter.

Shared medical appointments include individual evaluation and management of each patient as well as counseling with the group as a whole. This individual evaluation could take place either separately or within the group process, depending on the setting and group needs. Accordingly, the AAFP believes physicians who provide and document such appointments should code for the services provided using applicable, existing, evaluation and management (E/M) codes found in Current Procedural Terminology (CPT). Third party payers should cover and pay for submitted E/M services for shared medical appointments. (2008) (2013 COD)
The mission of the American Academy of Family Physicians (AAFP) is to improve the health of patients, families, and communities by serving the needs of members with professionalism and creativity.

In their patient-centered practices, family physicians identify and address the social determinants of health for individuals and families, incorporating this information in the bio psychosocial model to promote continuous healing relationships, whole-person orientation, family and community context, and comprehensive care.

Social determinants of health are the conditions under which people are born, grow, live, work, and age. The factors that strongly influence health outcomes include a person's:

- Access to medical care
- Access to nutritious foods
- Access to clean water and functioning utilities (e.g., electricity, sanitation, heating, and cooling)
- Early childhood social and physical environment, including childcare
- Education and health literacy
- Ethnicity and cultural orientation
- Familial and other social support
- Gender
- Housing and transportation resources
- Linguistic and other communication capabilities
- Neighborhood safety and recreational facilities
- Occupation and job security
- Other social stressors, such as exposure to violence and other adverse factors in the home environment
- Sexual identification
- Social status (degree of integration vs isolation)
- Socioeconomic status
- Spiritual/religious values

The AAFP supports the assertion that physicians need to know how to identify and address social determinants of health in order to be successful in promoting good health outcomes for individuals and populations. In preparing students for practice, medical schools must foster core competency in this patient-centric concept. Physicians in training must develop awareness of the potential obstacles patients confront when following treatment plans. Without this core competency, physicians and patients alike will be impeded by suboptimal outcomes.

Family medicine graduate medical education trains physicians to lead interdisciplinary teams to deliver patient-centered medical care. Family medicine residents develop competencies in the bio psychosocial model, cultural proficiency, evidence-based practice, quality improvement, informatics, and practice-based research. Through education on the social determinants of health during residency, family physicians learn to:

- Identify crucial social determinants of health for their community of patients
- Identify and partner with community resources that address social determinants of health
- Consistently individualize patient care based on the patient's social determinants of health
- Engage directly via community involvement to improve social determinants of health
Stay informed and act on local, state, and national policies affecting the social determinants of health of the populations that they serve.

The AAFP believes policymaking should be population based and evidence based, and should support current and future research on social determinants of health. Research conducted on social determinants of health should focus on effective interventions to reduce health inequities, including family physicians' roles in ameliorating social determinants of health.

Family physicians take a leading role in addressing the social determinants of health by partnering and collaborating with public health departments, social service agencies, and other community resources. Family physicians are integral within the continuum of care and use their skills and expertise in caring for patients across the lifespan to reach out to their communities, bridge health care gaps, and strive for better health for all. (October 2012 BOD) (2013 COD)
Specialty Hospitals

See also

- Economic Credentialing and Network Participation
- Hospital Medical Staff, Board Certification for Membership
- Hospital Medical Staff and Other Health Care Organizations, Board Recertification
- Hospital Medical Staff, Liaison Between Governing Boards and

AAFP encourages the Centers for Medicare and Medicaid Services to clearly define and strictly enforce the "whole hospital" exception to the prohibition of self-referrals by physicians for new and existing entities with a hospital provider agreement. (2006) (2013 COD)
Sports Medicine, Athletic Trainers for High School Athletes

See also

- Sports Medicine, Counseling About Risk of Contact/Collision Sports
- Sports Medicine, Health and Fitness
- Sports Medicine, Persons with Disabilities: Participation in Sports and Physical Activities
- Boxing, Sport of
- Protective Equipment for Recreational and Competitive Sports Activities
- Ultimate Fighting and Disabling Competitions

The AAFP encourages high schools to have, whenever possible, a National Athletic Trainers Association (NATA)-certified or registered/licensed athletic trainer as an integral part of the high school athletic program. (1989) (2012 COD)
Sports Medicine, Counseling About Risk of Contact/Collision Sports

See also

- Sports Medicine, Athletic Trainers for High School Athletes
- Sports Medicine, Health and Fitness
- Sports Medicine, Persons with Disabilities: Participation in Sports and Physical Activities
- Boxing, Sport of
- Protective Equipment for Recreational and Competitive Sports Activities
- Ultimate Fighting and Disabling Competitions

The American Academy of Family Physicians recommends that family physicians understand risks associated with each contact/collision sport and advise patients about their individual risks and benefits and how to manage and minimize any risks associated with their specific sport. (1990) (2013 COD)
Sports Medicine, Health and Fitness

See also

- Sports Medicine, Athletic Trainers for High School Athletes
- Sports Medicine, Persons with Disabilities: Participation in Sports and Physical Activities
- Sports Medicine, Counseling About Risk of Contact/Collision Sports
- Protective Equipment for Recreational and Competitive Sports Activities
- Ultimate Fighting and Disabling Competitions
- Physical Activity in Children

The need for fitness begins at an early age and extends well into later life. As such, the issue of sports participation is integrally related to the patient's sense of well-being, both physically and emotionally. The family physician is uniquely positioned to be involved across the entire age spectrum and is able to recognize that health and fitness are dependent on a certain degree of physical activity and regular exercise throughout one's life.

The pre-participation assessment as well as diagnosis and treatment of exercise-related injuries and diseases are best incorporated into comprehensive medical management. The pre-participation assessment is best performed within the context of the medical home or, at a minimum, by a physician, nurse practitioner, or physician assistant. The family physician is uniquely qualified to be the sports medicine "doctor of choice" because of a broad knowledge base and experience.

The AAFP promotes continued medical education and supports patient education products for its members in the area of sports medicine, health, fitness and nutrition. It encourages the family physician to be the sports medicine doctor in his or her own community.

The American Board of Family Medicine (ABFM) states that “Sports Medicine is a body of knowledge and a broad area of health care which includes: 1) exercise as an essential component of health throughout life; 2) medical management and supervision of recreational and competitive athletes and all others who exercise; and 3) exercise for prevention and treatment of disease and injury.” The ABFM has developed a Certificate of Added Qualifications to recognize excellence among those with special expertise in Sports Medicine. (1988) (2015 COD)
Sports Medicine, Persons with Disabilities: Participation in Sports and Physical Activities

See also

- Sports Medicine, Athletic Trainers for High School Athletes
- Sports Medicine, Health and Fitness
- Sports Medicine, Counseling About Risk of Contact/Collision Sports
- Protective Equipment for Recreational and Competitive Sports Activities

The AAFP encourages participation of persons with disabilities in sports and physical activities to the full extent of their abilities in the appropriate setting. Family physicians need to become informed about the unique risks of athletes with disabilities and their involvement in sports and physical activity.

The AAFP recognizes that a program of regular exercise for persons with disabilities contributes to improved health, rehabilitation, a sense of self-worth and improved productivity.

The AAFP recognizes that appropriate supervision, facilities and accessibility should be integral parts of any sports and physical activities for individuals with disabilities. (1996) (2013 COD)
Stimulant Drinks and Products

SEE ALSO

- Substance Abuse and Addiction

The AAFP recognizes the increased consumption of stimulant drinks (often referred to as “energy drinks”) and related products (e.g. snacks, shots, chews, candies), especially by young people, despite growing evidence of their harmful effects. These products typically contain one or more of the following ingredients: caffeine, methylxanthines, B vitamins, guarana, yerba mate, bitter orange, ginger, ginkgo, St. John’s Wort, ginseng and taurine. Manufacturers advertise that these stimulant drinks and products improve neurological and/or psychophysiological performance and efficiency, though evidence supporting these claims is lacking. A common marketing practice of manufacturers is the provision of free or discounted samples of these products to minors.

The Food and Drug Administration has not yet defined energy or stimulant drinks and their related products. The food and beverage industry may use these labels and make these claims at will, without external monitoring or regulation. Stimulant ingredients in energy drinks and products may cause significant adverse health effects in vulnerable populations, particularly those with cardiac disease, asthma and other conditions requiring the use of certain prescription medications. The stimulant ingredients can be especially dangerous when combined with other recreational substances.

The AAFP supports the formal definition and classification of stimulant drinks and products by the Food and Drug Administration, including standardization of labeling information and ongoing monitoring of ingredients and regulation of these products. The AAFP opposes the sale and marketing of stimulant drinks and related products to individuals under the age of 18 in the United States of America. (2014 COD)
The AAFP calls on entities including, but not limited to medical schools, state governments, the federal government, and private firms to develop and support programs and incentives that encourage student career choice of family medicine. In doing so, the AAFP recognizes the multifaceted and complex factors leading to specialty choice. These programs and incentives could be financial, educational, institutional, or political in nature. They include, but are not limited to:

**Financial**

1. Financial incentives, including scholarship programs and tuition waivers for students who commit to family medicine, medical student educational loan forgiveness programs, and low-interest loan programs for family medicine residents and practicing physicians.

**Pipeline**

2. Innovative educational programs for students from elementary school through medical school that provide age-appropriate mentoring and experiential learning.

**Family Physicians as Mentors**

3. Resources, support, and training for physician-mentors and faculty to include financial and professional incentives for community-based family physician preceptors.
4. Enhance medical school leadership development that prepares family physicians to be leaders in team-based primary care.
5. Support the development of medical school family medicine alumni networks that serve as clinical training sites for medical students.

**Medical School**

6. Medical School admissions policies that recognize and value attributes found in successful primary care clinicians, and include family medicine faculty interviewers on the admission committee.
7. LCME standards that require family medicine education early in medical school training.
8. GME modernization proposals that protect and expand funding for family medicine residencies.
9. Highlight the global medicine opportunities within family medicine.
10. Promotion of model medical school curricula, governance and programming that lead to increased choice of family medicine.
11. Widespread enhanced support for family physician preceptors.
13. A family medicine department at all medical schools.
14. Investing in and supporting medical school pathway/pipeline programs for students interested in
underserved populations.
15. Investing in family medicine interest groups.

**Advocacy and Leadership**

16. Preservation of full scope family medicine training and practice opportunities.
17. Payment reforms that appropriately values payment for primary care services.
18. Innovative research for primary care at all levels including quality improvement, comparative effectiveness, translational, and community-based participatory research.
19. State and federal policies that selectively value a primary care based physician workforce.
20. Expand exposure and opportunities to highlight family medicine’s unique position and involvement in public health and advocacy efforts.
21. Define and clarify the role of family medicine as a distinct and unique specialty within primary care.
22. Early premedical and medical school exposure to family medicine.

Student-Run Free Clinics

The American Academy of Family Physicians (AAFP) supports the concept of access to essential health care for all people regardless of social and economic status, and ideally through a patient-centered medical home (PCMH).

Student-run free clinics often provide access to indigent and underserved populations who otherwise may not receive basic health care services. A student-run free primary care clinic is a service-learning, student driven outreach project that strives to enhance the health and well-being of a community through the provision of medical care. The AAFP supports the inclusion of family physicians within the student-run free clinic setting since a family physician can provide the following unique benefits:

- Provide comprehensive, community-based medical care
- Deliver basic, essential patient-centered health care services
- Expose medical students to the specialty of family medicine
- Provide clinical instruction for students

(July 2013 Board) (2013 COD)
Substance Abuse and Addiction

See also

- Marijuana
- Impaired and Clinically Deficient Physicians
- Electronic Cigarettes
- Tobacco and Smoking
- Tobacco: Preventing and Treating Nicotine Dependence and Tobacco Use (Position Paper)
- Alcohol Advertising and Youth (Position Paper)
- Athletic Performance Enhancing Drugs
- Graduated Driver's License
- Stimulant Drinks and Products
- Chronic Pain Management and Opioid Misuse: A Public Health Concern

Substance abuse and addiction are complex health and societal problems. Substance abuse is the inappropriate and harmful use of any substance, including prescription drugs, OTC medications, supplements and alcohol. Addiction to substances includes the element of loss of control and is recognized as a chronic relapsing disease.

The AAFP promotes a society which is free of alcohol, drug and substance abuse. The AAFP strongly urges its members to be involved in the diagnosis, treatment and prevention of substance abuse and addictive disorders as well as the secondary diseases related to their use. Education in the treatment of all aspects of these complex disorders, including knowledge and usage of evidence-based strategies, should be a defined part of medical school and family medicine residency curricula.

To better care for patients with such disorders, a comprehensive strategy should be adopted by physicians that includes:

1. Recognition of the gravity, extent, and broad-based nature of substance abuse and addiction in our society, including the development of novel mechanisms to ingest medications and alcohol;
2. Inclusion of substance abuse prevention in patient education;
3. Early diagnosis, treatment and referral of those struggling with substance abuse and addictive disorders;
4. Recognition of the effects of addiction on family members, especially children, offering support and treatment for family members and inclusion of family members in the treatment of the addicted member when possible; and
5. Partnering with community resources in the prevention, education and treatment of substance abuse and addiction.
6. Advocating for inclusion of and parity for substance abuse treatment in all health care plans;
7. Advocating for legislation and governmental policies facilitating the prevention, diagnosis and treatment of substance abuse, including funding for further research into substance abuse;
8. Reinforcement of laws and strategies to limit exposure of the population, particularly adolescents and children, to the abuse and misuse of these substances;
9. Supporting harm reduction strategies such as bystander naloxone programs, syringe exchange programs, educational programs and policy initiatives to prevent the secondary diseases associated with abuse and addiction.
Opioid Pain Relievers and Abuse

Concurrent with the increased use of opioid analgesics for pain control has been an explosive growth in the rate of abuse, misuse and overdose of these prescription medications. The AAFP recognizes the vital role that family physicians and other primary care clinicians have in the proper provision of pain management services including prescribing opioid analgesics. The AAFP supports the training of family physicians regarding the proper assessment, referral and treatment of chronic pain patients in an effort to lessen the diversion, misuse and abuse of opioid pain relievers. The AAFP also supports further research into evidence-based guidelines for the treatment of chronic pain syndromes, implementation of prescription drug monitoring programs nationwide and greater physician input into pain management regulation and legislation. Please see the AAFP position paper, “Pain Management and Opioid Abuse, A Public Health Concern” for further information.

Heroin

Heroin, which can be sniffed, smoked or injected, is experiencing a rebound in usage, partially related to efforts to reduce the abuse of prescription pain relievers and with increased usage there has been a corresponding increase in overdose related deaths. The AAFP encourages its members to be aware of this and other trends in substance abuse and to recognize injection drug use as a vector in the transmission of HIV and hepatitis B and C.

Marijuana, Medical Use of

The AAFP recognizes that there is support for the medical use of marijuana but advocates that usage be based on high quality, patient-centered, evidence-based research and advocates for further studies into the use of medical marijuana and related compounds. The AAFP requests that the Food and Drug Administration change marijuana’s classification for the purpose of facilitating clinical research. This process should also ensure that funding be available for such research.

The AAFP also recognizes that some states have passed laws approving the medical use of marijuana; the AAFP does not endorse such laws. The AAFP encourages its members to be knowledgeable of the laws of their states and consult with their state medical boards for guidance regarding the use of medical marijuana.

Marijuana, Recreational Use of

The AAFP opposes the recreational use of marijuana, however supports decriminalization of the possession and personal use of marijuana. The AAFP recognizes that several states have passed laws approving limited recreational use or possession of marijuana and therefore advocates for further research into the overall safety and health effects of recreational use as well as the effects of those laws on patient and societal health.

Alcohol Abuse

A significant portion of the population is affected by alcoholism. The American Academy of Family Physicians promotes a society, free of alcohol abuse. The AAFP strongly urges its members to be involved in the diagnosis, treatment and prevention of alcoholism as well as diseases related to alcohol use and abuse. Detoxification is only the beginning of treatment and must be followed by adequate rehabilitation under expert guidance. Education in the treatment of all aspects of this complex disease should be a defined part of medical school and family medicine residency curricula.

The AAFP recommends that hospitals not discriminate against the admission and treatment of patients with alcohol-related illness or injury. The AAFP encourages its members to document alcohol abuse and alcohol related disease in the medical record and encourages members document alcohol abuse on death certificates when implicated as a contributing cause of illness, injury or death.
Alcohol Abuse in Adolescents

The AAFP recommends that all youth not consume alcohol. Although overall alcohol consumption by adolescents has decreased modestly over the past decade, alcohol use and abuse remains a significant public health concern for that population. The AAFP urges its members to educate themselves and the public regarding the recognition, prevention and treatment of this medical problem in our nation's youth. Please also see the AAFP position paper, "Alcohol Advertising and Youth."

Advertising

The AAFP supports a ban on the advertising of alcoholic beverages, particularly those advertisements which appeal to adolescents. Please also see the AAFP position paper, "Alcohol Advertising and Youth."

Drinking and Driving

The AAFP supports efforts to reduce the number of alcohol and substance impaired drivers on our highways. Significant reduction in morbidity and mortality have been widely reported when laws provide a strong deterrence to driving while impaired and the AAFP recommends the adoption of such laws in the interest of public safety. The AAFP recognizes the impaired driver as having a medical problem and recommends that impaired drivers receive appropriate referral and treatment for their condition. The AAFP supports the following recommendations:

1. Reduction of the legal blood alcohol concentration (BAC) for drivers to 0.04 gm/dl.;
2. State legislation to fund comprehensive alcohol-impaired driving prevention and treatment programs;
3. State legislation to immediately confiscate drivers' licenses for those found to be above the legal BAC while driving (this is known as administrative license revocation);
4. Increased enforcement of drinking and driving laws and expanded use of sobriety checkpoints;
5. Support of state and federal messaging regarding alcohol and substance abuse and its effects on driving.

Standardized Drinking Age

The AAFP favors age 21 as the minimum legal age to purchase or consume alcohol.

Taxes on Alcohol Beverages

The AAFP, along with other professional and public health organizations advocates for the following:

1. Strong support for increased federal taxes on beer, wine, and distilled spirits equally based on alcohol content with a substantial portion of that revenue earmarked for the prevention and treatment of alcohol abuse and drunk driving;
2. Strong support for increased state and local taxes on beer, wine, and distilled spirits with funds earmarked as outlined in #1.

Parity

Substance abuse is a treatable medical illness that, if left untreated or inadequately treated, incurs undue costs for the affected individual and for society as a whole. Treatment of substance abuse is often long-term and may be lifelong for selected individuals. Therefore, the AAFP supports full parity for substance abuse treatment in health care plans.

Pregnant Women, Substance Use and Abuse by
The AAFP recognizes that the literature does not support any lower limit of substance use at which potential fetal harm is mitigated. As such, the AAFP supports public and individual education about the risks of any substance use and abuse during pregnancy.

The AAFP opposes imprisonment or other criminal sanctions of pregnant woman solely for substance abuse during pregnancy, but encourages facilitated access to an established drug and alcohol rehabilitation program for such women.

**Neonatal Drug Withdrawal**

As described in the preceding section, no level of substance abuse during pregnancy is noted in which fetal harm is mitigated. In addition to the congenital anomalies and growth impairment associated with substance abuse, family physicians involved in newborn care are increasingly noting the problem of neonatal drug withdrawal or neonatal abstinence syndrome. The AAFP encourages the education of all its members providing newborn care into the recognition, diagnosis and treatment of this syndrome.

**Injection Drug Use**

The AAFP supports a comprehensive public health policy to prevent infectious diseases and other complications associated with injection drug use and abuse.

The AAFP supports dispensing and prescribing of injection equipment to patients as a means of preventing the transmission of disease where permitted by law. It also supports syringe exchange programs as a component of that strategy and supports the modification/passage of laws to accommodate those injection equipment programs. The AAFP recommends that physicians and other health care workers counsel their injection drug-use patients about using sterile syringes to inject drugs while simultaneously educating those patients about the harms of continued drug use and their treatment options.

**Prevention of Overdose Deaths**

In addition to efforts to improve the treatment of overdoses in the EMS and healthcare facility settings, efforts have begun to educate the lay public about the early recognition and treatment of overdoses. This includes efforts to ensure improved access to naloxone for management of overdoses, including its usage by the lay public, and efforts to encourage the public to access EMS earlier when an overdose is suspected. The AAFP supports those efforts including the promotion of naloxone kits for lay public usage as part of overdose prevention programs and promotes the passage of 911 Good Samaritan Immunity laws to exempt the lay public from prosecution when contacting EMS to report overdoses.

The American Academy of Family Physicians supports the implementation of programs which allow first responders and non-medical personnel to possess and administer naloxone in emergency situations.

The American Academy of Family Physicians supports the implementation of policies which allow licensed providers to prescribe naloxone to patients using opioids or other individuals in close contact with those patients.

The American Academy of Family Physicians supports the implementation of legislation which protects any individuals who administer naloxone from prosecution for practicing medicine without a license.

**AAFP Resources**

*American Family Physician*

Substance Abuse


Alcohol Abuse and Dependence
FamilyDoctor.org

Alcohol Abuse: Treatment

Inhalant Abuse Overview

Opioid Addiction: Overview

Prescription Drug Abuse in the Elderly

Safe Use, Storage, and Disposal of Opioid Drugs

Substance Abuse: Overview

Substance Abuse: Symptoms

Substance Abuse: Questions to Ask Your Doctor

Substance Abuse: Treatment

Sugar Sweetened Beverages

SEE ALSO:

- Healthy Foods
- Obesity and Overweight

The AAFP supports taxation of sugar sweetened beverages for the purpose of reducing over-consumption as a method of both improving the health of the public and combating the obesity epidemic. Tax monies should be directed towards programs that improve the health of the public. (2010 COD) (2015 COD)
Surgery, Office-Based

SEE ALSO

- Pre- and Post-Operative Care

The American Academy of Family Physicians supports the delivery of office-based surgery, and anesthesia services for this surgery (such as regional block anesthesia or moderate (conscious) sedation, by family physicians based on the individual physician's documented training and/or experience, demonstrated abilities, and current competence. In fee-for-service environments, family physicians' surgical services should be paid using a resource-based relative value scale (RBRVS) and should include payment for appropriate surgical supplies and either facility or equipment fees (including direct and indirect costs attributable to providing these services). In capitated environments, surgical services included in the family physician's capitation rate should be specified by Current Procedural Terminology code. Surgical services not included in the capitation rate should be paid by the RBRVS methodology. (1982) (2014 COD)
Surgery - Outreach - Policy

The American Academy of Family Physicians (AAFP) defines outreach surgery as surgery performed by a qualified, non-local physician while a different physician provides the postoperative care and selected aspects of the preoperative care of the patient. Consistent with their training and experience, family physicians are able to provide high quality preoperative, intraoperative and postoperative care as an essential component of outreach surgery.

The AAFP recognizes the importance of outreach surgery to assure access to health care where surgical services are not otherwise available locally. Accordingly, the AAFP supports the practice of outreach surgery as one method of providing needed services when coordinated by a team including the patient's family physician and the physician/surgeon, with appropriate coordination of patient care between team members during each phase of surgical care (preoperative, intraoperative and postoperative).

In the unique setting where outreach surgery has occurred, the primary operating physician should be paid for services actually performed. The family physician providing pre- or postoperative care should receive appropriate payment for such care. Each physician involved in such care should charge separately for his/her services, and should be paid separately. (2007) (2014 COD)
Teaching, Physician Responsibility

See also

- Physician Reentry
- Family Medicine Faculty Training
- Family Medicine, Undergraduate Training
- Family Medicine Clerkship
- Student Choice of Family Medicine, Incentives for Increasing
- Preceptorships

The development of a strong and diverse family medicine workforce sufficient to meet the interdisciplinary needs of a primary care medical home is dependent upon trained, supported and available preceptors. The American Academy of Family Physicians needs physicians to actively engage in physician education, including the teach of resident physicians, medical students and other health providers. The AAFP supports efforts to recruit, develop, train and retain faculty and preceptors in medical school departments, residencies and the community building a diverse workforce that addresses health disparities. Supporting efforts that enhance faculty mentoring, training and teaching resources will improve family medicine education and attract and develop the next generation of family physicians, clinicians, leaders and educators. (1987) (2015 COD)
Team-Based Care

See also

- Non-Physician Providers (NPPs)
- Nurse Midwives, Certified
- Nurse Practitioners
- Physician Assistants
- Payment, Non-Physician Providers
- Primary Care
- Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants
- Non-Physician Providers, Family Physician Training With

The AAFP encourages health professionals to work together as multidisciplinary, integrated teams in the best interest of patients. Patients are best served when their care is provided by an integrated practice care team led by a physician.

The medical home represents an example of an integrated practice arrangement in which a licensed physician (MD/DO) works with other health care personnel to manage the care of an individual patient and a population of patients using a multidisciplinary, collaborative approach to health care. The arrangement should support an interdependent, team-based approach to comprehensive care delivery. It should address patient needs for high-value, accessible health care and be supported by enhanced communication and processes that empower non-physician staff to effectively utilize the skills, training and abilities of each team member to the full extent of their professional capacity.

The central goal of team-based care is to provide the most effective, efficient, and accessible evidence-based care to the patient. Patient-oriented outcome measures and patient experience should be central in assessing the quality of care delivered by the team. (1996 COD) (March 2017 BOD)
Telehealth and Telemedicine

The AAFP supports expanded use of telehealth and telemedicine as an appropriate and efficient means of improving health, when conducted within the context of appropriate standards of care. The appropriateness of a telemedicine service should be dictated by the standard of care and not by arbitrary policies. Available technology capabilities as well as an existing physician-patient relationship impact whether the standard of care can be achieved for a specific patient encounter type.

Telehealth technologies can enhance patient-physician collaborations, increase access to care, improve health outcomes by enabling timely care interventions, and decrease costs when utilized as a component of, and coordinated with, longitudinal care. Responsible care coordination is necessary to ensure patient safety and continuity of care for the immediate condition being treated, and it is necessary for effective longitudinal care (for clarification, forwarding documentation by electronic means, including fax, is not acceptable for coordination of care with the primary care physician or medical home). As such, the treating physician within a telemedicine care encounter should bear the responsibility for follow-up with both the patient and the primary care physician or medical home regarding the telemedicine encounter.

The AAFP recommends streamlined licensure processes for obtaining several medical licenses that would facilitate the ability of physicians to provide telemedicine services in multiple states. The AAFP encourages states to engage in reciprocity compacts for physician licensing, especially to permit the use of telemedicine. Within a state licensure framework, the AAFP strongly believes that patients with an established relationship, who are traveling, should be allowed to be treated by their primary care physician, so long as the physician is licensed in the state in which the patient receives their usual care.

Payment models should support the patient’s freedom of choice in the form of service preferred (i.e., copays should not force patients to a specific modality). Additionally, payment models should support the physician’s ability to direct the patient toward the appropriate service modality (i.e., provide adequate reimbursement) in accordance with the current standard of care. The AAFP believes current reimbursement policies warrant increased standardization among payers, especially in regard to eligible originating and distant sites, and use of asynchronous store-and-forward technology. The current unneeded variability in policies among payers leads to administrative complexity and burden for physicians and patients.

As telemedicine services are expanded and utilized to achieve the desired aims, it is imperative that outcomes are closely monitored to ensure disparities in care are not widened among vulnerable populations, attributed to increased use of telemedicine.

The AAFP defines telehealth and telemedicine as:

Telemedicine is the practice of medicine using technology to deliver care at a distance, over a telecommunications infrastructure, between a patient at an originating (spoke) site and a physician, or
other practitioner licensed to practice medicine, at a distant (hub) site.

Telehealth refers to a broad collection of electronic and telecommunications technologies and services that support at-a-distance healthcare delivery and services. Telehealth technologies and tactics support virtual medical, health and education services.

Telehealth is different from telemedicine in that it refers to a broader scope of remote healthcare services than telemedicine. While telemedicine refers specifically to remote clinical services, telehealth can refer to remote non-clinical services such as provider training, continuing medical education or public health education, administrative meetings, and electronic information sharing to facilitate and support assessment, diagnosis, consultation, treatment, education, and care management.

(1994) (July 2016 BOD)
Television, Ethics

See also

- Alcohol Advertising and Youth (Position Paper)
- Advertising: Youth Products
- Violence in the Media
- Violence, Media (Position Paper)

The American Academy of Family Physicians supports television programming that encourages healthier lifestyles, promotes positive social behavior, portrays social and political issues, and avoids modeling the use of tobacco, alcohol and other abused drugs. (1989) (2012 COD)
Third Party Payer Credentialing

SEE ALSO:

- Privileges

The American Academy of Family Physicians (AAFP) supports a single, nationally standardized health care professional credentialing application as one way to support administrative simplification.

The AAFP believes that payers:

- who require board certification as a requirement should permit physician participation for residents who have evidence of completing the required training and are actively pursuing meeting the requirements for board certification;
- should make final physician credentialing determinations within 45 calendar days of receipt of a completed application;
- should grant provisional credentialing, pending a final credentialing determination, if the credentialing process exceeds 45 calendar days;
- should provide an electronic means for the physician to track the application;
- should retroactively compensate physicians for services rendered from the receipt date of physicians’ completed credentialing application upon final, successful credentialing determination;
- should provide an electronic copy of the fee schedule to the provider upon being successfully credentialed.

(2007) (2016 September BOD)
Tiered and Narrowed Physician Networks

Since the American Academy of Family Physicians (AAFP) supports quality improvement activities that focus on improving the health of patients, families, and communities, it is the AAFP position that physician networks offered by payers and health systems must provide patients sufficient access to health care, support the physician-patient relationship, and focus on improving patient care.

The long-term value of patients having an ongoing relationship with a personal family physician will outweigh the short-term financial benefits of frequent switching of primary care physicians due to tiered or narrowed networks. Therefore, substantial caution should be exercised when using systems that disrupt the on-going patient relationship with their personal physician and cause difficulty with access to continuous and comprehensive care. Steering patients to high quality and/or efficient-designated physicians who are already operating at their practice capacity, may result in interrupted or impeded care, which could be further exacerbated by physician workforce shortages. Thus, health insurers’ program must have mechanisms in place to ensure patient access to a primary care physician.

Tiering and narrowing methodologies and policies are often proprietary and may vary among payers and health systems. Any data methodology used to tier, rate, or designate family physicians should be transparent and align with AAFP policies on "Physician Performance Measures," "Transparency," "Health Care for All," "Performance Measures Criteria," "Physician Profiling," and "Transparency." Attributes of patient steering may also vary but should maintain the continuity of existing physician patient relationships whenever possible and adhere to the AAFP policies on "Physician Performance Measures," "Transparency," "Health Care for All," "Performance Measures Criteria," "Physician Profiling," and "Transparency." Patient steering and tiered or narrowed network programs should adhere to the following principles:

1. Networks should not be exclusively based on the cost-of-care delivered by the physician.
2. Programs should provide full, adequate access to necessary physicians and non-physician providers.
3. Insurers that do not have a sufficient number of skilled and proficient physicians in their network should provide coverage for the out-of-network services without additional cost to the patient.
4. Quality-of-care assessments should be a prominent feature of steering programs and based on accepted national standards using evidence-based medicine clinical guidelines whenever possible.
5. Programs should provide educational and reference materials to assist patients in making informed health care decisions.
6. Programs should fully disclose to a patient or employer the participation and availability of primary care physicians, sub-specialty physicians, and health care facilities prior to making decisions regarding a payer’s steering program.
7. Quality and cost data used in steering programs must be accurate and specific to the identified physician.
8. All patient data used to evaluate a physician should be age, gender, and severity adjusted, including adjustments for socioeconomic factors.
9. If a physician is removed from a network, they should have sufficient opportunity to challenge the decision of the network.

Tobacco and Smoking

See also

- Electronic Cigarettes
- Substance Abuse and Addiction
- Tobacco: Preventing and Treating Nicotine Dependence and Tobacco Use (Position Paper)
- Marijuana

Tobacco Use, Prevention and Cessation

Tobacco use (cigarettes, cigars, snuff, chewing tobacco, and other tobacco products) is documented as the leading preventable cause of death and illness in our nation. The number of deaths (more than 400,000 annually) caused by tobacco use is greater than the combined number of deaths due to AIDS, alcohol, automobile accidents, murders, suicides, drugs and fires.

Nicotine, a key ingredient in tobacco products, is an addictive drug. Tobacco use by and around children and adolescents is of particular concern due to increased risk for addiction and passive exposure. Smoking is a known cause of cancer, heart disease, stroke and chronic obstructive pulmonary disease. Special dangers exist for specific subpopulations of smokers such as pregnant women who suffer higher rates of spontaneous abortions, stillbirths, premature births and low birth weight babies.

The American Academy of Family Physicians strongly encourages all of its members and staff to personally avoid tobacco use. The AAFP urges its members to:

- save lives by working toward elimination of all tobacco use;
- document use of tobacco products in patient charts;
- work cooperatively with other health professionals to provide cessation counseling and other treatments;
- discourage tobacco use in all public and workplace settings; and,
- list tobacco as a cause on death certificates when appropriate.

The AAFP acknowledges that some religious practices involve the ceremonial use of tobacco.

The AAFP has no direct association with organizations involved in the manufacture of tobacco products and urges its members to avoid such association.

The AAFP supports this policy by prohibiting the use of tobacco products in all AAFP buildings, at all meetings sponsored by the AAFP, and by physicians and staff representing the AAFP. The AAFP encourages constituent chapters to prohibit the use of tobacco products in their offices, and at constituent chapter sponsored meetings. Finally, the AAFP encourages the use of smoke free meeting and conference space whenever possible.

The Framework Convention on Tobacco Control (FCTC): Because of the devastating shift in tobacco-related morbidity, mortality, and health care costs projected to fall upon the world's developing nations, the AAFP joins WONCA and other healthcare organizations in support of the FCTC, the World Health Organization health treaty on tobacco control, and urges its ratification by the US Senate and signature by the President.

Tobacco Advertising: The AAFP opposes all forms of advertisement of tobacco products for human
consumption especially the direct or indirect marketing of tobacco products to children. It commends sources that provide information on the hazards of smoking and tobacco products to the public, including the direct or indirect marketing of tobacco products to children. Whenever possible, the AAFP will place advertising material and develop relationships with publications that do not accept tobacco advertising. If advertising must be placed in publications that carry tobacco advertising, the publication must assure that adjoining page(s) do not promote tobacco or alcohol. The AAFP also urges removal of corporate tax deductions for the advertising of tobacco products.

The AAFP strongly supports labeling of all tobacco products warning potential users of health hazards and believes such labeling should be prominently displayed on packaging and advertisements with clear wording.

**Community Education:** The Academy recommends tobacco prevention and cessation programs, such as TAR WARS that discourage tobacco use, counter tobacco advertising, and teach skills to resist those influences, for all elementary and secondary students. The Academy urges members to become involved in teaching tobacco prevention and cessation programs within their schools and community.

**Treatment of and Payment for Tobacco Use:** The AAFP supports health plan coverage and appropriate payment for evidence-based physician services for treatment of tobacco use. The AAFP recommends that all tobacco users in the United States be aware of the existence of and have barrier-free access to all evidenced-based FDA-approved therapies and counseling as described in the US Public Health Service's 2008 update of the Clinical Practice Guideline: Treating Tobacco Use and Dependence, released May 2008.

**Distribution and Sales:** The AAFP recognizes that the majority of states have laws restricting the sale of cigarettes to minors and commends those states. It urges the federal government or all states to enact laws restricting the sale of tobacco products to individuals under the age of 18 and these laws be strictly enforced. The AAFP further urges legislation raising the legal age for the purchase of tobacco products from 18 to 21 years of age and requiring active enforcement of age-at-sale for tobacco purchases. The AAFP supports requiring that all tobacco products be placed behind sales counters in retail stores. It opposes the sale of cigarettes and tobacco products via the Internet and vending machines and supports legislation to ban such sales. Further, the Academy strongly opposes the promotional distribution of free cigarettes and tobacco products, supports legislation designed to prohibit such distribution, and urges that such laws be strictly enforced.

**Sales of Tobacco Products by Facilities that Provide Health Care Services:** Facilities that provide direct health care services, pharmacies, and related institutions are integral parts of our healthcare system, with the overt and/or implicit goal of improving the health of their patrons. The sale of tobacco products is an inherent conflict of interest for such facilities, given that tobacco use represents the leading cause of death in the United States and contributes greatly to the nation's excess healthcare costs. Several Canadian provinces and the cities of San Francisco and Boston have banned the sales of tobacco products in retail pharmacies. The AAFP supports a ban on the sale of tobacco products in facilities that provide clinical patient care services, pharmacies, and retail outlets housing health clinics. The AAFP urges its constituent chapters to support state and local laws to this end, and the AAFP will advocate for federal legislation on this issue.

**Food and Drug Administration (FDA) Regulation of Tobacco Products:** Given that nicotine is an addictive drug, the FDA must have full jurisdiction over all tobacco products and nicotine delivery devices and be permitted to use the same procedures to regulate tobacco. Further, FDA decisions should be subject to the same standard of review that generally applies under the Food, Drug and Cosmetic Act. The tobacco industry should respond to the same regulatory forces that govern other similar industries and should not be able to choose the amount of regulation they accept. Further, the FDA should have authority to regulate the manufacture, sale, labeling, distribution and marketing of tobacco products and nicotine delivery devices including products such as nicotine water.

**Health Care Facilities:** The AAFP calls on its members to act in their local areas and hospitals to implement and enforce restrictions on tobacco use on hospital premises and other health care facilities making them tobacco-free premises with no designated smoking areas.
**Medical Education:** The AAFP strongly encourages all family physicians to participate in CME activities/programs related to prevention or cessation of tobacco use and provides current educational materials to members at [www.askandact.org](http://www.askandact.org). All medical school and residency training programs should provide in-depth, effective education in prevention and cessation of tobacco use.

**Passive Smoking:** The AAFP strongly supports the prohibition of the use of tobacco products in all public places. Family physicians should advise their patients, especially those with cardiovascular diseases or other chronic disease, to avoid establishments that permit smoking and to request that family members do not smoke in the patient’s home or vehicle. Family physicians should specifically address the problems of exposure of children to tobacco smoke, as well as encourage cessation of adult household members. The AAFP will urge all employers to provide smoke-free work and breaktime environments for their employees and incentives for employees who participate in cessation programs.

**Smoking in Movies:** The AAFP supports efforts to reduce the impact of smoking in movies on youth tobacco initiation, and calls on the film industry to adopt the following voluntary steps:

1. Require movies containing scenes depicting smoking to have an “R” rating. The only exceptions should be when the presentation of tobacco clearly and unambiguously reflect the dangers and consequences of tobacco use or is necessary to represent the smoking of a real historical figure.
2. Require producers to certify on screen that no one on the production received anything of value in consideration for using or displaying tobacco.
3. Require strong anti-smoking ads before any movie with tobacco use, regardless of rating.
4. Stop identifying tobacco brands.

**Taxation and Subsidies:** The AAFP recognizes that most states and the federal government tax cigarettes and believes that increasing taxes on tobacco provides a major disincentive to potential buyers, especially youth. The Academy encourages the development of health education programs funded by a dedicated tax on cigarettes. Further it strongly opposes all federal price support of the tobacco industry. The AAFP supports its state chapters as they seek to ensure that funds from the Master Settlement Agreement and/or excise taxes on tobacco products be used for tobacco prevention, cessation, education, and other elements of comprehensive tobacco control. Suggested spending levels from the Centers for Disease Control and Prevention’s “Best Practices for Comprehensive Tobacco Control Programs” should be followed in funding of these activities across the nation. (2003) (2009 COD)
Tobacco: Preventing and Treating Nicotine Dependence and Tobacco Use (Position Paper)

See also
- Electronic Cigarettes
- Marijuana
- Substance Abuse and Addiction
- Tobacco and Smoking

Introduction

Since the first Surgeon General’s report in 1964 more than 20 million premature deaths can be attributed to cigarette smoking. Due to sustained efforts in the United States, the prevalence of current cigarette smoking among adults has declined from 42% in 1965 to 18% in 2012. However, more than 42 million Americans still smoke.¹ This year approximately half a million people will die due to tobacco related causes. Thus smoking remains the leading preventable cause of premature disease and death in the United States.³ Annually, the total economic costs due to tobacco are now over $289 billion. And if we continue on our current trajectory, 5.6 million children alive today who are younger than 18 years of age will die prematurely as a result of smoking.¹

Since the 1964 Surgeon General’s report, cigarette smoking has been causally linked to diseases of nearly all organs of the body, to diminished health status, and harm to the fetus. Research continues to link smoking to other common diseases, including diabetes mellitus, rheumatoid arthritis, and colorectal cancer. Other critical information we learned in the past 50 years is that exposure to secondhand tobacco smoke causes cancer, respiratory, and cardiovascular diseases, and adverse effects on infants and children. Now the evidence is sufficient to infer that nicotine activates multiple biological pathways through which it increases risk for disease. Finally, this latest report highlights that very large disparities in tobacco use remain across racial/ethnic groups and between groups defined by educational level, socioeconomic status, and region.¹

In spite of serious efforts by physicians, government, the Center for Disease Control (CDC) and community organizations we are still not able to eliminate this serious threat to health of the public.² While we have witnessed a significant decrease in smoking rates in adult population there is a significant increase in tobacco and nicotine product use by young people.¹ There are still myriad tobacco products and nicotine in various forms available to the public including minors. The most recent surge in use of tobacco related products containing nicotine in the form of electronic cigarettes is alarming.³ Despite the progress we made in decreasing smoking rates, we still have innumerable threats to public health due to tobacco and tobacco derived products flooding the markets and some of those products are freely available to minors for use. Under these changing circumstances family physicians have a tremendous opportunity to make a significant impact on the tobacco use behavior of Americans. The American Academy of Family Physicians (AAFP) outlines its position on prevention and treatment of tobacco use and nicotine dependence beginning with a call to action for all family physicians.

Call to Action

The AAFP urges all national, state, federal, and private sector institutions involved in tobacco prevention and cessation activities to increase and coordinate their efforts. Bold new initiatives are necessary to rapidly decrease the harm caused by tobacco and nicotine use. The AAFP has joined with American Academy of Pediatrics, American Cancer Society, Cancer Action Network, American Heart Association, American Lung Association, Americans for Nonsmokers’ Rights, Campaign for Tobacco-Free Kids and Legacy® to call for action by all levels of government to achieve three bold goals.⁴

- Reduce smoking rates to less than 10% within 10 years (“10 in 10”)
- Protect all Americans from second-hand smoke in 5 years
- Ultimately eliminate the death and disease caused by tobacco use

Family physicians should become active in advocating for tobacco and nicotine control measures at the patient, community, state, and national levels. In order to reach these bold goals, the AAFP calls for action in the following areas:

In the Office

- Counsel all patients on the harms of nicotine and tobacco products

• Implement or enhance office-based prevention programs and policies, including those that target high-risk populations
• Engage the health care team in the patient centered medical home to provide tobacco/tobacco product cessation counseling and medical treatments
• Document use of tobacco and nicotine products in patient electronic health records
• List tobacco use as a cause of death when appropriate
• Advocate for insurance coverage with no co-pays or cost sharing, including Medicaid coverage, for evidence-based cessation tools, counseling, as well as both prescription and over the counter tobacco-cessation medications
• Promote medical education sessions focused on effective cessation tools and ways to overcome barriers

In the Community

Advocate for:

• Evidence-based tobacco control policy changes, including increased tobacco excise taxes
• Smoke free indoor air laws covering all public and workplace settings
• Availability of smoke-free housing
• Tobacco-free pharmacies
• Comprehensive tobacco control programs using tax revenue
• Promote or participate in Tar Wars

At the National Level

Advocate for:

• Rigorous research on e-cigarettes to assess their safety, quality, and efficacy as a potential cessation device and the cessation of access and marketing of e-cigarettes, children and youth
• Enhanced access to tobacco cessation services for all patients regardless of health Insurance
• More aggressive FDA Center for Tobacco Products (CTP) regulation of all products containing nicotine including e-cigarettes

Through these and other actions, the AAFP, its constituent chapters, and its individual members will work in partnership to help eliminate the epidemic of tobacco-related death and disease.

The Changing Landscape

Health Concerns of Tobacco Use

The 2014 Health Consequences of Smoking--50 Years of Progress: A Report of the Surgeon General states that due to the impact of tobacco use on specific populations, the changing cigarette, nicotine addiction, specific smoking-related diseases, and dangerous secondhand smoke, a steady movement away from smoking as an acceptable social norm emerged. The prevalence of smoking among adults is now less than one-half of what it was in 1964. Despite this milestone, each year, more people in the United States die from smoking than from acquired immunodeficiency syndrome, alcohol, cocaine, heroin, homicide, suicide, motor vehicle crashes, and fires combined. Tobacco use remains the leading preventable cause of disease, disability, and death in the United States. There are remarkable changes currently underway in tobacco and nicotine dependence with transformation in products, prevention, disparities, and treatment.

A distinct change in the landscape of tobacco and nicotine use is the variety of products that have flooded the market. While cigarette smoking is the predominant form of tobacco use in the United States, other tobacco products include cigars, pipes, and smokeless tobacco products (e.g., chewing tobacco, dipping tobacco, and snuff). Newer tobacco products which in many ways are targeted to appeal directly to children and young people include bidis, smoking tobacco through the use of a hookah (i.e., waterpipe), snus, dissolvables, electronic nicotine delivery systems (e-cigarettes), and little cigars/cigarillos.

There is also increasing awareness regarding the need for strong tobacco prevention initiatives. According to Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General 2012, very few people initiate smoking after age 26: 99% of adult smokers start to smoke by age 26.3 The AAFP’s tobacco prevention program seeks to keep youth from using tobacco and nicotine products. Other initiatives include the FDA’s national public education campaign to prevent youth tobacco use and reduce the number of kids who become regular smokers. “The Real Cost” campaign is the FDA’s first campaign targeted at 10 million young people ages 12-17 who have never smoked a cigarette and youth who are already experimenting with cigarettes including e-cigarettes and are at risk of becoming regular smokers. The AAFP’s Tar Wars tobacco education and prevention program, FDA’s youth campaign, Campaign for Tobacco-Free Kids, Legacy® and many other local and national initiatives continue to work towards reinforcing prevention.

Perhaps the most intriguing way that treatment has evolved is the focus on nicotine dependence and behavioral health, as well as health disparities. The integration of behavioral health into primary care has been instrumental in effective treatment. People with mental illnesses smoke at rates that are twice as high as the general population. Nearly half the cigarettes smoked in the
United States are used by people with co-occurring psychiatric disorders; the smoking prevalence rates are even higher (60-80%) for those who are diagnosed with depression, bipolar disorder, or schizophrenia. In spite of the overall decline in tobacco-use, higher rates persist in certain population groups. These groups are defined by educational level and socioeconomic status, geographic region, sexual identity (including individuals who are gay, lesbian, bisexual, and transgender), and presence of severe mental illness.

The Family Physician’s Role

Nicotine and tobacco dependence is a chronic disease that often requires repeated intervention by health care professionals and takes multiple attempts to quit. Family physicians have a tremendous opportunity to make a significant impact on the tobacco use behavior of Americans because approximately 70% of the people who use tobacco products see a physician each year.

Recent evidence reinforces the impact primary care physicians can have by addressing tobacco use with their patients. The Morbidity and Mortality Weekly Report: Quitting Smoking Among Adults 2001-2010, indicates that 68.8% of current cigarette smokers said they would like to stop smoking, and 52.4% had tried to quit smoking in the past year. However, 68.3% of the smokers who tried to quit did so without using evidence-based cessation counseling or medications, and only 48.3% of those who had visited a health-care provider in the past year reported being advised to quit smoking. If physicians would advise 90% of smokers to quit and offer them medication or other assistance, 42,000 lives could be saved each year.

Of the 42.1 million people in the United States who smoke cigarettes, only 5% are able to quit without assistance from healthcare providers. Less than one half of smokers make a quit attempt each year. Most smokers who try to quit do so on their own, without participating in evidence-based programs; more than 95% relapse. The use of evidence-based programs can more than double success rates. The 2008 Update of the U.S. Public Health Service (USPHS) Clinical Practice Guideline, Treating Tobacco Use and Dependence, calls on physicians to change clinical culture and practice patterns to ensure that every patient who uses tobacco is identified, advised to quit, and offered scientifically proven treatments. This update also calls for systems-level interventions to ensure that tobacco and nicotine use is systematically assessed and treated at every clinical encounter. The current rates of comprehensive intervention by physicians are well below what is desirable and effective.

Tobacco dependence is a chronic disease characterized by remission and relapse, and family physicians should approach treatment for tobacco use with this in mind. To ensure comprehensive intervention, medical practices need to establish a team-based system to implement the following:

- Use tobacco-use status as a vital sign
- Utilize electronic health records (EHR) that include automatic prompts that remind clinicians to screen for tobacco use and nicotine dependence
- Provide a clearly-defined role for clinicians to assess interest in quitting, encourage quitting for those not currently interested, and encourage use of cessation medications and follow-up
- Include a systematic way to provide patients with more information and support for quitting, using appropriate members of the medical team besides physicians, such as having an office nurse or educator provide this information, and provide a referral to a quitline or other counseling resource
- Initiate automatic follow-up phone calls by a nurse or health educator for those who have set a quit date
- Create a flow sheet in the patient’s record so the clinician can see a summary of past smoking discussions and quit attempts

The AAFP encourages its members to use behavioral intervention techniques to address tobacco and nicotine dependence, such as motivational interviewing, the use of brief interventions, and group visits. Further issues surrounding tobacco use and dependence involve the existence of barriers to successful intervention and treatment. These barriers exist at both the physician-patient level as well as system-wide issues. There are many barriers to successful implementation of interventions to help prevent tobacco use and nicotine dependence as well as help patients quit tobacco use and nicotine dependence. These barriers can be separated into two categories one at the physician-patient level and the second at the system level.

Physician/Patient barriers:

- Lack of patient motivation to quit
- Prolific use of non-evidence-based treatments by patients for cessation with high failure rates (95% of unaided smokers fail to successfully quit)
- Non-adherence to medications and counseling
- Reduced time with patients
- Inconsistency in asking patients to make healthy lifestyle behaviors changes

Systemic barriers may include inadequate:

- Tracking of patients to determine who needs preventive and counseling services

Contact with those patients to remind them to get the services
Physician reminders physicians to deliver preventive services when they see their patients
Follow-up to ensure appropriate referrals and follow-up occur
Communication checks to make certain patients understand what they need to do
Reimbursement/payment for cessation counseling and treatments

Tobacco Cessation Tools For the Family Physician

Ask and Act

In the early 1990s the National Cancer Institute developed the publication: How to Help Your Patients Stop Smoking: A National Cancer Institute Manual for Physicians. The guide recommended that physicians Ask, Advise, Assist and Arrange follow-up to help smokers quit. These four A’s were expanded to five in the 1996 Agency for Health Care Policy and Research guidelines. The USPHS guideline also encourages five A’s (i.e., Ask, Advise, Assess, Assist, and Arrange) as a “brief intervention” for patients who smoke. Many physicians have found the five A’s cumbersome, hard to remember, and not practical for every patient at every visit. Several medical specialty organizations have integrated components of the five A’s into an abbreviated intervention: “Ask, Advise, Refer.” In this model, health professionals ask patients about tobacco use, advise them to quit, and refer them to quitlines or web-based or local cessation programs.

The AAFP encourages its members and their practice teams to Ask all patients about tobacco use, and then to Act to help them quit. The AAFP Ask and Act Tobacco Cessation program (www.askandact.org) is an evidenced-based strategy based upon the USPHS guideline. This easy-to-remember approach provides the opportunity for every member of a practice team to intervene at every visit. Interventions can be tailored to a specific patient based on his or her willingness to quit, as well as to the structure of the practice and each team member’s knowledge and skill level. Interventions can include any combination of these:

- Five A’s (i.e., Ask, Assess, Advise, Assist, and Arrange)
- Ask, Advise, and Refer
- Providing self-help materials
- Brief, intermediate, or intensive counseling (motivational interviewing) with or without follow-up visits
- Pharmacotherapy and nicotine replacement therapies (NRT)
- Group visits

Office Champions

AAFP’s Office Champions model has proven successful in integrating system changes into the clinic workflow to support tobacco cessation efforts. Office Champions is a quality improvement project systems-change model. Visit http://www.aafp.org/askandact/officechampions for additional information.

Patient-Centered Medical Homes

The transformation of primary care offices into patient-centered medical homes (PCMH) offers a significant opportunity to improve the rate of interventions for nicotine and tobacco dependence. This new model of care is based on an expanded relationship between the patient, the physician, and the practice health care team, where each takes collective responsibility for the patient’s ongoing healthcare needs.

Electronic Health Records

Electronic health records (EHRs) allow for integration of the USPHS guideline recommendations into the practice workflow, facilitating system-level changes to reduce tobacco use. The AAFP and the American Academy of Pediatrics developed a joint statement advocating that:

- EHRs include a template that prompts clinicians or their practice teams to collect information about tobacco and nicotine use, secondhand smoke exposure, current cessation interest, and past quit attempts.
- EHRs include automatic prompts that remind clinicians to screen for use, encourage quitting, connect patients and families to appropriate cessation resources and advise them about the benefits of smoke-free environments.
- The AAFP encourages all its members who use EHRs to set tobacco and nicotine use documentation and intervention as Meaningful Use targets and to link them to incentive plans such as Pay for Performance measures. One focus area may be, for example, improvement in screening and cessation intervention rates for all clinicians in the practice.

Electronic Resources for Patients

The wide availability of smartphones and advances in mobile health and other digital technologies have resulted in a dramatic increase in mobile applications (“apps”) for health behavior change, including those for smoking cessation. However, a recent review of 47 iPhone apps for smoking cessation revealed that most “apps” did not adhere to best practices or USPSTF evidence-based recommendations.
based guidelines.21 The AAFP encourages its members to take note of some of the more popular smoking cessation “apps” and discuss the pros and cons of their use with their patients. For example, the U.S. Department of Health and Human Services (HHS) has a “Quitstart App” which is a free smartphone app that can help track cravings and moods, monitor progress toward achieving smoke-free milestones, identify smoking triggers, and upload personalized “pick me ups” and text message reminders to use during challenging times to assist smokers in quitting. It was created to target teens, but can be used by adults as well. For more information, visit http://smokefree.gov/apps-quitstart.

Tobacco Use in Special Populations

High-risk Populations

The AAFP encourages its members to take note of some of the more popular smoking cessation “apps” and discuss the pros and cons of their use with their patients. For example, the U.S. Department of Health and Human Services (HHS) has a “Quitstart App” which is a free smartphone app that can help track cravings and moods, monitor progress toward achieving smoke-free milestones, identify smoking triggers, and upload personalized “pick me ups” and text message reminders to use during challenging times to assist smokers in quitting. It was created to target teens, but can be used by adults as well. For more information, visit http://smokefree.gov/apps-quitstart.

Tobacco Use in Special Populations

High-risk Populations

The AAFP encourages its members to be extra vigilant in screening members of high-risk populations for nicotine and tobacco use. Higher rates of tobacco and nicotine use in these populations puts them at increased risk for the harmful health effects. This poses an immediate and increased health threat to tobacco users in the following populations:

- Children and adolescents (issues with early initiation of smoking and/or hookah use and exposure to second-hand smoke)3,22-23
- Those with low socioeconomic status and/or limited formal education24
- Populations living in rural areas (cigarette and smokeless tobacco use is higher in rural compared to urban areas)25
- Individuals with mental illness including substance abuse disorders26-27
- Racial and ethnic minority populations28
- Individuals with comorbid conditions (cancer, cardiac disease, chronic obstructive pulmonary disease, diabetes, and asthma)29
- Lesbian, gay, bisexual and transgender individuals30
- Pregnant patients31
- Human immunodeficiency virus (HIV) positive patients32
- Athletes (increased smokeless tobacco use)23,33
- Individuals from the Middle East and North Africa (traditional hookah use)34

Tobacco Use in Adolescents

According to 2014 Report of the Surgeon General, each day more than 3,200 youth under age 18 in the United States try their first cigarette; another 2,100 who are occasional smokers become daily smokers and more than 700 kids under age 18 become daily smokers.1 If current rates continue, 5.6 million children alive today will ultimately die prematurely from smoking-caused disease.1 In addition to the well-known, long-term health effects, children who smoke may immediately experience increased heart beat and blood pressure, respiratory problems, reduced immune function, increased illness, tooth decay, gum disease, and precancerous gene mutations.35

In 2011, cigarette companies spent $8.37 billion on advertising and promotional expenses in the United States, an increase from $8.05 billion in 2010.36 In addition, the five major U.S. smokeless tobacco manufacturers spent $451.7 million on smokeless tobacco advertising and promotion in 2011, up from $442.2 million spent in 2010.37 There is clear evidence to conclude that there is a causal relationship between Tobacco Company advertising and the influence, initiation, and progression of tobacco use among youth.3 This pattern of predatory marketing brings results as high school students and young adults now smoke cigars at far higher rates than all adults.38-41

Tar Wars

The AAFP encourages its members to talk to children and adolescents about the risks of using tobacco and nicotine products, and to participate in community awareness and prevention activities, such as Tar Wars (http://www.aafp.org/about/initiatives/tar-wars.html). Developed by a family physician and a health educator in 1988, Tar Wars is an educational program that teaches children about effects of tobacco use, the cost associated with using tobacco products, and the advertising techniques used by the tobacco industry to market their products to children. Tar Wars provides an opportunity for family physicians, family medicine residents, and medical students to introduce family medicine to their community. These health professionals serve as role models in their communities as volunteer presenters in elementary schools. Tar Wars is the only tobacco prevention program for children offered by a medical specialty organization in the United States, and has reached more than 10 million children. It has been active in all 50 states, several territories, and 16 other countries.42

E-Cigarettes—An Emerging Health Hazard

Electronic Cigarettes—the relatively new nicotine delivery devices also known as e-cigarettes—have become increasingly popular in the past few years. According to the CDC, use and experimentation among US middle and high school students in 2011-2012
has doubled from 3.3% to 6.8% of children in grades 6-12, leading to approximately 1.78 million students having reported ever-using an electronic cigarette as of 2012.43 Several studies have recently described “rapid expansion” in their use among adolescents, high school and college students, as well as among adults.44-48 Sales of electronic cigarettes, also known as e-cigarettes, Personal Electronic Vaporizing Units, and Electronic Nicotine Delivery Systems (ENDS), more than doubled in the last few years and are projected to be 10 billion dollar industry by 2015.49

Manufacturers and marketers tout e-cigarettes as cheaper and safer alternatives to traditional cigarettes.50 These claims are being made despite a general lack of evidence for their potential benefits, and a number of studies that show several harmful effects such as increases in blood nicotine level51, multiple physical symptoms52, and negative effects on indoor air.53-54 The most significant danger, however, is the increased focus—by manufacturers, marketers and retailers—on their use as a smoking cessation tool. Critics note these major issues with studies on e-cigarettes as smoking cessation devices: They are inherently biased, methodologically flawed, or they do not provide adequate evidence to draw a conclusion about e-cigarettes’ efficacy as a smoking cessation method.56-58

The AAFP recognizes the alarmingly increased use of e-cigarettes, especially among youth and those attempting to quit smoking tobacco.6 E-cigarettes are unregulated, battery-operated devices that contain nicotine-filled cartridges. The resulting vapor is inhaled as a mist that contains flavorings and various levels of nicotine and other toxic substances. Although e-cigarettes may be less toxic than smoking combustible tobacco cigarettes, currently there is no evidence supporting the efficacy of e-cigarettes as a smoking cessation device. Nevertheless, some physicians and public health groups consider the use of these devices as a viable harm-reduction strategy. Many are concerned that e-cigarettes may contribute to nicotine dependence, promote dual use of both products (cigarettes and e-cigarettes), and encourage nicotine consumption. E-cigarettes may also introduce children to nicotine leading to potential addiction. Reports are increasing of nicotine-related toxicity and poisoning, especially among children, associated with the nicotine refill cartridges (“nicotine juice”). The CDC has reported a dramatic increase in calls to poison centers, from one per month in September 2010 to 215 per month in February 2014.60-61 A recent concern is the ability to replace the nicotine liquid with hashish oil in order to smoke marijuana. Reports have surfaced of people about using e-cigarettes to smoke marijuana, particularly in public places, and there are numerous websites providing instruction on how to convert e-cigarette cartridges to smoke marijuana.62 Additionally, there have been instances of e-cigarettes and their batteries exploding resulting in damage to persons and property.63

Due to the current lack of good evidence and regulation of manufacturing, marketing and sales, the AAFP has established a formal policy on e-cigarettes which calls for rigorous research in the form of randomized controlled trials of e-cigarettes to assess their safety, quality, and efficacy as a potential cessation device. The AAFP also recommends that the marketing and advertising of e-cigarettes to children and youth should cease immediately until e-cigarette’s safety, toxicity, and efficacy are established.6 The AAFP encourages all members to screen for e-cigarette use in all age groups, to discuss the potential harms of e-cigarette use, and to recommend evidence-based smoking cessation interventions with e-cigarette users.

Opportunities for Advocacy

Research and Development

The available budgets in the public and private sectors for development of new technologies and approaches to screening and treatment are not commensurate with the size of the tobacco and nicotine use epidemic. The AAFP encourages increased funding for the pursuit of innovative approaches to identifying those at risk for tobacco and nicotine use and helping people quit, including providing medications, counseling, policy change, and improvements in primary care clinic systems.

Medical Education

Not all health care professionals are aware of the evidence-based guidelines for treating tobacco dependence.64 The World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) and the USPHS guideline recommend that all health care professionals, including students in health care training programs, receive education in the management of tobacco use and dependence.10, 65 Despite these recommendations, students in the health professions receive inadequate training for treating tobacco use and dependence. In an international survey assessing the tobacco-related content in medical school curricula, only 34% of schools reported that they provide training on smoking cessation techniques.66

The AAFP strongly advocates in-depth, effective education in prevention and cessation of tobacco use in medical schools and residency programs, and encourages family physicians to participate in CME activities and programs related to prevention or cessation of tobacco use. The AAFP also strongly encourages organizations involved in the creation of CME to integrate tobacco and nicotine use screening, prevention and treatment into their curricula. Organizations involved in the ongoing credentialing of primary care physicians, such as the American Board of Family Medicine, should include questions about tobacco dependence treatment in examinations and test preparation materials. The AAFP provides educational materials for members at www.askandact.org.

Taxation and Subsidies
The AAFP recognizes that most states and the federal government tax cigarettes and numerous reports have demonstrated that increasing taxes on tobacco products provides a major disincentive to potential buyers, especially youth. The AAFP encourages the development of health education and other tobacco control programs funded by the taxes collected on cigarettes.

Furthermore, the AAFP supports its constituent chapters as they seek to ensure that funds from the Master Settlement Agreement (MSA) or excise taxes on tobacco products be used for tobacco prevention, cessation, education, and other elements of comprehensive tobacco control. Suggested spending levels from the CDC's Best Practices for Comprehensive Tobacco Control Programs should be followed in funding of these activities across the nation. Despite the fact that states receive massive amounts of revenue annually from tobacco taxes and state tobacco lawsuit settlements with cigarette companies, the vast majority of states fail to invest the amounts recommended by the CDC to reduce tobacco use and minimize its health harms and costs. Between 2007 and 2014 the percentage of state funds spent on such tobacco prevention programs fell from a 2008 high of $717.2 million, 44.8% of the CDC's recommended minimum, to a low in 2014 of $481.2 million, 13.0% of the CDC's recommended minimum. This compares to $8.37 billion spent in advertising and promoting tobacco in 2011. The 2014 Surgeon General's report estimates the annual economic costs of nicotine addiction at $300 billion annually, with direct medical costs of at least $130 billion, more than $150 billion of lost productivity due to premature death, and $5.6 billion in lost productivity due to secondhand smoke exposure. Despite progress in educating the public on the harms of tobacco use, it remains a deadly and costly health threat due, in part, to low utilization of cost-effective, evidence-based treatments, which could be subsidized by allocation of more MSA funds to tobacco control and prevention.

Secondhand Smoke

Secondhand smoke is a mixture of gases and fine particles that includes smoke from a burning tobacco product as well as smoke that has been exhaled by the person. More than 7,000 chemicals, including hundreds that are toxic and about 70 that can cause cancer are present in second hand smoke. Most exposure to secondhand smoke occurs in homes and workplaces and continues to occur in public places such as restaurants, bars, and casinos, as well as multiunit housing and vehicles. Since 1964, 2.5 million nonsmokers have died from exposure to secondhand smoke. Eliminating smoking in indoor spaces is the only way to fully protect nonsmokers as simply separating smokers from nonsmokers within the same air space, cleaning the air, opening windows, or ventilating buildings does not completely eliminate secondhand smoke exposure. The AAFP strongly supports prohibiting the use of tobacco and nicotine products in all public places. Family physicians should advise their patients, especially those with cardiovascular diseases or other chronic conditions, to avoid establishments that permit smoking and to request that family members not smoke in their home or vehicle. Family physicians should specifically address the problems of exposing children to tobacco smoke, and encourage cessation for all adult household members. The AAFP urges all employers to provide smoke-free work environments and incentives for employees who participate in cessation programs. Family physicians and AAFP constituent chapters are encouraged to work with local governments and agencies to advocate for clean indoor air ordinances and regulations.

Payment/ Covered Benefits

Repeated clinical tobacco-cessation counseling is one of the three most important and cost-effective preventive services that can be provided in a medical practice. The AAFP strongly advocates for health plan coverage and appropriate payment for evidence-based physician services for screening and treatment of tobacco use. Consistent with the United States Preventative Services recommendations, the AAFP recommends that all tobacco users in the United States be aware of the existence of and have access to all evidenced-based FDA approved therapies and counseling as described in the USPHS guideline. The Centers for Medicare and Medicaid Services (CMS) pays for physician services related to smoking cessation counseling provided to Medicare beneficiaries since 2005. In 2014, the Affordable Care Act (ACA) requires insurance plans to cover many clinical preventive services including tobacco-use screening and counseling. A coding reference is available online at www.askandact.org.

FDA Regulation of Tobacco and Nicotine Products

The AAFP believes the FDA should have authority to regulate the manufacturing, sale, labeling, distribution and marketing of all tobacco products including cigars of all sizes and flavors. It should also regulate nicotine delivery devices, including e-cigarettes. The FDA is currently considering expanding its jurisdiction to include e-cigarettes. The AAFP supports this proposed rule change as outlined in a letter to the FDA.

Framework Convention on Tobacco Control Health Treaty

Across the world, tobacco use claims more than 5 million lives each year, with projections that by 2030, the toll will rise to about 8 million annual deaths. Because of shifts in consumption trends away from developed nations like the United States, most of this pandemic will occur in developing nations in Asia, South America, and Africa, where health care systems may be too challenged to adequately address prevention, cessation, and chronic disease management issues. The FCTC is the world's first global public health treaty that requires nations to adopt a comprehensive range of measures designed to reduce the devastating health and economic impact of tobacco use. Work on the treaty began in 1999 at the World Health Organization.
The FCTC calls for the following reduction provisions:

- Price and tax measures to reduce the demand for tobacco products
- Non-price measures to reduce the demand for tobacco products address:
  - Protection from exposure to tobacco smoke
  - Regulation of the contents of tobacco products
  - Regulation of tobacco product disclosures
  - Packaging and labeling of tobacco products
  - Education, communication, training, and public awareness
  - Tobacco advertising, promotion, and sponsorship
  - Demand reduction measures concerning tobacco dependence and cessation

The core supply reduction provisions address:

- Illicit trade in tobacco products
- Sales to and by minors
- Provision of support for economically viable alternative activities to tobacco farming and production

The United States signed the treaty in 2004, but it has yet to be sent to the Senate for ratification. The AAFP supports the FCTC, and urges Senate ratification and presidential signature of the treaty.

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73. Communication from AAFP to the FDA regarding a change in policy on regulation of e-cigarettes. Sent June 2, 2014.


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(2009 COD) (2014 COD)
The American Academy of Family Physicians (AAFP) believes that transparency in health care refers to reporting information which can be easily verified for accuracy. Both data and process should have transparency and an explicit disclosure of data limitations. Transparency in health care includes, but is not limited to, easy availability of:

- paysers' payment policies
- paysers' claims adjudication software logic edits
- paysers' fee schedules
- paysers' clinical policies
- paysers' data analysis methodology and performance measures used in rating
- physician performance
- reporting of physician health care cost and quality information

Treatment of Survivors of Sexual Assault

See also

- Prevention and Control of Sexually Transmitted Diseases and Blood Borne Infections
- Child Abuse
- Adolescents, Protecting: Ensuring Access to Care and Reporting Sexual Activity and Abuse (Position Paper)
- Violence as a Public Health Concern
- Violence, Media (Position Paper)

The AAFP recognizes that while health care providers may determine which services they provide to survivors of sexual assault, immediate referral should be available for any aspect of services related to the care and follow up of survivors not provided by the treating physician or institution. These services should include treatment of physical injuries; access to emergency contraception in the absence of confirmed pregnancy; appropriate collection and preservation of forensic evidence consistent with chain of custody requirements; identification and management of psychological sequelae of sexual assault including, posttraumatic stress disorder and potential revictimization; and prophylactic treatment of sexually transmitted diseases, including HIV/AIDS, chlamydia, gonorrhea, trichomoniasis, and Hepatitis B. (2002) (2014 COD)
Ultimate Fighting and Disabling Competitions

See Also

- Boxing, Sport of
- Physical Activity in Children
- Sports Medicine, Counseling About Risk of Contact/Collision Sports
- Sports Medicine, Health and Fitness

The AAFP recommends to its members that physicians discourage their patients from participating in competitions between two or more persons designed with the intent to cause concussion or disabling injury in order to be proclaimed the winner. (2008) (2013 COD)
Unsupported Screening and Diagnostic Testing

The AAFP supports evidence-based age, gender, and risk appropriate screening. The AAFP recommends against mass screening or direct-to-consumer screening of non-evidence-based testing. (2009) (2014 COD)

Unnecessary Direct-to-Consumer Screening Exams: Example Letter for a Specific Screening Test (2 page PDF) (PDF 2 pages)
Urban/ Inner-City Training Program in Family Medicine

See also

- Medically Underserved
- Graduate Medical Education in Rural Practice (Position Paper)
- Medical Schools, Service to Minority, Vulnerable and Underserved Populations

An "Urban/Inner-City Training Program in Family Medicine" may be defined by any one of the following three criteria:

1. A program with at least 80% of training based at an inner-city location, or
2. A program that includes all of the following components in addition to the longitudinal experience of clinical practice in the urban/inner-city environment:
   1. A mission statement that includes a commitment to care of the urban underserved.
   2. A Family Medicine Center located in and serving an urban/inner-city patient population;
   3. Training to provide culturally effective community-responsive primary care;
   4. At least one month of significant educational experience (may be longitudinal) of clinical experience in an urban community health center, homeless shelter or similar facility;
   5. At least one month of significant educational experience (may be longitudinal) experience in an urban public health department setting;
   6. At least 200 hours of clinical hands-on experience in the Emergency Department of an urban/inner-city Level II or higher trauma center;
   7. At least one month of significant educational experience (may be longitudinal) of clinical hands-on experience in an HIV/AIDS clinic or similar setting;
   8. A required structured educational experience in occupational health;
   9. A required structured educational experience in adolescent medicine;
   10. A required structured educational experience in the care of patients with acute and chronic mental illness;
   11. A required clinical hands-on experience in a substance abuse treatment facility or program;

The current federal definition for an urban/inner-city metropolitan area is one with a population of 500,000 persons or more. There may be many family medicine residency programs that can meet the elements of A. above in a metropolitan area of less than 500,000 persons.

Value-Based Insurance Design

See Also

- Value-Based Payment
- Pay-for-Performance
- Physician Profiling, Guiding Principles
- Tiered and Narrowed Physician Networks

Value-based insurance design (VBID) is a strategy that minimizes or eliminates out-of-pocket costs for high-value services in defined patient populations. The primary objective of VBID is to reduce and eventually eliminate financial barriers to high-value health care services. High value health care services are identified through evidence-based analysis. The more clinically beneficial and cost-effective the therapy is for a patient group, the lower the out-of-pocket costs.

The AAFP supports flexibility in the design and implementation of value-based insurance design programs, consistent with the following principles:

1. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.

2. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.

3. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included.

4. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.

5. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.

6. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices.

7. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.

8. VBID should encourage innovations in Medicare Advantage and Medicaid managed care plans. Within both program, there exists an extremely vulnerable population to health care costs being shifted onto them. VBID should encourage beneficiaries, with chronic conditions, to seek out and receive the care they need before ending up in the emergency room or hospital.

9. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence. VBID should avoid rigid, uniform requirements for co-pays, co-insurance, and deductibles. Patient cost-sharing requirements should include clinical nuance to ensure high-value services are used over low-value services. VBID should explore expanding evidence-based, secondary prevention health care services for patients with chronic conditions and diseases.
Secondary prevention health care services should align with various quality improvement programs and health plan accreditation.

10. VBID programs must be consistent with AAFP policies on “Value-Based Payment,” “Pay-for-Performance,” “Physician Profiling, Guiding Principles,” and “Tiered and Select Physician Networks.”

(2015 COD) (2016 COD)
Value-Based Payment

Value-Based Payment (VBP) is a concept by which purchasers of health care (government, employers, and consumers) and payers (public and private) hold the health care delivery system at large (physicians and other providers, hospitals, etc.) accountable for both quality and cost of care.

The American Academy of Family Physicians (AAFP) recognizes the urgency to improve both efficiency and effectiveness in the delivery of medical care, in which "efficiency" is understood to mean "doing the thing right" and "effectiveness" means "doing the right thing." VBP is one approach to achieving a balance between efficiency and effectiveness. However, given the technical, legal and ethical challenges in designing and implementing VBP, it is imperative that the key physician measurement processes used in VBP should be transparent and adhere to the AAFP policies on "Physician Profiling," "Data Stewardship," and "Transparency."

Value-Based Contracting

VBP's aim is to promote enhanced population health management that should result in the improvement of health and/or systemic cost containment or reduction. VBP uses alternative payment models (APMs) or pay-for-performance (PFP) arrangements to create a combination of incentives and disincentives intended to encourage better health care decision making by tying compensation to certain performance measures. The AAFP believes increased investments in primary care, as a part of the total cost of care, is a necessity for enhanced population health management. Increased investments in primary care, using APMs and PFP, can be structured in many ways using a blended payment model and the guidelines listed in the AAFP policy on "Care Management Fees." The most notable difference with value-based contracts is exposure of physicians to performance risk, or utilization of unnecessary services.

It is important to distinguish between insurance risk and performance risk. Insurance risk spreads the financial burden of disease, accident, or injury over a large number of people. Insurance companies or health plans are regulated by state law and have required financial reserves to take on the insurance risk. Physicians should not take on insurance risk but should be responsible for managing the rates of utilization of services along with the quality and availability of those services. Contracts that require physicians to assume performance risk should be tailored to specific market dynamics, socio-demographic factors, physician readiness, and available resources.

Performance Measures

In the current health care environment, family physicians face an unprecedented number of performance measures required by different payers. Because VBP incentives are tied to performance on specific quality measures outlined by each payer, the AAFP believes that measure harmonization across payers is imperative for success in value-based models. In addition, family physicians need to understand what is being measured and how those measurements are used in determining performance and payment. Appropriate criteria for performance measures can be found in the AAFP policy on "Performance Measures Criteria."

Care Delivery, Management and Coordination

In order to achieve the expected outcomes and performance required by VBP, primary care must review key components to providing quality care such as delivery, care management, and care coordination across the medical neighborhood. Quality improvement lays the foundation for practices to meet expected outcomes and performance required by VBP. With a focus on health outcomes, practices will need an infrastructure that supports population health management and risk-stratified care management, which begins with attributing patients to their primary care physician. By identifying panels, physicians and their care teams are able to risk-stratify patients based on the individual care and support needs of each individual patient, thereby allowing for a current state assessment of the health of the population and a gap...
analysis of resource needs. For those patients with complex or multiple conditions, the primary care physician and care team will need to collaborate with any specialists, care provider, or community organization providing care to the patient to ensure ongoing timely and effective communication and coordination of care. Utilizing processes and coding such as Transitional Care Management (TCM) and Chronic Care Management (CCM) will assist in the implementation of new processes and may provide additional funding to support those changes.

Value-Based Payment Principles
The AAFP recognizes the importance and potential of VBP and supports these principles in its design and deployment:

1. Be flexible in the following ways:
   - Responsive to community needs, preferences, and resources
   - Adaptable to different practice organizational models, structures of care, and physician specialties
   - Responsive to individual patient preferences and socio-cultural backgrounds
   - Respectful of differences in adoption of health information technology (HIT) while encouraging its effective spread

2. Focus on tangible improvements in clinical outcomes.
3. Reduce the per capita cost of health care.
4. Utilize performance measures that are evidence-based, preferably endorsed through the National Quality Forum, clinically relevant, and aligned across payers.
5. Involve multidimensional and comprehensive measurement of both quality and cost.
6. Encourage the establishment of robust patient-centered medical homes, including the systems and HIT that are structurally necessary.
7. Align payment models and performance measures among payers, providers, purchasers, and patients.
8. Use reliable, accurate, scientifically valid, transparent, and timely data.
9. Determine physicians' capacity to carry performance risk and tolerance for such risk.
10. Recognize, disclose, and balance the administrative burden and costs to physicians and other providers of participation and measurement in VBP with the incentives of the program.
11. Recognize the path of quality improvement and cost containment or reduction in the medical practice and system, and not solely the outcome.
12. Be accountable to patients, providers, payers and purchasers.
13. Advance knowledge of effective and efficient episodes of care.
14. Recognize explicitly the tradeoffs in value decisions.
15. Be sensitive to the issue of health disparities.
16. Involve practicing physicians in program design.
17. Offer voluntary physician participation.

(2009 COD) (2016 COD)
Value-Based Purchasing

SEE ALSO

- Value-Based Insurance Design

Value Based Payment (VBP) is a concept by which purchasers of health care (government, employers, and consumers) and payers (public and private) hold the health care delivery system at large (physicians and other providers, hospitals, etc.) accountable for both quality and cost of care.

The American Academy of Family Physicians (AAFP) recognizes the urgency to improve both efficiency and effectiveness in the delivery of medical care, in which "efficiency" is understood to mean "doing the thing right" and "effectiveness" means "doing the right thing." VBP is one approach to achieving a balance between efficiency and effectiveness. However, given the technical, legal and ethical challenges in designing and implementing VBP, it is imperative that the key physician measurement processes used in VBP should be transparent and adhere to the AAFP policies on "Physician Profiling," "Data Stewardship," and "Transparency."

Value-Based Contracting

VBP's aim is to promote enhanced population health management that should result in the improvement of health and/or systemic cost containment or reduction. VBP uses alternative payment models (APMs) or pay-for-performance (PFP) arrangements to create a combination of incentives and disincentives intended to encourage better health care decision making by tying compensation to certain performance measures. The AAFP believes increased investments in primary care, as a part of the total cost of care, is a necessity for enhanced population health management. Increased investments in primary care, using APMs and PFP, can be structured in many ways using a blended payment model and the guidelines listed in the AAFP policy on "Care Management Fees." The most notable difference with value-based contracts is exposure of physicians to performance risk, or utilization of unnecessary services.

It is important to distinguish between insurance risk and performance risk. Insurance risk spreads the financial burden of disease, accident, or injury over a large number of people. Insurance companies or health plans are regulated by state law and have required financial reserves to take on the insurance risk. Physicians should not take on insurance risk but should be responsible for managing the rates of utilization of services along with the quality and availability of those services. Contracts that require physicians to assume performance risk should be tailored to specific market dynamics, socio-demographic factors, physician readiness, and available resources.

Performance Measures

In the current health care environment, family physicians face an unprecedented number of performance measures required by different payers. Because VBP incentives are tied to performance on specific quality measures outlined by each payer, the AAFP believes that measure harmonization across payers is imperative for success in value-based models. In addition, family physicians need to understand what is being measured and how those measurements are used in determining performance and payment. Appropriate criteria for performance measures can be found in the AAFP policy on "Performance Measures Criteria."

Care Delivery, Management and Coordination

In order to achieve the expected outcomes and performance required by VBP, primary care must review key components to providing quality care such as delivery, care management, and care coordination across the medical neighborhood. Quality improvement lays the foundation for practices to meet expected outcomes and performance required by VBP. With a focus on health outcomes, practices will need an infrastructure that supports population health management and risk-stratified care management, which begins with attributing patients to their primary care physician. By identifying panels, physicians and their care teams are able to risk-stratify patients based on the individual care and support needs of each individual patient, thereby allowing for a current state assessment of the health of the population and a gap
analysis of resource needs. For those patients with complex or multiple conditions, the primary care physician and care team will need to collaborate with any specialists, care provider, or community organization providing care to the patient to ensure ongoing timely and effective communication and coordination of care. Utilizing processes and coding such as Transitional Care Management (TCM) and Chronic Care Management (CCM) will assist in the implementation of new processes and may provide additional funding to support those changes.

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(2009 COD) (2016 COD)
Violence, Harassment and School Bullying

See also

- Firearms and Safety Issues
- Hate Crimes
- Violence (Position Paper)
- Violence in the Media and Entertainment (Position Paper)
- Intimate Partner Violence
- Child Abuse
- Violence, Illegal Acts Against Physicians and Other Health Professionals
- Violence as a Public Health Concern

Violence, harassment, and bullying that takes place in any venue, including electronic media, for any reason including, but not limited to ethnicity, socioeconomic status, religion, sexual orientation, gender identity, gender expression, physical status, disability, or other personal characteristics, has significant and harmful physical and psychological effects and should not be tolerated.

Violence, Illegal Acts Against Physicians and Other Health Professionals

See also

- Firearms and Safety Issues
- Hate Crimes
- Violence (Position Paper)
- Violence in the Media and Entertainment (Position Paper)
- Intimate Partner Violence
- Child Abuse
- Violence, Harassment and School Bullying
- Violence as a Public Health Concern

The AAFP condemns violence or other illegal acts against physicians and other health professionals and urges prompt enforcement of laws prohibiting such activities.

The AAFP encourages all physicians to have a security manual/protocol in place and to include security issues when orienting and training new staff. Physicians and other health professionals should be aware of their surroundings and alert to potentially threatening situations or individuals at all times.

The AAFP deplores any illegal activity that interferes with patient welfare or harms those who are providing patient care. To those ends, physicians and other health providers are encouraged to build working relationships with their local law enforcement agencies to ensure community safety. (1993) (2011 COD)
The American Academy of Family Physicians recognizes violence as a major public health concern. Members are best able to adequately counsel patients when they are aware of the various manifestations of violence (including sexual violence), both risk and protective factors related to violence and of available services for survivors of violence in their community.

Experts suggest that violence is related to a plethora of environmental factors including pervasive media images that violent responses are acceptable means of addressing problems. Another factor is the remarkable availability of handguns and ammunition. The Academy believes it is important to address these factors by supporting the efforts of those attempting to reduce the level of all violence and encouraging members to become actively involved with such activities. (1987) (2011 COD)
Violence (Position Paper)

Definition of Violence

The World Health Organization defines violence as “the intentional use of physical force or power, threatened or actual, against oneself, against another person or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.” Violence and abuse may be physical, sexual, or psychological. Three broad subtypes of violence exist: self-directed, interpersonal, and collective. Self-directed violence includes suicide and self-abuse. Interpersonal violence is violence among individuals, including violence among related individuals in the context of a family or extended family, and violence among unrelated individuals who may be friends, acquaintances, or strangers. Collective violence includes social, political, and economic violence. Self-directed, interpersonal, and collective violence are overlapping phenomena which occur within a larger social and cultural context. Common economic, social, and cultural risk factors influence all three. Vulnerable populations are often at increased risk of all three forms of violence. All violence is functional, intended to dominate, punish, control, harm, or eliminate an individual, a group, or a community. As physicians, we have many opportunities to identify patients at risk of victimization or perpetration, and to prevent or influence the outcomes associated with violence.

Incidence & prevalence—United States and Worldwide

Every family physician knows patients in his or her practice who have experienced violence—survivors of child abuse, sexual assault, or intimate partner violence; war veterans; refugees from high conflict regions...
of the world; individuals who have been the target of a hate crime, etc. Many patients who have been exposed to violence will present with symptoms of posttraumatic stress disorder (PTSD), depression, anxiety, substance abuse disorders, chronic pain syndromes, or chronic health problems such as diabetes or heart disease. In others, however, the effects of violence may not be obvious, and the physician may be unaware of histories of violence and trauma. How many of our patients have been exposed to one or multiple forms of violence?

Understanding the total disease burden of violence in family medicine clinics is challenging because of limitations in the current state of our knowledge. No comprehensive national or international epidemiological studies exist to document the total disease burden of all forms of violence, in part because the public health science of violence is at an early stage of development. Operational definitions are still evolving, and researchers have generally focused on specific types of violence and used varying methodologies. We lack comprehensive national and international public health systems of violence surveillance. Another factor that complicates family physicians’ understanding of the impact of violence upon their patients’ lives is the fact that family physicians have a well-documented optimistic bias and consistently and dramatically underestimate the number of patients in their own practices who have experienced violence.

In spite of the limitations, sound evidence exists documenting the high prevalence in the United States of some specific forms of violence. One in five U.S. children experience one or more forms of child maltreatment: 1 percent are victims of sexual abuse; 4 percent are victims of child neglect; 9 percent are victims of physical abuse; and 12 percent are victims of emotional abuse. Maltreatment is a significant cause of child mortality. In 2008, an estimated 1,740 children up to age 17 died from abuse and neglect, a rate of 2.3 per 100,000 children. Homicide is the second leading cause of death for children and young adults 10 to 24 years old. For teenagers in grades nine through twelve, 31.5 percent report being in a physical fight in the past 12 months, 17.5 percent report carrying a weapon (gun, knife, or club), and 19.9 percent report being bullied on school property. In an emerging area of concern, between 9 and 35 percent of young people say they have been victims of aggression through a variety of forms of social media. According to the 2010 Pew Research Center Teens and Mobile Phones survey, one in four 12- to 17-year-old cell phone users (26 percent) have been bullied or harassed through text messages and phone calls, and 15 percent of teens say they have received a text message with a sexually suggestive nude or nearly nude image of someone they know, although only 4 percent of teens say they have sent such a message. According to the 2009 Youth Risk Behavior Survey (YRBS), 9.8 percent of high school students nationwide reported being the victim of physical violence at the hands of a romantic partner during the previous year. In a study of gay, lesbian, and bisexual adolescents, youths involved in same-sex dating are just as likely to experience dating violence as youths involved in opposite sex dating. A study published in the November 2009 issue of Pediatrics found that as many as one in five adolescent females and one in 10 adolescent males have been abused physically or sexually by a dating partner.

Rates of sexual assault are high for all ages. Nationally, 10 percent of women and 2 percent of men reported experiencing forced sex at some time in their lives; 20 to 25 percent of women in college reported experiencing an attempted or completed rape in college; and 11 percent of girls and 4 percent of boys in grades nine through twelve reported being forced to have sexual intercourse at some time in their lives. Regarding intimate partner violence (domestic violence), 22 percent of women report a physical assault by an intimate partner in their lifetime; 8 percent report sexual assault; and 5 percent report stalking, making for an overall victimization rate of 26 percent. Although research on war-related trauma is at an early stage, a large majority of war veterans experience traumatic events and are at higher risk of PTSD, depression, anxiety, and intimate partner violence. Among service members and veterans who served in the Afghanistan and Iraq wars, it appears that 10 to 18 percent will experience persistent PTSD following deployment.

Beyond U.S. borders, rates of violence are high throughout the world. Consider, for example, the World Health Organization Multi-country Study on Women’s Health and Domestic Violence, a survey of 24,000 women from 15 urban and rural regions in 10 countries with diverse cultural settings. Between 13 and 62
percent of women report physical abuse by an intimate partner while 6 to 59 percent report sexual abuse or rape by an intimate partner. The overall prevalence of physical and/or sexual abuse by an intimate partner ranged from 15 to 71 percent. Violence in all forms is a significant cause of mortality worldwide. In 2000, 1.6 million people died as a result of self-inflicted, interpersonal, or collective violence: 49 percent from suicide, 31 percent from homicide, and 19 percent from war-related violence.3

Based upon our current understanding of the epidemiology of violence, family physicians cannot predict the total burden of violence in their patient population, but we can draw some conclusions: 1) many patients have experienced one or more forms of violence and trauma; 2) although risk varies among subpopulations, no economic, racial, religious, or other group is immune; and 3) there are important age and gender differences in the types of violence for which people are most at risk.

**Impact Upon Health**

Exposure to violence and abuse has long been associated with adverse health outcomes. Caring for patients with trauma histories, sometimes referred to as trauma-informed care, involves understanding the sources of trauma (e.g., interpersonal violence [physical, sexual, and emotional] and neglect, along with community and political violence) and how they interact within and between individuals and relate to health and healthcare utilization. Clinicians should also work from an appreciation of the ecological context in which violence occurs, accounting for the overlap and interplay between factors shaping the development and impact of domestic, intimate, interpersonal, neighborhood, community, and social and political violence.

Violence impacts personal health through both direct tissue injury and the resultant morbidity and mortality (i.e., soft tissue damage, broken bones, organ damage, or death) and emotional trauma leading to mental health and stress-related conditions. Chronic and severe exposures to violence and abuse have been associated with the development of physical and mental disorders through a variety of proposed mechanisms that are violence specific. Studies controlling for tissue injury, maladaptive behaviors, lifestyle choices, and comorbid mental illness do not fully explain the associations between violence exposures and chronic illness, suggesting the presence of other pathophysiological mechanisms related to violence exposures that result in negative health-related outcomes.14 Research suggests that the primary mechanisms by which exposure to violence causes adverse health outcomes, such as chronic disease, include stress-mediated dysregulation of homeostatic pathways regulating neuroendocrine systems and the hypothalamic-pituitary-adrenal (HPA) axis. Neurobiological mechanisms include alterations in monoamines (serotonin and norepinephrine), hormones of the HPA axis (corticotropin-releasing hormone, adrenocorticotropic, cortisol, and dihydroepiandosterone), substance P, and neuropeptide Y. Many chronic illnesses that result in increased rates of mortality and years of potential life lost, including respiratory disorders (asthma and chronic obstructive pulmonary disease), obesity, cardiovascular disease, and cancer, have an independent risk associated with exposure to violence and abuse.

For pregnant women, the impact is particularly serious. Homicide is a leading cause of traumatic death for pregnant and postpartum women in the United States, accounting for 31 percent of maternal injury deaths.13 Evidence exists that a significant proportion of all female homicide victims are killed by their intimate partners.14 Complications of pregnancy, including low weight gain, anemia, infections, and first and second trimester bleeding, are significantly higher for abused women,17,18 as are maternal rates of depression, suicide attempts, and use of tobacco, alcohol, and illicit drugs.19

Longitudinal studies are beginning to describe associations between early childhood exposures to violence (both direct and indirect) and long-term health. The Adverse Childhood Experiences (ACE) study has been instrumental in establishing the relationship between childhood exposures to violence and abuse and risk for poor health-related outcomes in adulthood.15 Childhood adversity, characterized as abuse (emotional, physical, or sexual), neglect (emotional or physical), or household dysfunction (exposure to domestic violence directed at the mother, substance abuse, mental illness, parental separation or divorce, or maternal incarceration) has a strong, dose-dependent association with adult substance abuse, chronic obstructive pulmonary disease, depression, fetal death, health-related quality of life, illicit drug use, ischemic heart disease, liver disease, risk of intimate partner violence, multiple sexual partners (and early initiation of
sexual activities), sexually transmitted infections, smoking (and early initiation of smoking), suicide attempts, unintended pregnancies, and adolescent pregnancy. The ACE study provides a conceptual framework describing how childhood adversity results in social, emotional, and cognitive impairment that predisposes the exposed to developing health risk behaviors associated with disease, disability, and social problems that ultimately result in early death. Girls and boys experiencing teen dating violence are more likely to suffer long-term negative behavioral and health consequences, including suicide attempts, depression, cigarette smoking, and marijuana use. Teen victims of physical dating violence are more likely than their non-abused peers to engage in unhealthy diet behaviors (taking diet pills or laxatives and vomiting to lose weight) and to engage in risky sexual behaviors (first intercourse before the age of 15 years old, not using a condom during last intercourse). Being physically or sexually abused by a dating partner leaves teen girls up to six times more likely to become pregnant and more than two times as likely to report a sexually transmitted disease.

Promoting Resiliency

Identifying families in need can make a difference, and promising research suggests that we can address these poor health consequences and help prevent the cycle of violence. Psychotherapy designed for parents and children together can increase the quality of parenting and increase positive outcomes for children. We know that many abusive men are concerned about the devastating effects of violence on their children and the children of their partners; some men may be motivated to stop using violence if they have a better understanding of these effects. Finally, we know that a safe, stable, and nurturing relationship with a caring adult can help a child overcome the stress associated with exposure to violence.

Causes of Violence

Although no single theory can describe all causes of violence and abuse, the Centers for Disease Control and Prevention recommends an ecological model as a framework for prevention and intervention. Seeking to understand factors that shape and create risk for the development of violence and abuse is not intended to excuse or mitigate personal responsibility for criminal or immoral behaviors. For primary prevention, however, it is critical to understand individual and social factors related to risk for perpetration of violence and abuse. Macrosocial factors are likely related to the development of violent behaviors. Power and control are often described as the underpinnings of violence and abuse. The patriarchal social structure can produce a social environment that supports male domination of women from the feminist perspective. Poverty, lack of economic opportunity, racism, and discrimination also support power differentials in society and are key drivers for the development of stress. Stress appears to be related to biologic pathways potentiating increased risk for developing maladaptive behaviors (e.g., substance abuse). Stress may also serve as a trigger for violent outbursts. The media likely play a role in the shaping of social norms related to violence and abuse and sustaining a culture of violence. Although alcohol abuse and substance abuse are strongly associated with violence, debate exists in the literature regarding the causal relationship between the two. A clinically relevant issue for clinicians is the transgenerational transmission of violence and abuse. Data strongly suggest that childhood exposures to violence and abuse put individuals at risk for developing perpetration behaviors. Many researchers have developed typologies to categorize perpetrators with common subtypes ranging from perpetrators who are psychotic with antisocial personality disorders and little hope for remediation to perpetrators of common-couples violence that occurs in the context of bidirectional relational dysfunction. Family physicians should watch for new research and future developments in violence prevention; in particular, they should look for findings that can be implemented in the primary care setting.

Family Physician's Role

Violence, Traumatic Stress, and the Family Medicine Patient
Since violence and traumatic stress affect our patients and present to us as family physicians in many different ways, it is vital that we understand them in the context of our patients’ lives. As family physicians, we all see these patients in our offices and care for them daily. Recognizing the risk factors and asking questions about experiences with violence helps our patients understand that violence is related to their health conditions and gives them permission to talk about it within the context of their health. Many physicians worry about the time it may take once this line of questioning begins, but a study by Alpert shown that when answers to the screening questions suggest a history of abuse, it adds less than 10 minutes to the visit during which this information is uncovered. Often identifying the experiences leads to appropriate referral for counseling or use of other resources that help the patient. Recent clinical studies have supported the effectiveness of a two-minute screening for early detection of abuse of pregnant women. Additional longitudinal studies have tested a 10-minute intervention that was proved highly effective in increasing the safety of pregnant abused women. Understanding the many presentations of violence and its effects on our patients helps us provide better care.

Family violence affects approximately a third of family physicians’ patients. Victims of family violence interact with the health care system twice as often as non-victims in a typical year. Patients welcome inquiry about violence and abuse as it relates to their health and the health of their families, as long as the inquiry is nonjudgmental. In a study performed by Burge and Schneider, nearly 97 percent of patients said they wanted their family physician to ask them about violence, regardless of whether they had a history of violence. Physicians should be equally attentive to screening for family violence in heterosexual, gay, lesbian, bisexual, and transgender patients. In addition to the traditional role as a secondary responder, primary care providers are ideally situated to be agents of primary prevention. Family physicians have expertise in case management; treating medical and mental health comorbidities associated with violence-exposed patients; developing a referral base for subspecialty evaluation and treatment; working from a preventive framework with longitudinal, therapeutic relationships with patients; and addressing at-risk behaviors that tend to occur with exposures to violence and abuse.

Some presentations (anxiety, depression, and other mental health disorders; chronic pain syndromes such as fibromyalgia and pelvic pain; and multiple somatic complaints) are much more likely than others to be related to violence. It is important for family physicians to be aware of the issue, and to remember to inquire about their patients’ relationships and stressors.

Family physicians have a responsibility to assess the level of risk for the patient and to support and empower patients in promoting harm-reduction strategies. Certain scenarios may put patients at particularly high risk for life-threatening family violence. These include a change in the severity and frequency of violence, drug or alcohol use, possession of a firearm, threats of suicide or homicide, recent break up, threats or assault with a weapon, attempted strangulation, and stalking behavior. Physicians must know the local and national resources available for patients affected by family violence and be able to refer patients appropriately, especially when these warning signs are identified. Physicians should be also familiar with local or national resources available to assist patients in danger that are responsive to the needs of special patient populations, such as gay, lesbian, bisexual, transgender, adolescent, elderly, or immigrant patients. Physicians should counsel patients about the acute and long-term risks posed by exposures to violence. The office staff and other team members in the family medicine practice should be trained to know the clues to violence and be able to respond, as many patients have strong relationships with other staff within a primary care office and may disclose to staff about the violence. A comprehensive response includes the following steps

- Disclose the limits of confidentiality
- Inquire about violence and assess immediate safety
- Offer support and harm reduction
- Offer supported referral
- Provide primary prevention through patient education about healthy relationships

Prevention of Violence-Primary and Secondary

Prevention of Violence—Primary and Secondary

Asking about violence exposures may be an intervention in and of itself, with education and patient-centered empowerment strategies increasing the capacity of victims to avoid future exposures. Family physicians can also use their clinical practice and office environment to educate patients about positive skills that may reduce the risk of violence. For example, providing educational materials on parenting skills and offering the Reach Out and Read program (http://www.reachoutandread.org/) support the development of healthy parent-child relationships. Information on healthy relationships may help reduce the risk of teen dating violence and adult intimate partner violence. Evidence regarding the clinical burden of victimization and the prevalence of patients of family physicians reporting perpetration clearly defines a role for family physicians in the recognition and appropriate referral for treatment of perpetration as a primary prevention strategy.27,28 With adolescent patients, a discussion of their dating relationships and safety can help them understand appropriate behaviors they may not have considered.

As family physicians, we have many opportunities to influence policies and bring together resources for our communities to help our patients cope with violence and its effects on health. Many family physicians are on local school boards where strong policies on school bullying are developed, work with police departments that have domestic violence response teams, and serve in nursing homes where elder neglect often occurs. It is our responsibility to create and contribute to policies designed to keep our communities healthy.

REFERENCES


(1994) (2014 COD)
Violence in the Media and Entertainment (Position Paper)

See also

- Hate Crimes
- Child Abuse
- Elder Mistreatment
- Violence as a Public Health Concern
- Intimate Partner Violence
- Violence, Illegal Acts Against Physicians and Other Health Professionals
- Violence, Harassment and School Bullying
- Firearms and Safety Issues
- Violence (Position Paper)

The World Health Organization has defined violence as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.”

Violence occurs at an alarming rate in the United States. Among Americans aged 15 to 34 years, two of the top three causes of death are homicide and suicide. In a given year, more U.S. children will die from gunfire than will die from cancer, pneumonia, influenza, asthma, and HIV/AIDS combined.

The rate of firearm-related death or injury in the United States is the highest among industrialized countries, with more than 32,000 deaths each year. In recent years, this has meant that 88 people die each day from firearm-related homicides, suicides, and unintentional deaths. Further, the number of nonfatal injuries due to firearms is more than double the number of deaths.

While there are multiple factors that lead to violent actions, a growing body of literature shows a strong association between the perpetration of violence and the exposure to violence through the media.

Media Violence in the United States

Children and adolescents in the U.S. spend an average of about seven and a half hours a day using various forms of entertainment media, such as television, video games, the Internet, and recorded music. Research suggests that the time they spend interacting with various media surpasses all other activities except sleep.

Moreover, studies have shown that by the time young people living today reach their 70s, they will have spent the equivalent of 7 to 10 years of their lives watching television.

Today's children live in environments where, on average, families own nearly four televisions, nearly three DVD players, one DVR, two CD players, two radios, two video game consoles, and two computers. Television still dominates children’s media consumption, but the number of kids watching television are dropping with each age group. At the same time, media consumption through mobile devices and the Internet is increasing in every age group.
Studies demonstrating an association between exposure to violence in the media and real-life aggression and violence began appearing in the 1950s. Since then, various government agencies and organizations have examined the relationship. These include a 1972 Surgeon General’s report, a 1982 National Institute of Mental Health (NIMH) review, and a 2000 Congressional summit which issued a joint statement on the impact of entertainment violence on children. In 2000, the Federal Bureau of Investigation (FBI) released a report noting that media violence is a risk factor in shootings in school. A 2003 NIMH report noted media violence to be a significant causal factor in aggression and violence. The Federal Communications Commission (FCC) issued a 2007 report on violent programming on television, and noted that there is “strong evidence” that exposure to violence through the media can increase aggressive behavior in children.

These reports and others are based on a body of literature that includes more than 2,000 scientific papers, studies, and reviews demonstrating the various effects that exposure to media violence can have on children and adolescents. These include increases in aggressive behavior, desensitization to violence, bullying, fear, depression, nightmares and sleep disturbances.

Some studies found the strength of association to be nearly as strong as the association between cigarette smoking and lung cancer, and stronger than the well-established associations between calcium intake and bone mass, lead ingestion and IQ, and failure to use condoms and acquisition of HIV.

Violence is ubiquitous in mass media in the U.S., whether consumed through television, video games, music, movies, or the Internet.

**Television**

An average American youth will witness 200,000 violent acts on television before age 18. Violence is often considerable, even in programs not advertised as violent. Overall, weapons appear on prime time television an average of nine times each hour. An estimated 54 percent of American children can watch this programming from the privacy of their own bedrooms.

Children’s shows are particularly violent. Watching Saturday morning cartoons used to be a common aspect of American life. Now, networks feature cartoons continuously. Studies analyzing the content of popular cartoons noted that they contain 20 to 25 violent acts per hour, which is about six times as many as prime time programs. Overall, 46 percent of television violence occurs in cartoons. Additionally, these programs are more likely to juxtapose violence with humor (67 percent) and less likely to show the long-term consequences of violence (5 percent). Although some claim that cartoon violence is not as “real” and therefore not as damaging, cartoon violence has been shown to increase the likelihood of aggressive, antisocial behavior in youth. This makes sense in light of children’s developmental difficulty discerning the real from the fantastic.

**Video Games**

Nearly all American teens – one survey documenting 97 percent – play video games. Studies have shown the average time spent playing to be around 13 hours per week. Many games have violent content and studies have shown a significant association between violent content with increases in aggression, desensitization to violence, decrease in positive social behaviors, and increases in delinquent behaviors. Video games offer players the opportunity to be “virtual perpetrators,” by assuming the roles of aggressors and soldiers. These interactive games also reward players for successful violent behavior. Studies have shown that the general effects of violence may be more profound when children play these interactive games than when they watch violence in a more passive manner, such as when watching television.
Music (Lyrics and Music Videos)

Music plays a central role in adolescent and young adult lives, helping them sort through emotions and identify with certain peer groups and develop a sense of self. Children 8 to 18 years of age have been found to listen to at least two and a half hours of music a day.\(^5\)

Fewer studies have looked at the effects of violence portrayals in music. One study by the American Psychological Association (APA) found a correlation between violent lyrics, and aggressive thoughts and emotions, but not actions.\(^32\)

Music videos have been sources of violent content for decades. Content analysis has shown that in music videos more than 80 percent of violence is perpetrated by attractive people, and that it depicts acts of violence mainly against women and minorities.\(^33\) Violent scenes were of a sexual nature in many, with one study showing that 81 percent of videos that portrayed violence contained sexual imagery, often intertwined. Additionally, artistic features and editing may juxtapose violence with beautiful scenery, potentially linking it to pleasurable or pleasing experiences.\(^34\)

Several studies have focused on rap music, and found them to contain more violence than other genres. They also found viewers to be more likely to accept the use of violence, to accept violence against women, and to commit violent or aggressive acts themselves.\(^34\)

Movies

Studies have found that 91 percent of movies on television contained violence, even extreme violence.\(^35\) Several researchers have described an increase of violent content in movies, despite a national rating system. They note that the amount of gun violence in top grossing PG-13 films has more than tripled since the introduction of the rating in 1985.\(^36\) It was also noted that, in 2012, popular PG-13 films contained significantly more gun violence than R-rated films.\(^37\)

Children, adolescents and young adults consume entertainment from a variety of sources that are accessible 24 hours a day, are mobile, and offer passive, as well as more active engagement. Many of these media platforms feature entertainment that contains significant doses of violence, and portrays sexual and interpersonal aggression. Multiple studies have shown a strong association, and suspicion or suggestion of causality between exposure to violence in the media, and aggressive or violent behavior in viewers. This is a serious public health issue that should concern all family physicians.

What Can Family Physicians Do

1. Clinical Setting
   a. Consider discussing media use during well-child visits
      - Ask at least two media-related questions: 1) How much entertainment media per day is the child or teenager watching? 2) Is there a television set or Internet connection in the child's or teenager's bedroom?
      - Question patients about excessive exposure to media violence.
      - If you identify heavy use (more than 2 hours daily), take additional history of aggressive behaviors, sleep problems, fears, and depression.
      - Suggest healthy alternatives.
      - Children under two years of age should be discouraged from watching television.
      - Incorporate warnings about the health risks of violent media consumption into the well-child visit.
   b. Encourage parents and caregivers to monitor content. Parental monitoring has been shown to have protective effects on several academic, social and physical outcomes, including aggressive behaviors.\(^36\)
• Urge parents to co-view shows and content with their children.
• Encourage parents to discuss the content of television, films, video games, music videos, and the Internet with their children and make comparisons to real-life situations and consequences.
• Consider and discuss movie and video game ratings and labels with parents to set expectations and guide choice of content.

Although film ratings and advisory labels can help parents decide on programs to be avoided, there are two major problems with relying on this system. First, certain labels, such as “parental discretion advised” and “R” have been shown to attract children, especially boys. Second, violence is present in many programs not considered to be violent, such as children’s cartoons.

c. Counsel parents and caregivers to limit exposure duration

• Exposure can be limited by removing televisions, video games, computers, and Internet connection from the bedroom.
• Limit screen time to no more than two hours a day.
• Use technology that locks certain channels or turns off the computer or television after a certain amount of time.

d. Clinical environment

• Limit video and television use in waiting rooms.
• Provide only nonviolent media choices in outpatient waiting rooms and inpatient settings.
• Provide books, toys, and other alternative activities for patients who are waiting.

2. Promote Media Education

In addition to limiting exposure to violent media, educational efforts should be developed to help children understand the divide between real and fictionalized violence. Such media literacy programs have been shown to be effective, both in limiting the negative effects of media, as well as in exploring the potential positive social uses of media.

• Encourage patients, children, families, and caregivers to participate in media education, and media literacy programs.
• Advise adults to watch with their children, and help them process media violence. Taping programs beforehand enables pausing for discussion or processing.
• Support the development of media education programs that focus on demystifying and processing media violence. Emphasis should be placed on the inappropriate and unrealistic nature of violence on television and films, and the consequences, responsibility, and complexity involved with true violence.

3. Support and Engage in Professional Education

• Become familiar with the research of trends of media use, and the effects of medial violence on patients.
• Disseminate this knowledge via teaching at medical schools, residencies, grand rounds, and via community-based lectures.
• Request, attend, or create CME.

4. Advocacy and Policy Changes

• Partner with other medical organizations, government entities, and educators to advocate keeping this issue on the public’s health agenda.
• Partner with families and community-based organizations to demand that media producers limit the amount and type of violence portrayed in mass media.
• Advocate for research funding to continue studying this topic.
• Advocate for enhancements to media rating systems to enable parents and caregivers to guide their
children to make healthy media choices.

References

1998.

Visa (J-1) Waiver Program

See also

- Visa (J-1) Fast Track

The Academy reaffirms its position that it is the responsibility of the United States to train and distribute an adequate number of physicians to meet the diverse health care needs of its people, as well as to provide training opportunities for physicians from other countries. The AAFP supports strategies designed to provide physicians to serve rural, underserved and disadvantaged populations and to eliminate health care disparities within the United States. In the meantime, the AAFP supports J-1 visa waivers for physicians from countries not currently in need of those physicians' specialty medical services, but the AAFP cannot support J-1 visa waivers for physicians whose countries of origin are currently in need of those physicians' specialty medical services. (2003) (2014 COD)
Visa (J-1) Fast Track

See also

- Visa (J-1) Waiver Program

The AAFP supports a J-1 Visa fast track process similar to the Premium Processing service available to H-1B Visa applicants. (2003) (2014 COD)
Women's Health Specialty

See also

- Women's Health Care
- Women's Health Care, Family Physicians Providing

The American Academy of Family Physicians supports excellence in the health care of women, but opposes the creation of a separate medical specialty or subspecialty in women's health. (1999) (2015 COD)
Women's Health Care

See also

- Women's Health Care, Family Physicians Providing
- Women's Health Specialty
- Maternal/Child Care (Obstetrics/Perinatal Care)
- Reproductive Decisions
- Female Genital Mutilation
- Long-Acting Reversible Contraceptives

The AAFP affirms the concept that a sufficient family physician workforce is essential in order to adequately meet public needs for appropriate women's healthcare. (1993) (2015 COD)
Women's Health Care, Family Physicians Providing

See also

- Maternal/Child Care (Obstetrics/Perinatal Care)
- Reproductive Decisions
- Women's Health Care

Family physicians are well trained, qualified and involved in providing comprehensive, continuing care of women throughout their lifecycle. (1993) (2015 COD)
Workforce Reform

See also

- Area Health Education Centers
- Expansion of Residency Training Programs at Federally Qualified Community Health Centers
- Family Medicine Department, Definition of
- Family Physicians, Workforce and Residency Education
- National Health Service Corps
- Medical Home
- Primary Care, Definition of
- Rural Health Care in Medical Education
- Student Choice of Family Medicine, Incentives for Increasing Student Interest

FAMILY PHYSICIAN WORKFORCE REFORM:
Recommendations of the American Academy of Family Physicians

Mission

1. To speak with a unified and cohesive voice regarding the development of the family medicine workforce on state and national levels.

Objectives

2. Identify the appropriate proportion of the nation’s physician workforce that should be family physicians to ensure efficient healthcare delivery with attention to access and value, effective healthcare addressing quality and cost, and equitable care with regard to disparities and distribution.

3. Review demographic changes in the U.S. population and adjust workforce projections accordingly.

4. Discuss the impact of increased healthcare coverage on family physician demand, utilization, and access.

5. Review demographic changes in the family physician workforce, such as physician disengagement from clinical practice, part-time practice, and clinical reentry.

6. Identify needed changes in healthcare financing and medical education funding to meet stated priorities.

7. Address the ongoing increase in medical school production (through the addition of new schools, addition of branch and regional campuses to existing schools, and increases in medical school class size) and graduate medical education funding policies, and their anticipated impact on family medicine workforce.

8. Review trends in general internal medicine, general pediatrics, nurse practitioner and physician assistant workforce and identify how those trends influence family physician workforce and distribution.

9. Provide data that will be accessible to state chapters, medical schools and other constituents.

Background

10. The current AAFP Policy “Family Physician Workforce Reform” as approved by the Congress of Delegates in September 2011 states that the AAFP should regularly assess and report on the family physician workforce. Accessing reliable health care is a major concern of the American public, and consistently ranks high on national surveys.¹

11. Updating AAFP Workforce Policy is not only timely but also necessary because of the national discussion about medical school social accountability, the misalignment of GME spending with the workforce needs of the country,
health care delivery, physician practices, and patient access. Other important considerations include an increase in medically underserved populations, a new federal administration with an agenda to address health system reform and a new model of enhanced health care delivery. These changes require a workforce policy with greater specificity in its recommendations, and they present an opportunity to positively impact both national and state health policy. Addressing the national health workforce is a recognition of health care as a public good and that maintaining a sufficient number of well-trained and appropriately deployed family physicians is in the public's best interest. 2-5

12. The Council of Academic Family Medicine (CAFM), comprised of the Association of Departments of Family Medicine, the Association of Family Medicine Residency Directors, the North American Primary Care Research Group, and the Society of Teachers of Family Medicine, with contributions by the AAFP and the American Board of Family Medicine, created a position paper entitled “Four Pillars for Primary Care Physician Workforce Development” to serve as the foundation for family medicine workforce advocacy. The document recognizes that a successful workforce advocacy plan must address the physician pipeline, the process of medical education, practice transformation, and payment reform to promote, train, and sustain primary care physicians. 6

13. Projecting the appropriate family medicine workforce composition and distribution must be part of any discussion of high-quality and efficient health care delivery; it also must be part of an agreement on the population health outcomes goals to be achieved. The AAFP has commissioned studies of the health workforce that have resulted in policy statements.7,8 The need to have a sound, data-driven workforce plan with clearly articulated policy recommendations is critical to advocacy initiatives during times of health system change.

**Situation Analysis**

14. The demand for primary care is expected to continue to increase at least through the year 2020 based largely upon the needs of a population that is both growing and aging as well as a modest increase associated with health insurance expansion as a result of the Affordable Care Act. 9

15. There are approximately 275,000 primary care physicians currently in the United States. Of those, about 39 percent are family physicians.10 Adequate workforce projections are a key piece of the development of advocacy priorities if the AAFP is to meet its goal of ensuring access to care in a patient-centered medical home for everyone. Accurately projecting the health workforce is challenging, due to the complex nature of the many variables involved, the assumptions which underlie each variable, the methodology used, and the lack of a national workforce policy or model. For this reason, accurate health workforce projections remain elusive and controversial.

16. Recruitment, training, and retention constitute the longitudinal progression of the development of the family physician workforce. Differing factors influence each of these three components. Similarly, institutions with different missions influence various aspects of the overall physician workforce pipeline. Other variables that influence workforce include workforce trends of other healthcare disciplines and socioeconomic trends that influence the public’s ability to access healthcare resources.

17. The U.S. health care system is characterized by excessive cost and substandard population health outcomes. There are multiple calls for health system reform. One example is the 2012 Institute of Medicine report calling for an exploration of primary care and public health integration to improve the health of individuals, communities, and populations.11 A condition for any meaningful reform is a clearly articulated health workforce policy.

18. One durable finding is that primary care is essential to any efficient health care system. In order for the United States to control costs, reduce health disparities and deliver high-quality care, the primary care workforce must be strengthened and deployed in a manner consistent with the health needs of the population. Health reform without systematically strengthening the primary care base is unlikely to succeed.12

19. This policy statement goes beyond projecting a specific number of physicians, but rather describes key issues of national workforce coordination, fiscal reform, and delivery systems that are essential to contain health care spending and improve health outcomes.

**Discussion**

20. In 1961, half of U.S. physicians were generalists, primarily general practitioners. Since then, the percentage has dramatically declined.13
21. The demographics of the U.S. population will continue to change. Along with an increase in the overall population, the number of older Americans will continue to increase as people live longer, and they will have more chronic diseases. Cultural and ethnic changes will continue as the population becomes increasingly diverse. The U.S. physician workforce must be prepared to care for a larger, increasingly diverse and older population with an increasing number of chronic medical conditions.

22. The health care systems of countries now dedicated to universal coverage for and access to health care are based on a foundation of generalist physicians, usually family physicians, at a higher proportion than is now present in the United States. These countries, as well as the more cost-efficient, closed-panel health maintenance organizations (HMOs) in the United States, tend to use fewer subspecialist physicians and a higher proportion of generalist physicians.14

23. The increasing generalist-specialist imbalance in the United States undermines the nation’s ability to achieve universal health care access and limits its ability to meet needs of underserved populations. Primary care services provided by limited specialists and sub-specialists who have had little or no primary care training or continuing education can be expected to be both costly and inefficient, because limited specialists tend to use technologies and procedures of their specialties more than generalists. Furthermore, because of their narrower educational focus, limited specialists will more frequently seek consultation for patients who have common acute and chronic illnesses. Services may be fragmented and duplicated by visits to multiple specialists, and preventive services may not be provided adequately.15-17

24. Many nationally recognized groups, including the Council on Graduate Medical Education, the Association of American Medical Colleges, the Robert Wood Johnson Foundation and the Pew Health Professions Commission, have called for at least 40 percent of U.S. medical graduates to enter generalist careers.18-24 In 2006, the AAFP completed a comprehensive workforce study that identified the ideal ratio of family physicians to population calculated from a needs-based model.7 However, many other factors, such as the demographic changes of the U.S. population, new models of healthcare, achieving recommended health screenings, aging physician demographics and practice patterns, and health reform measures that may include expanded insurance coverage will affect the workforce need.

25. As an example, in April 2006, Massachusetts passed a state bill designed to provide health coverage for its 600,000 uninsured. Despite being the state with the highest ratio of primary care physicians to population (125.6 physicians per 100,000), the act resulted in an immediate crisis of health care access.22 Significant delays in care have resulted with some patients waiting more than a year for a simple physical examination.23

26. Recent projections from multiple workforce reports and publications predict major shortages in primary care providers, especially for the adult population. The American College of Physicians has expressed overt concern regarding the decline in the number of general internists.24 In 2008, a study in JAMA revealed that only 2 percent of medical students planned to pursue general internal medicine careers.25 The Association of American Medical Colleges (AAMC) reports an impending “crisis” in provider access, and even the organizations of non-physician providers are struggling with trends toward specialization and away from primary care.26 Recent trends in graduate medical education show that the number of family medicine and general internal medicine residency positions and training programs have dropped at the same time that there was continued growth in subspecialty training and non-primary-care core specialties.27 Even within the primary care specialties, there are significant differences between the specialty-to-population growth rates, with pediatric growth outpacing that of family medicine and internal medicine, despite a declining birth rate, which adds to the complexity of a primary care workforce projection.28 With the declining numbers of other providers of primary care, the number of ACGME trained family physicians must be increased to meet the public’s needs.

27. The results of the 2006 AAFP Workforce Study found that, in order for all in America to achieve adequate access to a primary care physician, 139,531 family physicians will be needed by the year 2020. The results of the 2006 AAFP Workforce Study reported that the nation will need approximately 39,000 more family physicians by 2020 in order for all Americans to achieve access to a primary care physician. In 2008, Colwill and others predicted that population growth and aging will result in a deficit of up to 44,000 adult care generalist physicians by 2025.29 Subsequent analysis and the more-rapid-than-expected decline in the production of general interns suggest that shortages of adult care generalists will be even worse than predicted, and that family physicians will be relied upon to close the bulk of that gap.30

28. A determined number of training positions in U.S. health professions education outside of residency pathways to
29. Both allopathic and osteopathic medical schools are rapidly increasing the pipeline of physicians both through expanding class sizes and opening new medical schools. Attention also must be paid to ensure that the increasing number of graduates will provide the kind of care most needed.

30. Federal funding for graduate medical education should reflect physician workforce policy, with preferential funding for training primary care physicians, particularly family physicians, and concomitantly less funding for the training of other physicians. All payers of health care services should contribute to paying the costs of medical education. A public-private entity should be established to allocate funding for residency positions among training programs based on the nation’s workforce needs. Preferential funding should be given to residency programs that have a track record of producing generalist physicians, physicians located in and or serving rural and inner-city populations, or physicians from underrepresented minorities.

31. The physician workforce is dynamic and changes in physician work patterns can be anticipated. Increasing numbers of physicians choosing to leave practice, return to practice after periods of clinical inactivity, part-time practice, and other factors will affect the number of physician FTEs (full-time equivalents) providing patient care.

32. A critical issue central to the AAFP’s current recommendations is the identification of the family physician as the provider of choice for primary care services for Americans, rather than abdicating the role of primary care provider to others, as it appears other adult specialties are doing. Given the extent and breadth of training, the quality outcomes and cost efficiency of practice, as well as the demands of delivery systems and satisfaction of patients, family physicians will be at a competitive advantage and will fill critical roles in the health care marketplace. Current recommendations are intended to support efforts to ensure health care access for all in America and to meet the needs of underserved rural and urban populations.

33. The delivery of emergency medical care in the US is an essential public service that requires a cooperative relationship among a variety of health care professionals. The Institute of Medicine Report on Emergency Care and others confirm the critical role of family physicians along with emergency medicine specialists in the emergency care workforce. The AAFP supports family physicians as essential and qualified providers of emergency care in a variety of settings, especially in rural and remote communities.

34. The number of students graduating from Nurse Practitioner (NP) and Physician Assistant (PA) programs continues to rise. However only approximately one half of NPs and one third of PAs are estimated to be practicing primary care. While PAs and NPs remain important contributors to the primary care workforce and are an important part of the team-based approach within the Patient-Centered Medical Home model of care, their contribution will be affected by the increase in the percentage of PAs and NPs who practice in subspecialty disciplines rather than primary care.

**SUMMARY RECOMMENDATIONS**

**National Workforce Planning:**

35. A national health workforce commission was established by the Affordable Care Act but never funded and therefore unable to meet as a commission. The need for a functioning national health workforce commission remains. This body will represent the multiple stakeholders and report to Congress and the Executive Branch as appropriate. The charge of this commission will be to establish a national workforce database and to develop a strategic plan to align graduate medical education policy with the needs of the country.

36. There should be established a public-private entity to allocate funding for graduate medical education positions in accordance with the national health workforce commission priorities.

37. The AAFP should regularly assess and report on the family physician workforce, including attention to GME positions, the number of family physicians, their geographic distribution, demographic information (including racial and ethnic diversity), practice patterns, and market share.

**Specialty Distribution of the Physician Workforce:**
38. The evidence for the efficiency of health systems based on robust primary care is compelling. The percentage of U.S. primary care physicians is low and falling. A 10-year national plan should target at least 40 percent of the total number of U.S. physicians to practice in true primary care specialties (Family Medicine, General Pediatrics, and General Internal Medicine). True primary care practice should be measured by the clinical practice of family physicians, general internists, and general pediatricians five years after medical school completion.

39. To support efforts to ensure health care access for all Americans, the primary care workforce needs to grow from 209,000 to approximately 261,000. Since family physicians currently make up about 38% of the primary care workforce, a conservative estimate is that an additional 21,000 family physicians are necessary to meet their share of the increased need. The annual production of new family physicians would have to increase by an average of about 65 each year, increasing from 3,500 today to 4,475 by 2025.

**Funding/New Financial Models:**

40. Funding for Title VII, Section 747 of the Public Health Service Act should be increased to support departments of family medicine. Medical schools that produce more primary care physicians should receive preferential funding.

41. The United States should increase payments to family physicians for clinical services in order to attract them to and sustain them in the new model of family medicine, and to promote improvement in health care delivery outcomes.

42. New physician payment models must be developed, tested, and implemented in order to remedy the unsustainable income gap between primary care physicians and other specialties. State and federal insurance programs should immediately undertake a series of demonstration projects in payment reform that emphasize primary care, underserved and rural practices. Care coordination fees should be developed, tested, and implemented.

43. All payers of health care services should be contributing to the costs of medical education.

44. High-quality ambulatory practice will be a major pathway to reducing overall health care expenditures. Approximately two-thirds of family medicine training takes place outside of the hospital. Two-thirds of CMS Graduate Medical Education funding should track directly to residency programs to support training in the ambulatory setting.

45. Collaborative rural training sites should be prioritized under expanded Title VII funding. Physicians trained to provide care in collaborative clinical training practices that include nursing, mental health providers, social workers and pharmacists, among others, will result in improved multi-disciplinary team-based care that is essential to delivering high quality preventive and chronic care services. Rural sites have unique challenges to developing these models, and federal funding should assist with eliminating barriers to the development of collaborative, multidisciplinary training programs.

46. Training programs that produce physicians from underrepresented minorities, or those whose graduates practice in underserved rural or urban communities should be preferentially funded.

47. National funding for graduate medical education should reflect population health needs in the United States, preferentially funding training for needed generalist physicians, particularly family physicians, with concomitantly less funding for the training of other physicians. Specifically, additional training positions will need to be funded for family medicine rather than for other specialties.

**Medical Schools:**

48. Medical school expansion must be developed in ways that target primary care practice, including rural and underserved areas. Medical school expansion without realigning incentives will add more non-primary care physicians, largely in areas where they are not needed, thereby increasing cost to the health system without improvement in population health outcomes.

49. The AAMC has formed a “Group on Regional Medical Campuses” to address issues and assess impact on the expansion of medical schools through the development of branch and regional campuses. This group is collecting reports that validate the perspective that regional campuses produce more primary care physicians.
50. As medical schools expand their class sizes, a portion of the new slots should be dedicated to students who plan to choose family medicine or other primary care careers.

51. Loan repayment programs for primary care careers should be significantly increased to eliminate medical school debt as a barrier to choice of careers in primary care. 

52. Medical schools must be funded with appropriate incentives to address the public’s physician workforce needs. Financial incentives to medical schools that consistently produce higher numbers of primary care physicians should be developed. Understanding the time it takes to adjust a teaching and training model, the incentives should be modified on a five-year needs-based model.

53. Medical schools should be encouraged to develop admissions policies that identify and recruit those students most likely to pursue careers in primary care.

54. Medical schools should develop programs that focus on the recruitment and training of underrepresented minority medical students. It is known that these students are more likely to provide a disproportionate share of health care to the growing minority and underserved populations in this country. 

55. All medical schools should manage their recruitment efforts to attract students most likely to select career paths and practice locations that will improve the current state of geographic, demographic, and specialty mal-distribution of both types and numbers of physicians across the nation.

56. All medical schools need to provide mentoring and role modeling to support medical students’ access to family medicine experiences with competent and caring family physician role models and mentors. Schools must ensure that students have quality clinical experiences in preceptorships, clerkships, and electives that showcase the full scope of family medicine.

Graduate Medical Education:

57. Graduate medical education represents the opportunity to prepare students who have selected the discipline of family medicine to deliver care that meets the needs of the communities that they will serve. The AAFP should continue its high level of support for graduate medical education in family medicine residency programs. Educational strategies should include:

- Enhancing the teaching skills of practicing physicians who work with family medicine residents and medical students, through the establishment of teaching skills' workshops and being supportive of efforts with similar goals sponsored by the other academic family medicine organizations.
- Continuing to support the activities of the Residency Program Solutions, which helps residency programs continually assess and improve the quality of their educational programs.
- Monitoring the practice locations and practice scope of graduates of family medicine residency programs to ensure that the public's needs continue to be met.
- Encouraging and recognizing innovation in training that ensures future family physicians will meet the needs of their patients in the context of their communities.

Delivery Systems:

58. The AAFP should continue development and implementation of the Patient-Centered Medical Home as defined by the Joint Principles of the Patient-Centered Medical Home.

59. Family medicine residencies should prepare family physicians for the evolving demography of the U.S. population, with special attention to using high functioning teams armed with data-driven quality improvement systems to provide continuity and access to care in order to manage the care of individuals and populations. The Patient-Centered Medical Home model should be implemented in all family medicine residency programs.

Access:

60. Community Health Centers (CHCs) are a major delivery system in rural and underserved areas of the United States that have a significant problem with access to primary care services. As the or previously uninsured are increasingly brought into the system, CHCs are likely to be critically important for health care access. If 30 million
patients are to be served by 2015, 15,585 additional family physicians will be needed. If 69 million are to be served — as some have projected — an additional 51,299 primary care physicians will be needed.\textsuperscript{30} CHCs should be increasingly utilized as teaching and training sites for physicians and funded to do so.\textsuperscript{28}

61. Strategies must be employed to improve access to health care for the 70.7 million designated as Medically Underserved Populations (MUP) and the 33.4 million people who live in geographic Health Professional Shortage Areas (HPSAs)\textsuperscript{48} Amelioration of HPSAs will require a comprehensive approach that includes training more family physicians in rural settings, expanding opportunities for students to trade medical school debt for service, expansion of the National Health Service Corps (NHSC), and improving physician payment for rural practice.

62. The AAFP supports policy that acknowledges the role of family physicians as providers of emergency medical care, especially in rural and other community hospital settings that depend upon family physicians as part of a comprehensive approach to addressing the nation's need for access to emergency care.

63. Physician compensation models for underserved practice locations (HPSAs, MUPs and Medically Underserved Areas) should be developed, tested, and implemented.

64. Primary care nurse practitioners and physician assistants should be practicing in integrated practices with primary care physician-led teams utilizing the Patient-Centered Medical Home model.\textsuperscript{49}

**Community Health Centers:**

65. In order to provide a pipeline of physicians for the nation's expanding CHC programs, the NHSC should be increased from 3 to 4 percent of physicians in the current program to provide opportunities for 6 to 12 percent of physicians.\textsuperscript{47}

66. Develop a Senior NHSC program. In addition to training new family physicians, retaining existing senior physicians and redeploying them to areas of need is an understudied strategy. This special program would retain experienced physicians who would otherwise retire, and employ them in areas of need.

67. Streamline the linkage of Graduate Medical Education (GME) funding to the development of “Educational Health Centers” in association with CHCs to ensure that higher proportions of family physicians complete training in rural and underserved sites. Family Medicine residents who train in CHCs are more likely to continue to care for underserved populations.\textsuperscript{36} The Teaching Health Center Graduate Medical Education Program funded by the Affordable Care Act in 2010 is designed to support direct payment to ambulatory organizations that sponsor new or expanded primary care residency programs. This program is limited in scope and its funding is tied to the annual federal appropriations process after the first five years.\textsuperscript{50}

68. Continue support and expansion of 1-2 Rural Training Tracks (RTT) with federal funding of these programs currently through the RTT Technical Assistance Demonstration Project.\textsuperscript{51}

**Geriatrics:**

69. Title VII funding should be expanded to encourage improved geriatrics training and care through support of Academic Departments of Geriatrics, geriatric fellowship programs, and incorporation of geriatric education throughout the training of all adult primary care providers.

70. New physician payment models for providing geriatric care under the Medicare program should be developed, tested, and implemented.

71. There should be an increased emphasis on the recruitment of a diverse student population reflecting those most likely to care for rural, underserved, and elderly populations, and who more closely resemble the racial and ethnic make-up of the U.S. population.

**International Medical Graduates**

72. International medical graduates will continue to be important contributors to the U.S. physician workforce. Care must be taken to avoid the recruitment of physicians from countries with shortages of health care providers and the
creation of a “brain drain” that will worsen the health care needs of their home countries.

73. A determined number of training positions should be available for exchange visitors who plan to return to practice in their home countries upon graduation. The national health workforce commission should study and make recommendations on this issue.35

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http://www.acponline.org/advocacy/advocacy_in_action/state_of_the_nations_healthcare/assets/statehc06_1.pdf
30. Personal communication, Jack Colwill, June 2009.
33. The Aging of the Primary Care Physician Workforce: Are Rural Locations Vulnerable? WWAMI Rural Health Policy and Research Centers, June 2009.
38. Personal communication, Stephen Petterson, March 2014. Projections are based on a 2010 study to determine 2010-2025 workforce projections. A conservative estimate is that an additional 20,000 family physicians are necessary to meet their share of the increased need. This target could increase to 21,000 family physicians, taking into account the declining number of general practitioners and their replacement by family physicians and other primary care physicians. Assuming a retirement age of 65 and an annual production of family physicians of approximately 3,500 in 2011, to increase the number of additional family physicians by 21,000, the production of new family physicians would have to increase by an average of about 65 each year, increasing from 3,500 to 4,475 by 2025.
44. Student Interest Strategies by Focus Area – Conducted by Family Medicine Organizations 2008-2009.


Previous Versions:

- Workforce Reform: Recommendations of the AAFP – September 1995 – AAFP Reprint 305a
- Workforce Reform: Recommendations of the AAFP – December 2006 – AAFP Reprint 305b
- Workforce Reform: Recommendations of the AAFP – February 2010 – AAFP Reprint 305b
- Workforce Reform: Recommendations of the AAFP – March 2014