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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) (2018 October BOD)

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. This policy is used often by family physicians providing obstetric and gynecological care and referred to by AAFP leadership when appropriate.
AAFP Definition: Certification/Maintenance of Certification

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.


**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 American Board of Medical Specialties (ABMS) describes Maintenance of Certification (MOC) as a system of ongoing professional development and practice assessment and improvement. It challenges physicians to focus on the continuous development of their skill set, especially those skills that enable them to function effectively in interprofessional teams, integrated systems of care, and community settings. The American Board of Family Medicine (ABFM) utilizes MOC to continually assess ABFM Diplomates.

ABFM's implementation of MOC, called Family Medicine Certification, has four basic components:

**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, and no sanctions imposed by entities with legal authority over the practice of medicine (e.g., U.S. Drug Enforcement Agency, Institutional Review Boards);

**Self-Assessment and Lifelong Learning**

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

**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;

**Performance Improvement**

Evidence of evaluation of performance improvement, 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) (2017 COD)
AAFP Definitions for Policy Statement, Position Paper and Discussion Paper

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)
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)
AAFP Promotions: Print Advertorials

See also

- Direct-to-Consumer Advertising of Infant Formula
- Drug Switching Notices
- Advertising: Youth Products
- Alcohol Advertising and Underage Alcohol Usage

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.

Adolescent Health Care, Confidentiality

See also

- Adolescent Health Care, Role of the Family Physician
- Adolescent Health Care, Sexuality and Contraception
- Child Abuse
- Health Education
- Health Education in Schools
- Certificates of Added Qualification

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:

- The AAFP believes that adolescents’ access to confidential healthcare is important for their health and well-being, while also recognizing the benefit of supportive parental involvement.
- 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 to health services, confidentiality must be maintained.
- The adolescent should be offered an opportunity for examination and counseling separate from parents/guardians, and the physician should encourage and assist the adolescent to involve parents or guardians in healthcare decisions.
- Physicians should deliver confidential health services in situations involving sexuality (including sexually transmitted infections, contraception, and pregnancy), substance use/abuse, and mental health to consenting adolescents.
- If communication between the adolescent and parent cannot be facilitated, every effort should be made by physicians and their staff to ensure confidentiality within the limits of legal and ethical standards.
- Adolescent 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 imminent danger, the suspicion or evidence of abuse, and the diagnosis of certain communicable diseases all must be reported to the proper authorities.
- 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 whose 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) (2018 COD)
Adolescent Health Care, Role of the Family Physician

See also

- Adolescent Health Care, Confidentiality
- Adolescent Health Care, Sexuality and Contraception
- Alcohol Advertising and Underage Alcohol Usage
- 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

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. A medical evaluation that addresses an adolescent's sexual and reproductive health should include a careful assessment for abusive or unwanted sexual encounters.
7. Family physicians must know their state laws and report cases of suspected sexual abuse to the proper authority in accordance with those laws.
8. Family physicians should also 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.
9. Adolescents receiving family planning services deserve confidential care. Family physicians should be aware of any state laws that may impact the reproductive rights of their patients. Updated state laws can be found through the Guttmacher Institute at https://www.guttmacher.org.
10. 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.
11. 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
12. 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.

(1987) (March 2019 BOD)
Advancing Health Equity: Principles to Address the Social Determinants of Health in Alternative Payment Models

As health care continues to transition to a value-based environment, there has been a growing call for the inclusion of social determinants of health (SDoH) as a criterion in advanced primary care delivery and value-based payment arrangements. Academic literature is beginning to show how significantly social determinants affect the health and well-being of patients.

The American Academy of Family Physicians (AAFP) defines SDoH as the conditions under which people are born, grow, live, work, and age. In their patient-centered practices, family physicians identify and address the SDoH for individuals and families, incorporating this information into the biopsychosocial model to promote continuous healing relationships, wholeperson orientation, family and community context, and comprehensive care. The AAFP supports the assertion that physicians need to know how to identify and address SDoH to be successful in promoting positive health outcomes for individuals and populations.¹

Opportunities to Advance Value-Based Payment and Measurement Methodologies

Research on the impact of social risk factors on health status and outcomes, coupled with the movement toward value-based payment, has created new policy opportunities and imperatives to address SDoH. While value-based payment programs often require physicians to assess and address SDoH, these models do not adjust or account for how these factors affect outcomes and performance. However, federal and state policy makers and key stakeholders are examining the issue more closely to determine how alternative payment models (APMs) can account for SDoH, and support physicians in advancing quality and patient outcomes and reducing costs.

Activity at the federal level has increased in recent years as more information on the effect of value-based payments on different patient populations and physicians emerges. Early programs, such as the Hospital Readmissions Reduction Program (HRRP), highlighted the impact of financial penalties on safety-net providers who often care for populations that have higher levels of social risk factors. In December 2016, the U.S. Department of Health and Human Services (HHS) and the Assistant Secretary for Planning and Evaluation (ASPE) released a congressionally mandated report that focused on the connections between social risk factors and performance in Medicare value-based payment programs in order to align payments with the goals of these programs.² Most recently, passage and implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) has prompted the development and testing of new APMs, underscoring the need to understand and account for the role of SDoH in physician assessment and payment. In response to new research, the Centers for Medicare & Medicaid Services (CMS) is also examining ways to account for social risk factors and reduce health disparities in its quality measurement programs.³

As more AAFP members participate in APMs, key issues for the AAFP include data on the role of social risk factors in health outcomes, the impact of such data on assessing physician performance, and policy opportunities to improve payment and measurement methodologies. The AAFP has developed five principles regarding SDoH to guide its assessment of APMs and value-based payment initiatives. These principles ensure that SDoH are appropriately accounted for in the payment and measurement design of APMs so that practices have adequate support to improve quality and outcomes for all patients, eliminate health disparities, and reduce costs for the health care system.

Principle #1: APMs should support practices’ efforts to identify and address social determinants that are shown...
to impact health outcomes.

- Payment risk-adjustment methodologies should include multiple variables representing social determinants linked to health outcomes.
- Variables included in any payment methodology should be evidence-based and demonstrably representative of SDoH.

Social determinants of health are the conditions in which people are born, grow, live, work, and age. They are shaped by the distribution of money, power, and resources at global, national, and local levels and lead to differences in health status among patients with otherwise similar demographic and physical characteristics. Social determinants of health are multifactorial, and these factors have been shown to have “marked associations with risks for different illnesses, life expectancy, and lifetime morbidity.”

The type and quantity of health care resources needed to care for patients varies according to their differences in health status. Therefore, payers use risk-adjustment methodologies to allocate financial resources to practices commensurate with the health status of their patient population. Practices incur costs to identify and address SDoH for their patient population, and some payers are beginning to incorporate variables representing SDoH into their risk-adjustment methodologies. Adjusting payments based on one or more of these variables improves payment to practices and the consequent allocation of resources to identify and address SDoH in their patient population. Models that incorporate variables representing SDoH should leverage existing data collection mechanisms to minimize new burdens on practices.

As variables representing SDoH are incorporated more systematically into payment models, reliance on any single variable as a proxy for SDoH should be discouraged. For example, one study of commercially insured children and adolescents showed that higher socioeconomic background was associated with greater levels of health care spending. Consequently, including socioeconomic information in risk-adjustment algorithms could potentially direct funds away from physicians caring for children and adolescents who are from lower socioeconomic backgrounds and are at greater risk of poor health. Risk-adjustment methodologies should allocate more resources to those most disadvantaged by SDoH.

**Principle #2: The incorporation of variables representing SDoH in APMs should be founded on evidence-based research methods.**

Practices should use additional risk-adjusted payments that account for SDoH to address health disparities in their patient population by supporting increased access, expanded population-based services, referrals, and comprehensive care.

- Evidence-based measurement of SDoH should be used by payers to provide resources to support additional services that patients with social risk may need.
- Measurement for payment adjustments should be made at a standardized geographic level, such as a census tract, census block group, or primary care service area.
- At a minimum, measurement should include the following: poverty, unemployment, household provider status, high-need age group (i.e., 17 years of age or younger; 65 years of age or older), education level, transportation, crowding, uninsured status, and race.
- Performance measurement should be risk-adjusted for SDoH when there is a clear relationship between social risk and health outcomes.

In the United States, there is a desire to use measurement of SDoH to guide the implementation of interventions at the clinic/community level and appropriate allocation of resources. This guidance may be carried out through policies or payment adjustments that support practices’ efforts to improve outcomes for patients whose social risk factors increase their risk for poor health outcomes. The HHS formed a committee to explore options for the inclusion of social risk factors in Medicare value-based payment. The committee presented five reports over 15 months and released its final report in 2017, outlining four categories that could be used individually or combined to include social risk factors in
payment methods: 

1. Stratified public reporting of quality and outcome measures
2. Adjustment of performance measure scores
3. Direct adjustment of payment
4. Restructuring of payment incentive design

Exploring the foundational aspects of these categories provides insight into the most effective methods for measuring and evaluating SDoH data to improve outcomes for patients and increase payments for clinicians. Many other nations use data to improve health outcomes at the community level. For example, the United Kingdom and New Zealand use data on material and social deprivation to create indices that measure socioeconomic variation across geographic areas and communities. The indices provide universal guidance to fundamental principles for population health, allowing the United Kingdom and New Zealand to more effectively provide services, allocate funding, guide research, and implement policy.

In the United States, efforts exist to collect and analyze SDoH data, although these data are not yet effectively integrated into policy, primary care delivery, and payment. These efforts build on work examining the geographic breakdown of health care services and population health outcomes. Prime examples of geographic stratification are Primary Care Service Areas (PCSAs) and the Public Health Disparities Geocoding Project, both of which use national data to evaluate health outcomes in the United States at a geographic level. PCSAs are based on ZIP code data and characterize utilization-based service areas that reflect the travel of Medicare beneficiaries to primary care clinics. They can be used to identify areas of health care underservice and related health outcomes. The Public Health Disparities Geocoding Project compared area-based socioeconomic measures at three different geographic levels: census block group level, census tract level, and ZIP code level. Analysis suggested that measuring “percentage of persons below poverty” at the census tract level could meaningfully augment U.S. public health surveillance systems to monitor socioeconomic inequalities in health.

One way to expand on the geographic analyses described above is to create an index that can easily be used to measure the social deprivation of specific areas. The Agency for Toxic Substances & Disease Registry’s (ATSDR’s) Social Vulnerability Index (svi.cdc.gov) and The Robert Graham Center for Policy Studies in Family Medicine and Primary Care’s Social Deprivation Index are examples of indices that, with more testing, could be valid measures to assess resource allocation in the United States. Comparison of the two indices reveals commonalities among the measures used for index development, including the following: poverty, unemployment, household provider status, high-need age group (i.e., 17 years of age or younger; 65 years of age or older), education level, transportation, crowding, uninsured status, and race. All measures suggested can be obtained from national, state, and/or local data sources and do not require additional reporting by the physician.

As noted, many efforts to measure SDoH exist in the United States, but few payers are using these data to adjust payment to practices and physicians. To date, two states—Minnesota and Massachusetts—are examining the role of SDoH in their Medicaid programs and trying to account for these factors. In 2015, Minnesota’s state legislature directed the Medicaid program to develop a payment methodology that increases payment to health care providers serving patients who have elevated social risk. Early work in the state focused on gathering qualitative information to identify which social risk factors are most predictive of poor health outcomes. A report to the Minnesota state legislature identified six social risk factors: substance use disorder, serious mental illness, housing instability, prior incarceration, deep poverty, and child protection involvement. These risk factors informed a new payment methodology. Participating practices receive a population-based per member per month payment based on the six social risk factors and a clinical/medical risk score that uses the Adjusted Clinical Groups model.

Massachusetts launched its Social Determinants of Health Model in 2016. The model uses enhanced risk adjustment to determine a per member per month payment for each participating program. Researchers in Massachusetts have found that this risk-adjustment model performs at the high end of the best-performing prospective models in Medicaid populations when used to predict cost for future years. Future work will include serious mental illness and substance use disorder measures to further increase the predictive power of the model.

These examples in Minnesota and Massachusetts show that measurement of SDoH is possible. They also show that inclusion of SDoH in payment and care delivery models presents an opportunity to increase payment to practices so that they can improve the quality of health care services to patients who have social risk factors and often experience poor outcomes. These developments underscore the opportunity to advance performance measurement and payment to address SDoH and broadly impact health disparities.

The National Quality Forum (NQF) and the National Academy of Medicine (NAM) have examined the inclusion of SDoH in performance measurement and payment methodologies. In 2015, the NQF convened a two-year trial period to examine whether performance measures should account for social risk factors to ensure fair, accurate comparisons of provider performance. According to the NQF’s final report, the trial period showed that adjusting measures for SDoH is “feasible, but challenging” and that SDoH should be included in risk adjustment of performance when there is a clear relationship between a social risk factor and a health outcome. The NAM produced a series of consensus-based reports on the issue, concluding that taking SDoH into account in quality measurement and payment design could improve quality, reduce costs, and address a range of health disparities.

Principle #3: Health information technology (HIT) platforms should facilitate SDoH data collection from medical records and other sources to support improved clinical decision making, care coordination, quality measurement, and population health management.

- Public and private payers should provide practices with relevant claims and enrollment data for use within the electronic health record (EHR).
- SDoH data should be defined, stored, and transmitted according to a defined set of standards that place minimal burden on the practice.
- Data should be accessible at the point of clinical encounter and easily integrated with other data from the EHR.
- Data should be readily transferable to other health care providers and community outreach programs.

The AAFP recognizes that practices will have to make changes to facilitate SDoH data collection. Any standards or changes that require the use of SDoH data should place minimal burden on practices. A significant amount of relevant data already exists outside the practice in various sources, such as all-payer claims databases, health plan enrollment, public social service case data, and self-reported patient data. If these “Big Data” sources are shared with practices, they have clinical utility for individual patient and population health interventions without the need for additional data capture by practices.

For data to be actionable and impactful, they must be easily accessible during the clinical encounter and within the patient record. In addition, payment models should include financial support to facilitate data collection and resource allocation to address SDoH within physician patient panels.

Patient data related to social and behavioral factors can improve clinical care and patient satisfaction, as well as being useful in research and public health initiatives. These data can support more personalized and effective clinical decision making. At the population level, information about patients’ social risk factors allows for more targeted care management and coordination programs. Payment methodologies should include standardized measures for storing and collecting all health data, including SDoH, for use in shared decision making, quality improvement, research, and population health management. Establishing the framework for a common data model that includes SDoH and using predictive analytics can potentially provide physicians with better information that leads to better patient outcomes and improved population health.

Standardized measures should be evidence-based and customizable to meet the needs of physicians and patients. In 2013, the Institute of Medicine (IOM) released an evidence-based set of core social and behavioral health domains and corresponding measures that should be included in all EHRs. The IOM and other health policy organizations continue to study and refine these measures to enhance the data available to improve health outcomes for individuals and communities. When leveraged correctly, EHRs can improve the integration of SDoH into clinical systems.
Principle #4: To minimize administrative burden on providers and patients, SDoH data should be collected by leveraging existing mechanisms.

- Variables representing SDoH in payment risk-adjustment formulas should use existing data collection infrastructure and mechanisms.
- Use of SDoH within payment models and care delivery settings should be transparent and harmonized.

Primary care physicians must comply with a daunting regulatory framework that often puts administrative burdens on them. In 2017, nearly 40% of AAFP members reported participating with 10 or more payers in the past 12 months. Standardization is not required among public or private payers, so practices are forced to learn and navigate the rules and forms of each payer. They spend countless hours reviewing documents and checking boxes to meet the requirements of health insurance plans. This time could be better spent caring for patients.

The regulatory framework for practices has driven operating costs up and reduced face time with patients. Administrative and regulatory burden is one of the top reasons independent practices close and is a leading cause of physician burnout. Despite the good intent of underlying health care policies, the burden has expanded to an untenable level and is a significant barrier to achieving the Quadruple Aim. For these reasons, the addition of SDoH to APMs should aim to decrease burden on practices and minimize any new burden.

While EHRs have the potential to collect data on SDoH for various purposes and integrate them into clinical systems, a significant amount of relevant data already exists outside the practice in various sources, such as all-payer claims databases, health plan enrollment, public social service case data, and self-reported patient data. Measures must be clearly defined and standardized for all health data before the EHR is programmed to incorporate SDoH. Thus, payers and HIT vendors are encouraged to use a consistent definition of SDoH and harmonize the variables and measures used to represent SDoH in risk-adjustment methodologies. Payers should be transparent in their incorporation of SDoH in their risk-adjustment methodologies and update them regularly or when new evidence is developed.

Principle #5: To ensure APMs improve access, quality, and health equity, practices should receive appropriate resources and support to identify, monitor, and assess SDoH.

- APMs that provide increased payment should also provide support to practices to allow for innovation in patient care delivery and beyond to meet the needs of patient populations.
- Support provided to practices may include the following:
  - Connection to EHR vendors dedicated to supporting the identification, monitoring, and assessment of SDoH
  - Access to relevant data sources outside the practice
  - Peer-to-peer collaboration, such as an online platform or in-person learning sessions
  - Training and technical assistance (TA)
  - Feedback reports and coaching on how to understand and use SDoH data to improve care delivery and health outcomes for their patient population

To adequately address the social needs tied to their patient population’s health outcomes, practices need resources and TA, in addition to increased funding. A systematic review of six primary care initiatives, which were convened by either a state entity or CMS, found that providing TA for practices had a positive effect on most outcomes; the form of assistance provided varied by outcome. The Comprehensive Primary Care Plus (CPC+) model is the first APM to provide this level of TA to help participating practices meet its increased care delivery requirements. Current CPC+ practices receive TA through national and regional learning contractors and can connect with and learn from other CPC+ practices through an online platform. Other support provided by CPC+ includes the following: web-based learning sessions; in-person learning sessions; EHR affinity groups; and regional practice coaching and facilitation.

Practices participating in CPC+ also receive feedback reports comparing their demographic, cost, and utilization data.
with data from other CPC+ practices in the region. Much of the information provided in the feedback reports is pulled from claims data. In future endeavors, APMs should continue this trend and rely on variables from extant data sources, such as claims (including all-payer claims databases, where available), health plan enrollment, public social service case data, and self-reported patient data. In addition, payers should share such data transparently with practices so the data can be integrated into the EHR to help practices identify and address SDoH in their patient population.26 By providing appropriate resources and support, APMs can help physicians and medical homes learn best practices and use data-driven approaches to meet the needs of their patient population.

References:


(April 2018 BOD)
Advertising: Youth Products

See also

- Alcohol Advertising and Underage Alcohol Usage
- 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) (2017 COD)
Aging

See Also

- Long-Term Care
- Continuity and Coordination of Care Long-Term Care Facilities
- 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) (2018 COD)
Alcohol Advertising and Underage Alcohol Usage

See also:

- Substance abuse and addiction
- Advertising: Youth Products
- Adolescent Health Care, Role of the Family Physician

The American Academy of Family Physicians (AAFP) recognizes the continued problem of underage alcohol usage, noting a direct correlation with lifetime alcohol dependence and its impact on individuals and on public health. The AAFP acknowledges alcohol advertising to youth may play a significant role in promoting underage alcohol consumption, and advocate for further research into this relationship. Specifically, the AAFP believes research should address how alcohol advertising disproportionately targets and impacts socioeconomically disadvantaged communities.

The AAFP supports the regulation of advertisements by the alcohol industry to reduce exposure to underage audiences.

Family physicians caring for and addressing the health care need of youth and adolescents should be aware of risk factors for underage alcohol consumption and alcohol-related health consequences, as well as available community-based resources and services in their region.

(2017 July BOD) (2017 COD)
Anti-Harassment Policy

The American Academy of Family Physicians is committed to providing our members, staff, and partners with an environment that is free from all forms of harassment, intimidation, hostility, or other offensive treatment. Accordingly, all members, exhibitors, vendors, customers, consultants, attendees, visitors, staff, and other representatives of the AAFP are expected to treat each other with respect and professionalism and to act within the boundaries of generally accepted social behaviors.

Harassment may take many forms. It may be, but is not limited to, verbal or written communications, physical contact, photographs, jokes, body language and gestures, and intimidation. It may be intentional or unintentional, but is unwelcome, unwanted, and harmful to the recipient and/or others.

Such inappropriate actions or comments based on age, race, color, ethnicity, religion, disability, gender (including sexual orientation and gender identification), national origin, military/veteran status, marital/partner status, parental status, or any other classification covered by state, federal and/or local laws are considered a violation of this policy and will not be tolerated.

This policy applies to all AAFP-related functions, whether held at the AAFP offices or off-site, including meetings, conventions, CME courses, networking and social events, travel to and from AAFP events, or any other function where the AAFP is represented.

Anyone who believes that he or she has observed or experienced conduct in violation of this policy should report the conduct immediately to an AAFP staff member. The AAFP will take every such report seriously, will promptly investigate it, and will take appropriate corrective action as needed while protecting confidentiality to the extent feasible. Upon request and to the extent appropriate, the complainant and any other affected party will be advised of the disposition of such a report. (January 2019 Board Chair)
Anti-Trust Policy

The American Academy of Family Physicians ("AAFP") is committed to adhering to the antitrust laws of the United States. All AAFP policies, practices and activities must comply with U.S. federal and state antitrust laws and must not unreasonably restrain trade. All meetings relating to the AAFP must be conducted in a manner that avoids the following prohibited conduct, as well as any agreement to engage in such conduct: (1) raise, lower, or stabilize prices or reimbursement rates (including costs, profits or any related items); (2) allocate, limit, or divide markets; (3) encourage boycotts; (4) foster unfair trade practices against any entity competing with AAFP or its members; (5) assist in monopolization; or (6) in any way violate federal or state antitrust laws.

Any activities of AAFP or AAFP-related actions of its officers, directors, commission chairs, members or staff that violate the antitrust laws are detrimental to the interests of AAFP and are contrary to AAFP policy. Compliance with both the letter and spirit of these laws is an important goal of AAFP and is essential to maintaining AAFP's reputation for the highest standards of ethical conduct. Notice regarding suspected violations of this policy should be directed to AAFP's General Counsel at (913) 906-6219 or to gencounsel@aafp.org. (January 2019 Board Chair)
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)
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) (2018 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 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) (2018 COD)
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
- Protective Equipment for Recreational and Competitive Sports Activities

The American Academy of Family Physicians (AAFP) encourages schools that provide an interscholastic sports program to create policies that enhance the well-being of their student athletes including:

- Emergency action planning
- The ready accessibility of automated external defibrillators to all athletic venues
- Training of coaches in first aid, cardiopulmonary resuscitation, and concussion recognition
- The utilization of board-certified athletic trainers as part of the athletic care team

The AAFP recommends state boards of education and departments of health work with the schools providing interscholastic sports programs to develop these policies and mechanisms for their implementation. (1989) (2017 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 (Policy Statement)

See Also

- Breastfeeding (Position Paper)
- Breastfeeding Accommodations for Trainees
- Maternal/Child Care (Obstetrics/Perinatal Care)
- Hospital Use of Infant Formula in Breastfeeding Infants

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) (2017 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) (2018 COD)
Breastfeeding, Family Physicians Supporting (Position Paper)

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.12

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 I 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.38, 39

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.40 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

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References


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

8. Educate mothers about the risks of unnecessary supplementation and pacifier use.  
9. Avoid the use of discharge packs containing formula samples and formula company advertising or literature.  
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.  
11. Identify breastfeeding problems in the hospital and assist the mother with these before discharge.  
12. Develop an appropriate follow-up plan for any identified problems or concerns.  
13. Provide the family with information about breastfeeding support groups in the community. 

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.  
3. Be knowledgeable about prevention and management of common breastfeeding challenges.  
4. Educate office staff on breastfeeding topics so that they can provide optimal breastfeeding triage and support.  
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. 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 often 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 antimetabolites. 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.

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 a 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 radioisotopes. 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

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https://www.aafp.org/about/policies/all/breastfeeding-support.content.pdflist.html[4/24/2019 3:01:31 PM]
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 ante partum 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. It is generally recommended that breastfeeding should be interrupted if the mother ingests most drugs of abuse, antimitabolite 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. 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. Babies who are breastfed immediately after their mother smokes demonstrate changes in their sleep and wake patterns. Breastfeeding infants who bed share with parents who smoke have a higher risk of sudden infant death syndrome (SIDS). Breastfeeding women who smoke are at risk of insufficient milk supply because of the negative effect of nicotine on prolactin levels. 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.

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.
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. Some of these chemicals may be transferred to fetuses in utero and possibly to infants postnatally 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. 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.

Women who breastfeed are concerned about chemicals in breast milk. Reporting of chemicals in breast milk may lead to early termination of breastfeeding. 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.

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.

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, 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 the U.S. government website.

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

https://www.aafp.org/about/policies/all/breastfeeding-support.content.pdflist.html
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.

Mother’s milk can be stored safely for longer periods than were previously recommended. 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.

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. 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 indicated 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.

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. 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. It is also important to supplement pregnant women so that babies are born with sufficient vitamin D levels.
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

https://www.aafp.org/about/policies/all/breastfeeding-support.content.pdflist.html
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.
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. 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. 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. 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.

Approval and support of breastfeeding by the father is associated strongly with the decision to breastfeed. 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. 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.

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. 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.

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 breastfeeding. 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.\textsuperscript{109}

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.\textsuperscript{109} Since teenage mothers living with their own mothers may be at especially high risk of early weaning,\textsuperscript{110} 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.\textsuperscript{111}

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.\textsuperscript{112}

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.\textsuperscript{113} 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.\textsuperscript{114, 115} 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.\textsuperscript{116} 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.\textsuperscript{117} 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.\textsuperscript{113}

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.\textsuperscript{56}

**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.

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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.

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. 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. Lack of breastfeeding is a significant risk to the public health of our nation and increases health care spending.

In order to establish and maintain breastfeeding, women need education and support from a knowledgeable health care community. Evidence-based knowledge, skills, and attitudes are lacking among health professionals in many disciplines. 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.

**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 postgraduate curricula of health professionals. 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) and the Agency for Healthcare Research and Quality (AHRQ).

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. 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
- Enhancing health and reducing:
  - long-term morbidities in infants and young children
  - morbidities in women
- 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
  - Following up with the family, when appropriate, in a culturally competent manner after breastfeeding care and services have been provided

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\(^39\)
2.3 seek assistance from and refer to appropriate lactation specialists\(^26, 28\)
2.4 safeguard privacy and confidentiality\(^40\)
2.5 effectively use new information technologies to obtain current evidence-based information about breastfeeding and human lactation\(^26, 41\)

**Attitudes**

All health professionals should:

3.1 value breastfeeding as an important health promotion and disease prevention strategy\(^34, 42\)
3.2 recognize and respect philosophical, cultural, and ethical perspectives influencing the use and delivery of breastfeeding care and services\(^22, 26\)
3.3 respect the confidential nature of the provision of breastfeeding care and services\(^40\)
3.4 recognize the importance of delivering breastfeeding care and services that are free of commercial conflict of interest or personal bias\(^26, 27, 38\)
3.5 understand the importance of tailoring information and services to the family’s culture, knowledge, and language level\(^22, 43\)
3.6 seek coordination and collaboration with interdisciplinary teams of health professionals\(^21\)
3.7 recognize the limitations of their own lactation knowledge and breastfeeding expertise\(^21\)
3.8 recognize when personal values and biases may affect or interfere with breastfeeding care and services provided to families\(^13\)
3.9 encourage workplace support for breastfeeding\(^44\)
3.10 support breastfeeding colleagues\(^45-47\)
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
- 5.4 recognize normal and abnormal infant feeding patterns
- 5.5 develop and appropriately communicate a breastfeeding care plan

References

37. World Health Organization UNICEF, Protecting, Promoting, and Supporting Breast-feeding: The Special Role of Maternity
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/breastfeeding

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.

The National Women’s Health Information Center

www.womenshealth.gov/breastfeeding

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


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](www.surgeongeneral.gov/library/calls/breastfeeding)

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
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 same title
La Leche League International
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.ibcle.org
The internationally recognized certifying agency for lactation consultants.

International Lactation Consultants Association
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
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
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
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

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 International Code of Marketing of Breast-milk Substitutes.

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

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

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)

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/uspshrfd.htm
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
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:

- WHO Growth Charts and Centers for Disease Control and Prevention (CDC) Growth Charts

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)
Cancer Care

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, credentialling, 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 telemedicine, 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)
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 I – 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 obstetrics subspecialists. 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 II – Training Methodology

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. Data indicate that many family physicians have achieved proficiency in operative delivery during residency, preparing them to perform cesarean delivery in various practice settings. 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.

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. 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. Another possible route to the acquisition of cesarean delivery skills is preceptorship by a family physician, an obstetrics subspecialist, 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. 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. 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. 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. 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. In addition, because cesarean delivery is an abdominal surgery, experience with other abdominal procedures is helpful for skill development.

Section III – 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.

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. 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.  

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.” 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 IV – 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:

“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 [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.”

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.”

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:

- Number of procedures performed during training and in practice
- Outcomes data (see suggested items in Table A3)
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.64 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.47,48,49 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.50 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 V – Miscellaneous Issues

A. 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.

B. 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,51,52 expanding and improving cesarean delivery skills could improve access to modern perinatal care for many patient populations.53,54 There is extensive literature that documents better birth outcomes when local maternity care services are available.55,56,57,58 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.59,60

C. 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

- 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.

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

- See the AAFP’s clinical practice guideline Planning for Labor and Vaginal Birth After Cesarean for additional information.61

D. Relationships 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.62,63 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 elsewhere64) should be encouraged.
Section VI – References


44. Joint Commission on Accreditation of Healthcare Organizations. 2015 Hospital Accreditation Standards. Oakbrook Terrace, IL: Joint Commission on Accreditation of Health Care Organizations; 2015.


Appendix

Table A1: Complications of Cesarean Delivery

<table>
<thead>
<tr>
<th>Complication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury to maternal bladder</td>
</tr>
<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>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preterm pregnancy</td>
</tr>
<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>Data Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient identification or code</td>
</tr>
<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

Chelation therapy is appropriate for cases of heavy metal intoxication, when diagnosed using validated testing in appropriate biological samples. Its use for other problems, such as atherosclerotic vascular or neuro-degenerative disease, remains investigational and should not be recommended. (2018 July BOD) (2018 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 includes physical and emotional maltreatment, sexual abuse, and neglect. It is a complex problem that can lead to negative physical and emotional health outcomes. Prevention, recognition, and treatment of child abuse requires a multi-disciplinary approach involving behavioral, environmental, and educational interventions. Since family physicians care for the entire family, they are in a unique position to recognize and help prevent child abuse, as well as take measures to treat victims of child abuse and their families.

Family physicians should provide information about child development, stages that can be stressful, and guidance about appropriate discipline techniques.

Family physicians should be able to recognize the signs and symptoms of child abuse and must report suspected abuse to the proper authorities. Family physicians should be aware of the resources available in their communities for children and families who require additional support. When child abuse is detected, family preservation is preferred, but the child's safety and well-being is the most important consideration. (1987) (March 2019 BOD)
Children's Health

See also

- Child Abuse
- Advertising: Youth Products
- Maternal/Child Care (Obstetrics/Perinatal Care)
- Female Genital Mutilation
- Parental Leave During Residency Training

The AAFP promotes and supports a safe and nurturing environment for all children that includes access to comprehensive medical, dental and mental health care, psychological and legal security and does not discriminate on the basis of adoption, foster care, religion, sexual orientation, or gender identity. (2002) (2017 COD)
Chronic Pain Management and Opioid Misuse: A Public Health Concern (Position Paper)

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-waived 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. On the basis of limited data, the U.S. Food and Drug Administration (FDA) —using varying degrees of scrutiny—approved many of the current extended-release opioids. The result was a false sense of security in the physician community about the efficacy and safety of these medications to address the growing issue of 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. 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.

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. Sales of prescriptions opioids quadrupled between 1999 and 2014. 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. Family physicians have played a role in this rising trend; primary care providers are responsible for about half of the opioid pain relievers dispensed.

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. In primary care settings, one in four people who receive prescription opioids chronically for noncancer pain struggles with opioid dependence. Every day, more than 1,000 people are treated in emergency departments for misusing prescription opioids. Concurrently, some of the challenges associated with obtaining prescription opioids,
as well as cost issues, have led to a rise in heroin use.\textsuperscript{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\%).\textsuperscript{23} The ultimate source remains prescribed medications. At least half of all U.S. opioid overdose deaths involve a prescription opioid.\textsuperscript{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.\textsuperscript{24} Other risk factors include concomitant use of multiple prescribed and illicit substances (especially benzodiazepines),\textsuperscript{25, 26} nicotine use, higher prescribed dosages, inappropriate prescribing procedures, methadone use, and having a history of substance abuse.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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,\textsuperscript{30} urine drug screening, standardized pain scales, and prescription drug monitoring databases.\textsuperscript{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.\textsuperscript{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.”\textsuperscript{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.\textsuperscript{34} 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 \textit{CDC Guideline for Prescribing Opioids for Chronic Pain--United States, 2016,}\textsuperscript{35} 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.\textsuperscript{35} 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.\textsuperscript{36, 37}

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 benzo diazepine 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 Treatment Act of 2000 (DATA 2000), medications for the treatment of substance abuse were available only via federally approved opioid treatment programs (OTPs). In these programs, personnel specifically trained in addiction medicine dispense certain Schedule II medications (methadone and levo-alpha-acetylmethadol [LAAM]) on a daily basis. With passage of DATA 2000, qualified physicians can now get a waiver to prescribe or dispense approved Schedule III, IV, or V medications for the treatment of opioid dependence outside of an OTP.

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) 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.53

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.54 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.54

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.55 In conjunction with the Association of Departments of Family Medicine (ADFM), 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.56 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.57

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,58 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.\(^{39}\) 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](iprcc.nih.gov), 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.\(^{59}\) 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](https://www.aafp.org/about/policies/all/pain-management-opioid.content.pdflist.html). 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

12. Public policy statement on the rights and responsibilities of health care professionals in the use of opioids for the treatment of...


(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) (2017 COD)

See also

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

Health care literature is replete with studies documenting the occurrence of clinical errors in hospital and office based medical practice. 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 an error and in ameliorating liability costs. 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:


Brunken JD. Disclosing adverse events: 3 steps physicians should take. Med Econ. 2016 Jan 10;93(1):53.


Gaskill JR. Disclosing medical mistakes: a communication management plan for physicians. Perm J. 2013 Fall;17(4):94. Full text available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3854818/


Lambert BL, Centomani NM, Smith KM, Helmchen LA, Bhaumik DK, Jalundhwala YJ,


(March Board 2006) (2017 COD)
Clinical Practice Guidelines

The American Academy of Family Physicians (AAFP) advocates for the development and use of patient-centered, evidence-based clinical practice guidelines that adhere to principles based on the National Academy of Medicine Standards for Trustworthy Guidelines. Furthermore, the AAFP may participate with other medical organizations in the development of clinical practice guidelines when the appropriate criteria are met.

Clinical Practice Guidelines:

- Should be informed by an independent systematic review of the evidence and provide an adequate assessment of the benefits and harms.
- Should follow a rigorous and evidence-based methodology with the strength of evidence for each recommendation explicitly stated.
- Should follow a sound, transparent methodology with limited potential for financial and intellectual bias.
- Should be feasible, measurable and achievable.
- Should be patient-centered, ideally with a patient or patient representative assisting with development of the guideline.
- When determining who should provide care, should emphasize appropriate specific competencies rather than a clinician’s specialty designation.
- Should undergo an external review that includes the relevant stakeholders.
- Should include a process for review and updating to maintain currency.

Clinical practice guidelines serve as a framework to provide guidance for clinical decisions and evidence-based best practices, but cannot substitute for the individual clinical judgment brought to each clinical situation by the patient’s family physician.

Clinical practice guidelines should reflect the best understanding of the science of medicine at the time of publication, but should be used with the clear understanding that continued research may result in new knowledge and changes to the recommendations.

To be effective, clinical practice guideline recommendations must be implemented. When implemented in the clinical setting, clinicians should prioritize those recommendations that have the strongest supporting evidence and the greatest impact on the patient population’s morbidity and mortality. Clinical performance measures may be developed from clinical practice guidelines and used in quality improvement initiatives. Research should be conducted on how to effectively implement clinical practice guidelines and the impact of their use as quality measures. (1995) (2018 COD)
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 should also 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 one 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. 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 will work in association with the Federation of State Medical Boards (FSMB) in its support of lifelong learning for family physicians. State licensure is currently mandatory, has minimal standards, and aligns state board missions with public protection and safety. The AAFP supports the FSMB Maintenance of Licensure (MOL) framework and supports CME as a required component of relicensure and/or MOL.

The AAFP does not support mandated topic specific CME for relicensure and/or MOL. The AAFP believes that physicians should select and engage in CME based on their own needs and professional practice gaps.

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.

(1977) (2018 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 ratio of learners who plan and/or demonstrate implementation of a meaningful change in their practices. (2010 COD) (2017 COD)
CME Requirements

CME REQUIREMENTS AND OPTIONS FOR MEMBERS

Continuing medical education (CME) is a cornerstone of the American Academy of Family Physicians (AAFP), and has been a requirement for continuing membership since the founding of the AAFP in 1947. CME for the family physician is emphasized because the responsibility for providing comprehensive and continuing health care to patients carries with it the responsibility to continue learning. The need to keep abreast of the rapid expansion of medical knowledge necessitates CME.

TYPES OF CME ACTIVITIES

Members may earn CME credit via a wide range of educational opportunities, in both formal and informal categories. Formal CME includes CME activities that have been certified by the AAFP for Prescribed or Elective credit. Informal CME includes self-directed learning activities that are not certified for credit. Options and limitations are summarized in the following table. Additional detail on each of the items follows.

Formal CME:

<table>
<thead>
<tr>
<th>Activity Type</th>
<th>Credit Designation Possible</th>
<th>Credit Maximum per Re-Election Cycle</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAFP Certified CME Activities in the following formats:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live (Group)</td>
<td>Prescribed</td>
<td>Elective</td>
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<tr>
<td>Enduring Material</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medical Journals</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Performance Improvement</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Point of Care</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>American Medical Association PRA Category 1 Credit™</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>American Osteopathic Association Certified</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>College of Family Physicians of Canada Mainpro Certified Credit</td>
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<td></td>
</tr>
</tbody>
</table>

Formal CME Definitions:

**Live Activities** take place in real time, involving two or more physicians. These activities provide the opportunity for real-time interaction between learners and faculty.

**Enduring Material** activities are based on independent learning materials designed primarily as self-study activities. These independent learning materials must, in themselves, constitute a planned CME activity.

**Medical Journals** are a regularly published collection of articles intended for medical professionals. The participant reads an article, engages in a self-directed phase stipulated by the CME provider that may include reflection, discussion, or debate about the article, and completes a pre-determined set of questions or tasks related to the article content.

**Performance Improvement (PI)** CME activities are structured long-term processes, by which physicians learn about specific performance measures, retrospectively assess their practice, apply performance measures prospectively over a useful interval, and reevaluate their performance. Five Prescribed credits may be awarded for the completion of each of the three stages, and participants must begin with Stage A. Physicians completing, in sequence, all three stages of a
structured PI activity may receive an additional five AAFP Prescribed credits, for a maximum of twenty credits.

**Point of Care** is practice-based learning that takes place in support of specific patient care. The physician uses a computer-based clinical decision-making support tool at the point of care to ask a clinical question, search evidence-based sources for practice recommendations, and apply a recommendation appropriately to the patient. Even in cases when the evidence-based recommendation is not appropriate for the patient, the physician still learns something in the process.

**AMA PRA Category 1 Credit™** -- Educational activities that have been approved as AMA Category 1 Credit™ for the American Medical Association Physician’s Recognition Award and that have not been certified for AAFP Prescribed credit may be self-reported by members as AMA Category 1 Credit™. This counts toward re-election as AAFP Elective credit.

**AOA CME** -- Educational activities that have been approved for credit by the American Osteopathic Association (AOA) and that have not been certified for AAFP Prescribed credit may be self-reported by members as AOA credit. This counts toward re-election as AAFP Elective credit.

**CFPC Activities** -- Activities approved by the College of Family Physicians of Canada (CFPC) for Mainpro+ CME credit and that have not been certified for AAFP Prescribed credit may be self-reported by members as AAFP Prescribed credit.

**Informal CME:**

<table>
<thead>
<tr>
<th>Self-directed Learning Activities</th>
<th>Prescribed</th>
<th>Elective</th>
<th>Credit Maximum Per Re-Election Cycle</th>
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</thead>
<tbody>
<tr>
<td>ABFM or AOA Certification</td>
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<td>25</td>
</tr>
<tr>
<td>Advanced Training</td>
<td></td>
<td>X</td>
<td>25</td>
</tr>
<tr>
<td>Teaching</td>
<td></td>
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<td>25</td>
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<tr>
<td>Scholarly Activities</td>
<td>X</td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Professional Enrichment</td>
<td></td>
<td>X</td>
<td>25</td>
</tr>
</tbody>
</table>

**Informal CME Definitions:**

ABFM or AOA Certification -- Credit may be claimed for the certification or recertification examination through the American Board of Family Medicine (ABFM) or the American Osteopathic Association (AOA).

**Advanced Training** -- Credit may be claimed for the completion of a medically-related master’s degree or a fellowship/mini-fellowship program beyond Family Medicine residency training.

**Teaching** -- Credit may be claimed for instruction of health professions learners in formal individual (e.g., preceptorships) or live educational formats.

**Scholarly Activities** – Credit may be claimed for the following types of scholarly activities:

- Publishing original scientific or socioeconomic research pertaining to patient care, public or community health, published in a state or national peer-reviewed Medline indexed journal.
- Participation in clinical research studies (participation in research studies conducted by pharmaceutical companies, device manufacturers, or other proprietary entities or in industry sponsored drug trials does not qualify)
- Scientific paper preparation and publication
- Scientific exhibit preparation and presentation
- Peer review of manuscripts for journals (journal must be listed in Medline)
- Test item writing for the NBME, ABMS member board or for peer-reviewed, published, self-assessment educational activities from a national medical specialty society.
**Professional Enrichment** – Credit may be claimed, commensurate with participation, for partaking in other medical educational experiences and activities, such as independent exam preparation and informal self-learning activities. These activities may or may not be documented, and are not certified by the AAFP, AMA, AOA, but are of a nature of professional enrichment to the family physician.

**Activities Ineligible for Credit:**

The following learning activities are not eligible for AAFP CME credit:

- CME activities produced by a commercial interest, i.e., any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients. This does not include providers of clinical service directly to patients.
- Enduring materials with expired term of approval.
- Activities on therapies determined by the COCPD as dangerous or proven ineffective.

**Appendix to CME Requirement for Members**

**GENERAL CME REQUIREMENTS**

(Established by the Commission on Membership and Member Services)

- Active members must complete 150 credits of CME every three years. Of these:
  
  A. A minimum of 25 credits must be obtained from live learning activities*, AND
  
  B. A minimum of 75 must be Prescribed credit. The remaining credits may be Prescribed, Elective, or a combination of both.

  *An exemption to the 25 live activity credits will be allowed for AAFP Active members who submit evidence that they are providing medical care in a missionary/charitable practice setting in an overseas practice for more than a 12-month period.

- Each AAFP Constituent Chapter has the option of requiring its members to obtain a portion of their CME credit from that chapter's produced or approved activities. In such case, no more than 25 credits may be required from these activities. It is the responsibility of each chapter to inform the CME Credit Systems and Compliance Department which activities should be designated in the CME database as chapter-approved.

**CME CREDIT SYSTEM ELIGIBILITY REQUIREMENTS**

(Definitions established by the Commission on Continuing Professional Development)

**Activity Level**


The CME activity must be relevant to the scope of family medicine.

**PRESCRIBED:**

The CME activity must be primarily designed for physicians and have an AAFP Active or Life member directly involved in the planning of the activity to ensure the relevance of the content to the specialty of family medicine.

**ELECTIVE:**
The CME activity may be primarily designed for health care professionals other than physicians. Direct involvement of an AAFP Active or Life member in the planning of the activity is not required.

Content Level

All clinical content presented in the activity must be evidence-based and/or customary and generally accepted (CGA) medical practice, OR, if some or all of the clinical content within the activity appears to be neither evidence-based or CGA, it must not appear to the COCPD to be dangerous or ineffective. In this case, content must offer a balanced explanation of potential benefits and risks, AND be presented in a manner that is intended to inform the physician, rather than train the physician in the practical application of the content.

The provider must also demonstrate that at least 50% of the educational content meets one or more of the following criteria:

1. The activity content has a direct bearing on patient care.

2. The activity content is related to selected non-clinical topic(s) that support the physician's professional role in patient care, including, but not limited to the following:
   (a) Medical ethics
   (b) Medico-legal
   (c) Patient-centered advocacy
   (d) Physician-patient relations
   (e) Professional and/or academic leadership
   (f) Teaching and faculty development

3. The activity content has a direct bearing on family physicians' ability to deliver patient care. These topics include, but are not limited to, the following:
   (a) Health care system/practice management
   (b) Laboratory regulations
   (c) Utilization review techniques/quality assurance

The Commission on Continuing Professional Development (COCPD) is charged with exercising its professional judgment in the interpretation and application of the AAFP CME Credit System Eligibility Requirements in order to ensure that AAFP CME credit is awarded to activities that are appropriate for AAFP members. The COCPD has the authority to deny any activity or portion of activity that does not appear to align with the intentions of the requirements.

(September 2015 BOD)
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 antitrust 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

- 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

Colonoscopy is an indispensable part of modern medical practice and one of the most commonly used invasive medical procedures. It is essential in diagnosing a variety of conditions, but it is most commonly used in the prevention and detection of colorectal cancer, the third most common cancer in men and women in the United States. Of cancers that affect both men and women, colorectal cancer is the second leading cause of cancer mortality in the United States, causing approximately 50,000 deaths each year. Colonoscopy screening is associated with a reduced risk of colorectal cancer mortality.

Gastrointestinal complaints are often first reported to a family physician. Since family physicians are trained to diagnose, treat, and, if necessary, appropriately refer patients who have gastrointestinal (GI) disorders, knowing when colonoscopy is required is one aspect of a family physician’s role. Like other endoscopic procedures, colonoscopy has become “despecialized” in recent years and is now performed by physicians in many specialties.

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 perform colonoscopy improves patients’ access to care. 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. Patients also benefit from more rapid diagnosis and treatment, and enhanced continuity of care.

Section I - Scope of Practice for Family Physicians

Colonoscopy can be a natural extension of the comprehensive care provided by a family physician. According to the American Academy of Family Physicians (AAFP) Member Census (as of December 31, 2017), 2 percent of AAFP members perform colonoscopy in their practice. Family physicians choose a personal scope of practice based on factors that include their training experiences, their practice interests, and the needs of their patient populations. Therefore, each family physician must assess the appropriateness of performing colonoscopy in his or her practice. The physician should consider his or her training and level of comfort with the procedure, the expertise of staff members, the set-up of the office, local standards of care, economic implications, and privileging requirements.

Adenoma detection rate (ADR), which is defined as the proportion of a physician’s screening colonoscopies that detect one or more adenomas, is the primary quality measure in colonoscopy. The American Society for Gastrointestinal Endoscopy (ASGE)/American College of Gastroenterology (ACG) Task Force on Quality in Endoscopy recommends a minimum ADR target of 25% or greater in a population of men and women 50 years or older who are undergoing screening colonoscopy. The recommended ADR target is 30% or greater for screening colonoscopy in men 50 years or older and 20% or greater for screening colonoscopy in women 50 years or older. Studies have shown that trained primary care physicians who perform colonoscopy can meet established quality targets and perform the procedure safely and effectively. For example, in a 2015 study, family physicians performing colonoscopy had an ADR of 38.15% for men older than 50 years and 25.96% for women older than 50 years. In addition, studies have shown that primary care physicians who perform colonoscopy compare favorably with gastroenterologists and general surgeons when other observable factors, such as cecal intubation rate, the time required to complete the procedure, and the rate of complications, are used to determine technical competence.
Both limited capacity for endoscopy and an insufficient number of physicians who perform colonoscopy contribute to suboptimal colorectal cancer screening rates, particularly in underserved populations. Geographic proximity (travel time to or physical distance from a health care provider) has also been identified as a barrier to colorectal cancer screening and a cause of poorer outcomes for patients in rural areas. The quality, safety, and efficacy indicators for colonoscopies performed by primary care physicians meet or exceed the benchmarks established by the ASGE/ACG Task Force on Quality in Endoscopy and compare favorably with subspecialists. Therefore, increasing the number of trained family physicians who perform colonoscopy has the potential to improve colorectal cancer screening rates and access to care, and to reduce both colorectal cancer incidence and later-stage diagnosis. Benefits to the patient of having his or her family physician perform a colonoscopy include less fragmentation of care; increased patient comfort in having the procedure done by a familiar, trusted physician; decreased travel time; decreased cost to the patient; fewer lab tests; and high patient satisfaction.

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 and outpatient clinical settings. In order to continue providing this care, rural hospitals and outpatient clinical settings need physicians who can perform colonoscopy. The presence of family physicians who can provide modern endoscopic care may be one key factor in the survival of small hospitals and outpatient clinical settings.

Section II - Clinical Indications

Colonoscopy is the most commonly used colorectal cancer screening test in the United States. The U.S. Preventive Services Task Force (USPSTF) recommends screening adults for colorectal cancer starting at age 50 years and continuing until age 75 years. This recommendation applies to individuals who are at average risk of colorectal cancer and who do not have a family history of known genetic disorders that predispose them to a high lifetime risk of colorectal cancer (such as Lynch syndrome or familial adenomatous polyposis), a personal history of inflammatory bowel disease, a previous adenomatous polyp, or previous colorectal cancer. The USPSTF does not recommend specific screening approaches, instead providing information about the effectiveness, strengths, limitations, and considerations for various screening tests, including colonoscopy, so that physicians can make informed decisions with individual patients.

The AAFP’s clinical preventive service recommendation for colorectal cancer screening in adults’ states: “The AAFP recommends screening for colorectal cancer with fecal immunochemical tests, flexible sigmoidoscopy, or colonoscopy starting at age 50 years and continuing until age 75 years. The risks, benefits, and strength of supporting evidence of different screening methods vary.” The American Gastroenterological Association (AGA) advises that individuals at average risk for colorectal cancer who undergo screening colonoscopy should have the exam every 10 years, beginning at age 50 years and continuing until age 75 years. Patients at higher risk may need more frequent screening.

The list of indications for GI endoscopy from the American Society for Gastrointestinal Endoscopy includes specific indications for colonoscopy (Table 1).

Table 1. ASGE Guidelines for GI Endoscopy and for Colonoscopy

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.

Colonoscopy

Colonoscopy is generally indicated in the following circumstances:

A. Evaluation of an abnormality on barium enema or other imaging study that is likely to be clinically significant, such as a filling defect and stricture.

B. Evaluation of unexplained GI bleeding:
   1. Hematochezia.
   2. Melena after an upper GI source has been excluded.
   3. Presence of fecal occult blood.

C. Unexplained iron deficiency anemia.

D. Screening and surveillance for colonic neoplasia:
   1. Screening of asymptomatic, average-risk patients for colonic neoplasia.
   2. Examination to evaluate the entire colon for synchronous cancer or neoplastic polyps in a patient with treatable cancer or neoplastic polyp.
   3. Colonoscopy to remove synchronous neoplastic lesions at or around the time of curative resection of cancer followed by colonoscopy at 1 year and, if normal, then 3 years, and, if normal, then 5 years thereafter to detect metachronous cancer.
   4. Surveillance of patients with neoplastic polyps.
   5. Surveillance of patients with a significant family history of colorectal neoplasia.

E. For dysplasia and cancer surveillance in select patients with long-standing ulcerative or Crohn's colitis. For evaluation of patients with chronic inflammatory bowel disease of the colon, if more precise diagnosis or determination of the extent of activity of disease will influence management.

F. Clinically significant diarrhea of unexplained origin.

G. Intraoperative identification of a lesion not apparent at surgery (e.g., polypectomy site, location of a bleeding site).

H. Treatment of bleeding from such lesions as vascular malformation, ulceration, neoplasia, and polypectomy site.

I. Intraoperative evaluation of anastomotic reconstructions typical of surgery to treat diseases of the colon and rectum (e.g., evaluation for anastomotic leak and patency, bleeding, pouch formation).

J. As an adjunct to minimally invasive surgery for the treatment of diseases of the colon and rectum.
K. Management or evaluation of operative complications (e.g., dilation of anastomotic strictures).
L. Foreign body removal.
M. Excision or ablation of lesions.
N. Decompression of acute megacolon or sigmoid volvulus.
O. Balloon dilation of stenotic lesions (e.g., anastomotic strictures).
P. Palliative treatment of stenosing or bleeding neoplasms (e.g., laser, electrocoagulation, stenting).
Q. Marking a neoplasm for localization.

Colonoscopy is generally not indicated in the following circumstances:

A. Chronic, stable, irritable bowel syndrome or chronic abdominal pain; there are unusual exceptions in which colonoscopy may be done once to rule out disease, especially if symptoms are unresponsive to therapy.
B. Acute diarrhea.
C. Metastatic adenocarcinoma of unknown primary site in the absence of colonic signs or symptoms when it will not influence management.
D. Routine follow-up of inflammatory bowel disease (except for cancer surveillance in chronic ulcerative colitis and Crohn's colitis).
E. GI bleeding or melena with a demonstrated upper GI source.

Colonoscopy is generally contraindicated in:

A. Fulminant colitis.
B. Documented acute diverticulitis.


Section III - Training Methodology

Family physicians most often acquire skills for performing colonoscopy during their family medicine residency training. The Society of Teachers of Family Medicine (STFM) Group on Hospital Medicine and Procedural Training includes colonoscopy on its list of core procedures for family medicine that all residents must have exposure to and be given the opportunity to be trained to perform independently by graduation. A task force of Council of Academic Family Medicine (CAFM) member organizations and experienced faculty and program directors published a consensus statement for procedural training in family medicine residency that includes colonoscopy as one of the more complex or advanced procedures for which training may be offered to interested residents in some family medicine residencies.

The AAFP believes that adequate training can consist of documented education in an Accreditation Council for Graduate Medical Education (ACGME)-approved residency program that prepares residents to practice colonoscopy; continuing medical education (CME) courses that provide didactic and procedural training; and/or precepted experience focused on colonoscopy.

Any training approach should develop both the cognitive skills involved in knowing when to perform colonoscopy and how to properly interpret and manage findings, and the technical skills involved in safely performing the procedure. Colonoscopy training should also address how to recognize and promptly treat procedure-related complications (Table 2).
Table 2. Possible Complications of Colonoscopy

- Bleeding
- Perforation
- Respiratory depression
- Bradycardia
- Hypoxemia
- Hypotension
- Cardiac arrhythmias or ischemia
- Transient bacteremia
- Postpolypectomy electrocoagulation syndrome
- Bloating
- Abdominal pain or discomfort


Because of the use of intravenous (IV) conscious sedation, Advanced Cardiac Life Support (ACLS) training and certification may be required by hospitals or outpatient clinical settings for colonoscopy privileging. Even if ACLS certification is not required, it is recommended so that the physician performing a colonoscopy is prepared for an anesthetic or cardiopulmonary complication.

Section IV – Testing, Demonstrated Proficiency, and Documentation

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. It is clear that individual physicians have varying levels of manual dexterity and prior experience with flexible sigmoidoscopy and acquire skills at different rates.

Based on its review of available evidence, the AAFP has determined that the standard for determining a family physician’s basic competence in colonoscopy should be 50 procedures performed as the primary operator.29-31 The American Association for Primary Care Endoscopy (AAPCE) concurs, stating that if a hospital or outpatient clinical setting chooses to require a specific number of procedures during training, the requirement should not exceed 50 colonoscopies.32 The amount of continuing colonoscopy experience needed to maintain proficiency has not been extensively studied.

The AAFP recommends that family physicians document all significant procedural skills training and experience so that this information can be reported in an organized fashion.33 This includes keeping a record of the procedure note for each patient (Table 3), a record of colonoscopy experience and training (Table 4), and an evaluation of competence or recommendation from a residency program or faculty instructor(s).

Table 3. Suggested Content of Procedure Note

- Patient identification or code
- Date of procedure
- Location of procedure (name of hospital or outpatient clinical setting)
- 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 4. Suggested Documentation of Colonoscopy Experience

Number of procedures performed during training and in practice
Outcomes data, including complication rate
Letters from instructors, preceptors, and proctors documenting training, experience, demonstrated abilities, and current competence
Letters from hospitals and outpatient clinical settings documenting experience and outcomes

Section V - Credentialing and Privileges

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. 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. It is the position of the 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. The AAFP has a policy that specifically addresses colonoscopy privileging.

The AAFP’s position is in line with the policies of other organizations with influence on credentialing and privileging:

- The American Medical Association (AMA) policy on patient protection and clinical privileges states, in part, “Concerning the granting of staff and clinical privileges in hospitals and other health care facilities, the AMA believes: (1) the best interests of patients should be the predominant consideration; (2) the accordance and delineation of privileges should be determined on an individual basis, commensurate with an applicant's education, training, experience, and demonstrated current competence. In implementing these criteria, each facility should formulate and apply reasonable, nondiscriminatory standards for the evaluation of an applicant's credentials, free of anticompetitive intent or purpose.”
- The Joint Commission's standards also require that the decision to grant or deny privileges, and/or to renew existing privileges, must be an objective, evidence-based process in which there are no barriers to granting privileges for a given activity to more than one clinical specialty. The Joint Commission Comprehensive Accreditation and Certification Manual for 2017 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” [MS.06.01.03]. All of the criteria regarding licensure, education, training, and current competence should be "consistently evaluated for all practitioners holding that privilege” [MS.06.01.05].

Lack of community need may be cited as a reason to withhold colonoscopy privileges from family physicians who practice in environments shared with subspecialists. However, this approach is not consistent with AAFP, AMA, or Joint Commission privileging policies.

Family physicians moving to a new practice site who plan on performing colonoscopy would benefit from researching the policies and procedures of their chosen site regarding privileges for colonoscopy 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 colonoscopy privileges in an environment in which gastroenterologists alone hold such privileges.

Table 5 lists recommended steps for family physicians applying for GI endoscopy privileges. Privileges for invasive procedures are usually granted provisionally with the requirement that the physician submit progress reports at designated intervals (e.g., three months, six months, one year). In a hospital departmentalized by specialty, the family medicine department should monitor these progress reports for department members and make recommendations for advancement from provisional privileges to active privileges. To ensure continuous monitoring of quality, physicians may be required to submit an annual census of all invasive procedures that lists any complications that arise.
Table 5. Applying for GI Endoscopy Privileges

1. Become thoroughly familiar with the hospital or outpatient clinical setting’s bylaws and processes related to credentialing and privileging. Be cooperative yet persistent during the privileging process.
2. Review the privileging resources available from the AAFP.
3. Prepare a brief curriculum vitae (CV) that describes educational background, including college, medical school, residency, board certification, and recertification. List affiliations with hospitals, outpatient clinical settings, and state/national medical societies, including the duration of these affiliations. List any professional honors, elected offices, or committee chair positions.
4. State the number of years in practice and describe provision of high-quality care for a variety of complicated cases. A physician can point to a record of exemplary service as evidence of professional excellence.
5. Describe all completed CME courses on GI endoscopy and GI-related self-study (e.g., atlases, articles). In addition, be able to demonstrate an ongoing commitment to relevant continuing medical education.
6. Obtain and include a summary letter from a residency or AAFP chapter stating that the requested privileges are within the scope of the specialty of family medicine.
7. State the number of rigid sigmoidoscopies, flexible sigmoidoscopies, colonoscopies, and/or upper GI endoscopies performed. Include a log that lists procedures by date, patient age and sex, and indication. Provide diagnostic findings and prominently highlight a low rate of complications.
8. If required, describe any hands-on proctorship experience(s) and/or identify someone who is willing to serve as a proctor. A hands-on proctorship is not necessarily a prerequisite for physicians who have equivalent training and experience in GI endoscopy.
9. Provide evidence of your ability to obtain malpractice insurance coverage.

Section VI – Miscellaneous Issues

A. Current research agenda

The AAFP supports the need to conduct and publish research regarding the performance of colonoscopy by family physicians. This research should focus on the following major areas:

- Quality assurance: Ongoing case review programs/studies to monitor the outcomes of colonoscopies performed by family physicians should be initiated, and these outcomes should be compared with those of other specialties.
- Training methods, including cognitive and procedural aspects: Questions concerning the learning curve for colonoscopy should be addressed. For continuing quality improvement purposes, research is needed to determine the relationship significance, if any, between the number of colonoscopies performed and demonstrated proficiency and maintenance of skills.

B. Relationships with other organizations

AAFP policy states, "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." Unfortunately, in the past, some specialty societies have 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. It would be ideal if the AAFP and other specialty organizations could work together to improve patient care by disseminating information to educate all physicians. The AAFP welcomes opportunities to partner with other groups that have members who perform colonoscopy.

Section VII – References


(B2000) (2018 COD)
Colonoscopy Privileging

See also

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

National screening guidelines for colon cancer include a number of options. Colonoscopy is the most commonly used screening tool to detect colorectal cancer. To meet this important public health challenge, communities must have adequate numbers of physicians capable of performing colonoscopy.

Hospital governing boards, outpatient facilities, or other clinical settings with the input of their medical staffs, or other credentialing committees, 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. All medical staff members should recognize that overlap occurs among specialties and that no one department "owns" or has exclusive rights to any particular privileges. (2003) (2018 October BOD)
Colposcopy (Position Paper)

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 12,900 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]

The main reason for this change is the increased use of the Papanicolaou (Pap) test. This screening procedure identifies changes in the cervix before cancer develops and can also identify early stages of cancer. 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 a diagnostic test indicated for evaluating patients with abnormal Pap test results. It can be used to evaluate cervical dysplasia even at early stages. 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 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] Colposcopy is also performed by some nurse practitioners and physician assistants.

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 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.[10] 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 (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. 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.”[11]
The Joint Commission requires hospitals or credentialing entities to establish a process that provides fair and equal treatment to all applicants. The 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.”[12]

Section II - Clinical Indications for Colposcopy

The following are generally considered to be indications for colposcopy[13], [14]:

- 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 a 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.[15] 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 - Credentialing and Privileges

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.[16] 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, an applicant should do the following:

- Ensure that the documentation of his or her 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 the privileges requested, and review his or her training and experience for any gaps 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, individuals who have monitored the applicant’s clinical performance, and colleagues who have worked with him or her throughout the years.

· Assemble case reports that include data about number and types of cases, treatment outcomes, etc.

· Assemble documentation maintained during 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 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 V - 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 through identification of cervical dysplasia at the time of colposcopy.

It is not known whether the performance of colposcopy by family physicians saves money and other resources at the societal level. However, it may offer the following benefits:

- Identification of disease at earlier stages
- Improved access to timely care for patients
- Better continuity of care, which may support improved compliance with follow-up regimens
- Increased knowledge of and attention to risk factors
- 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 - References


Commission Meetings, Officer Attendance At

See also

- Commissions, Orientation Manual (4 MB 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)
Comprehensive Care, Access to

See also

- Comprehensive Care, Definition of
- Health Care for All
- Family Medicine, Scope and Philosophical Statement
- Criminalization of Medical Practice
- Criminalization of the Provision of Medical Care to Undocumented Individuals
- Reporting on Residency Status of Patients

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) (2018 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) (2018 COD))
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) (2018 COD)
Consultations and/or Policies on Referrals

See al

- [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) (2017 COD)
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) (2017 COD)
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 and Coordination of Care Long-Term Care Facilities

See also

- Continuity of Care, Definition
- 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 clinicians. 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) (2018 COD)
Continuity of Care, Definition of

See also

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

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) (2017 COD)
Coverage Equity for Drugs, Testing, Procedure, Preventive Services, and Reproductive Technologies

See also

- Reproductive Decisions
- Reproductive Decisions, Coverage for
- Discrimination, Patient

Employers and health plans should not discriminate by the patient's birth gender, sexual orientation, or marital status in the provision of health care benefits including a) prescription drugs and devices, b) elective sterilization procedures, c) diagnostic testing, d) medically indicated surgical procedures, and e) assisted reproductive technologies. 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. Further, this coverage should extend to the medically-appropriate, sex-specific recommended preventive services determined appropriate by the patient's primary care physician. (2002) (2018 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

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) (2018 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) (2017 COD)
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 (Positon Paper)

Family physicians encounter patients whose cultural/ethnic backgrounds may be different from their 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 all 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) (2018 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 (1). 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 (2), 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 (3) 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 (4):

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 (5).

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 (3) 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 (3) 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 disparities in health outcomes. Preparing and supporting a workforce that demonstrates the attitudes, knowledge and skills necessary to work effectively with
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, 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) (2018 COD)
Data Stewardship

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

See also

- Electronic Health Records
- Transparency
- Information Technology Used in Health Care
- Pay-For-Performance
- Performance Measures Criteria
- Payment, Physician
- Public Reporting of Physician Performance, Guiding Principles
- Laboratories Sharing Data
- Vision and Principles of a Quality Measurement Strategy for Primary Care (Position Paper)
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
- Oral Health
- Oral Health Education and Advocacy

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
- Family Medicine's Role in Undergraduate Medical Education
- Medical Home
- Family Physician, Definition
- Primary Care Physician, Generic
- Role Definition of Family Medicine

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)
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 work site 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 worksite.

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 Advertorials

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.
- Patients must be provided with clear and accurate cost information on products, including compounded
  medications.
- 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 practice and payment model where patients/consumers pay their physician or practice directly in the form of periodic payments for a defined set of primary care services. DPC practices typically 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 DPC 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 periodic payments provide patients enhanced services over traditional fee-for-service medicine. Such services may include real time access via advanced communication technology to their personal physician, extended visits, 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 many 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, still carry insurance for coverage of healthcare services that cannot be provided in the primary care practice setting, such as specialty care and hospitalizations. The model is especially well suited for those patients with high deductible plans where they might normally be paying out of pocket for any primary care services that are not considered preventive.

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 American Academy of Family Physicians' (AAFP) advocacy of the advanced primary care functions and a blended payment method of paying family medicine practices. The AAFP provides resources for members tranforming to this model, including CME credit, and will continue to promote and support Direct Primary Care as an innovative advanced practice model. (2013 COD) (2018 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. The AAFP has created a manual titled "Disaster Preparedness" to help family physicians create a plan for use in the midst of a disaster or disaster recovery. (1987) (2017 COD)
Discipline in Schools

The American Academy of Family Physicians (AAFP) does not support zero-tolerance policies for violation of school rules in primary and secondary schools. Zero-tolerance policies require the same, predetermined punishment, regardless of the severity or circumstances surrounding the incident or violation of school rules. Suspension, expulsion, arrest, and referral to juvenile or adult criminal court are common forms of zero-tolerance policy punishment. Evidence shows that gender and racial disparities exist in the use of this disciplinary method, leading to increased suspensions, expulsions, arrests, and criminal court cases among marginalized populations. This contributes to the inequitable school-to-prison pipeline and increased drop-out rates, which negatively impact health outcomes. The AAFP encourages the academic community to continue to investigate alternative, evidence-based methods of discipline in schools. The AAFP encourages its members to advocate for disciplinary procedures that focus on the prevention of violating school rules and are alternatives to zero-tolerance policies. (2017 December BOD) (2018 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)
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
- Coverage Equity for Drugs, Testing, Procedure, Preventive Services, and Reproductive Technologies
- 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
- 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)
Distracted Driving

See also

- Driver Education
- Graduated Driver's License
- Motor Vehicle Occupant Protection

The American Academy of Family Physicians (AAFP) 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 AAFP encourages family physicians to include distracted driving as part of preventive health care discussions.

The AAFP supports national efforts to ban the use of text messaging while operating motor vehicles or machinery. (2001) (2018 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) (2017 COD)
Driver Education

See also

- Distracted Driving
- 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) (2018 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 (AAFP) 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.

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) (2017 COD)
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)
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)
The American Academy of Family Physicians (AAFP) 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 (e.g. quantity, dosage, or formulary) by a physician, except in an integrated practice supervised by a physician or when permitted by state law. Post-appointment prescription changes made due to physician/pharmacist consultation or insurance coverage issues should be communicated to the patient.

In order to preserve patient confidentiality the Academy opposes any requirement that a diagnosis be placed on a prescription form. (1995) (2018 October BOD)
Drugs - Therapeutic Substitution

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.

The AAFP opposes the repeal or dilution of any state or national anti-substitution laws or regulations governing the filling of the physician's medical prescription by a pharmacist particularly when a prescription includes a “dispense as written” clarification. Currently, some public and private payers require pharmacists to substitute patients’ prescription medications through policies such as fail first, step therapy, or drug formularies that encourage cost containment without consulting physicians or assessing patients’ medical histories. These policies undermine the doctor-patient relationship by requiring less expensive medications that are therapeutically equivalents. (1988) (2018 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)
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 and Training for New Procedures
- Privilege Support Protocol

Overview and Justification

Esophagogastroduodenoscopy (EGD) is an endoscopic procedure that is useful for the diagnosis and treatment 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. In fact, for the diagnosis of mucosal abnormalities, the sensitivity and specificity of EGD are greater than those of radiographic studies.1

Family physicians have demonstrated the ability to learn EGD and to perform the procedure safely and effectively in institutional and office settings. Their complication rates compare favorably with others in the GI literature.2-5 Performing EGD increases a family physician's knowledge of the anatomy and physiology of the upper GI tract, and his or her ability to detect significant upper GI pathology. As physicians are under increasing pressure to work in the most efficient and cost-effective manner possible to make accurate diagnoses and develop efficacious treatment plans, EGD is a useful tool in the family physician's armamentarium.

Because family physicians practice in all areas, including rural and underserved areas, their ability to perform EGD improves patients' access to care. Patients also benefit from more rapid diagnosis and treatment, and enhanced continuity of care. In addition, family physicians may find that the benefits of performing upper GI endoscopy including increased patient, better working relationships with their gastroenterologist colleagues, improved understanding of the pathology in individual cases, and a greater comfort level with chosen treatments.

Section I – Scope of Practice for Family Physicians

Esophagogastroduodenoscopy can be a natural extension of the comprehensive care provided by a family physician. Gastrointestinal complaints are often first reported to a family physician. Since family physicians are trained to diagnose, treat, and, if necessary, appropriately refer patients who have GI disorders, knowing when EGD is required is one aspect of a family physician’s role.

Family physicians choose a personal scope of practice based on factors that include their training experiences, their practice interests, and the needs of their patient populations. Therefore, each must assess the appropriateness of performing EGD in his or her practice. The physician should consider his or her training and level of comfort with the procedure, the expertise of staff members, the set-up of the office, local standards of care, economic implications, and privileging requirements. For many family physicians who perform EGD, economics may favor a GI lab setting over the office setting. The physician must also consider specific patient factors (e.g., the urgency and timing of the procedure) and preferences regarding outpatient EGD.

EGD is safe and rarely causes significant physical stress for the patient. However, IV sedation does carry a measurable risk and significant post-procedure observation is required. Physicians who perform in-office procedures requiring IV sedation should be able to provide the same level of care that is available in an outpatient or hospital GI lab. This includes appropriate personnel for assistance and observation, and may include oximetry monitoring and telemetry.

In Guidelines for Office Endoscopic Services, the Society of American Gastrointestinal and Endoscopic Surgeons
(SAGES) recommends that patients being considered for endoscopy in the office setting should be evaluated according to the American Society of Anesthesiologists (ASA) physical status classification system.\textsuperscript{6,7} The guidelines state that patients who have an ASA score of III (i.e., one or more moderate to severe systemic diseases, such as chronic obstructive pulmonary disorder [COPD] or acute myocardial infarction [MI]) should be further assessed to determine the impact of their specific health condition(s) on the risk of anesthesia and the endoscopic procedure in the office setting. According to SAGES, patients who have an ASA classification of IV should not undergo an in-office endoscopic procedure.

**Section II – Clinical Indications**

There are numerous indications for EGD. The list of indications for GI endoscopy from the American Society for Gastrointestinal Endoscopy (ASGE) includes specific indications statements for EGD (*Table 1*).

**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 hernia.
   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.


Section III – Training Methodology

Family physicians can obtain EGD training through a family medicine residency or a post-residency fellowship. The Society of Teachers of Family Medicine (STFM) Group on Hospital Medicine and Procedural Training includes EGD on its list of recommended advanced procedures that are within the scope of family medicine and require focused training (in residency or fellowship) in order for residents to be able to perform them independently by graduation. A task force of Council of Academic Family Medicine (CAFM) member organizations and experienced faculty and program directors published a consensus statement for procedural training in family medicine residency that includes
EGD as one of the more complex or advanced procedures for which training may be offered to interested residents in some family medicine residencies.9

Other options for obtaining EGD training include preceptorship, self-study resources, and CME activities or conferences. The AAFP and its chapters have provided hands-on CME opportunities focused on clinical procedures for decades. In fact, the first national course in EGD for family physicians was sponsored by the AAFP in 1989. Other organizations also offer procedural skills training through accredited CME activities and conferences. Any training approach should develop both the cognitive skills involved in knowing when to perform EGD and how to properly interpret and manage findings, and the technical skills involved in safely performing the procedure. EGD training should also address how to recognize and promptly treat procedure-related complications.

Section IV – Testing, Demonstrated Proficiency, and Documentation

The AAFP recommends that family physicians document all significant training and experience so that this information can be reported in an organized fashion.10 Recommended requirements for demonstration of proficiency and documentation in EGD are listed in Table 2. The amount of continuing EGD experience needed to maintain proficiency has not been extensively studied.

Table 2. Demonstration of Proficiency and Documentation in EGD

The learner shall demonstrate adequate clinical knowledge regarding the following:

- Indications
- Patient selection and contraindications (relative and 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 and 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 skillset 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 esophageal 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 cord

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 by circling the appropriate indications, medications, findings, and pathology. This type of documentation is also helpful when additional clinical privileges are requested and in clinical studies on EGD.


Section V – Credentialing and Privileges

It is the position of the 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. 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. This perspective is in line with the policies of other organizations with influence on credentialing and privileging.

The American Medical Association (AMA) policy on patient protection and clinical privileges states, in part, "Concerning the granting of staff and clinical privileges in hospitals and other health care facilities, the AMA believes: (1) the best interests of patients should be the predominant consideration; (2) the accordance and delineation of privileges should be determined on an individual basis, commensurate with an applicant's education, training, experience, and demonstrated current competence. In implementing these criteria, each facility should formulate and apply reasonable, nondiscriminatory standards for the evaluation of an applicant's credentials, free of anti-competitive intent or purpose."

The Joint Commission's standards also require that the decision to grant or deny privileges, and/or to renew existing privileges, must be an objective, evidence-based process in which there are no barriers to granting privileges for a given activity to more than one clinical specialty. The Joint Commission Comprehensive Accreditation and Certification Manual for 2017 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 [MS.06.01.03]. All of the criteria regarding licensure, education, training, and current competence should be "consistently evaluated for all practitioners holding that privilege [MS.06.01.05]."

According to the American Association for Primary Care Endoscopy (AAPCE), "Credentialing should not be limited to
specific medical specialties." The AAPCE also states, "Credentialing should be based upon demonstrated proficiency rather than a specified number of procedures performed during training."

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 EGD 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 EGD. Artificial and arbitrarily high experience requirements should not be created as barriers to the privileging of family physicians. If a volume threshold to demonstrate competence is established, it 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. For example, the AAPCE states that if a hospital chooses to require a specific number of procedures during training, the requirement should not exceed 35 EGDs.

Table 3 lists recommended steps for family physicians applying for GI endoscopy privileges. Privileges for invasive procedures are usually granted provisionally with the requirement that the physician submit progress reports at designated intervals (e.g., three months, six months, one year). In a hospital departmentalized by specialty, the family medicine department should monitor these progress reports for department members and make recommendations for advancement from provisional privileges to active privileges.

To ensure continuous monitoring of quality, physicians may be required to submit an annual census of all invasive procedures that lists any complications that 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.

Table 3: Applying for GI Endoscopy Privileges

1. Become thoroughly familiar with the hospital’s bylaws and processes related to credentialing and privileging. Be cooperative yet persistent during the privileging process.
2. Review the privileging resources available from the AAFP.
3. Prepare a brief curriculum vitae (CV) that describes educational background, including college, medical school, residency, board certification, and recertification. List affiliations with hospitals and state/national medical societies, including the duration of these affiliations. List any professional honors, elected offices, or committee chair positions.
4. State the number of years in practice and describe provision of high-quality care for a variety of complicated cases. A physician can point to a record of exemplary service as evidence of professional excellence.
5. Describe all completed CME courses on GI endoscopy and GI-related self study (e.g., atlases, articles). In addition, be able to demonstrate an ongoing commitment to relevant continuing medical education.
6. Obtain and include a summary letter from a residency or AAFP chapter stating that the requested privileges are within the scope of the specialty of family medicine.
7. State the number of rigid sigmoidoscopies, flexible sigmoidoscopies, colonoscopies, and/or upper GI endoscopies performed. Include a log that lists procedures by date, patient age and sex, and indication. Provide diagnostic findings and prominently highlight a low rate of complications.
8. If required, describe any hands-on proctorship experience(s) and/or identify someone who is willing to serve as a proctor. A hands-on proctorship is not necessarily a prerequisite for physicians who have equivalent training and experience in GI endoscopy.
9. Provide evidence of your ability to obtain malpractice insurance coverage.
10. Be prepared, if necessary, to discuss the criteria for credentialing proposed by the ASGE in *Alternative Pathways to Training in Gastrointestinal Endoscopy*. It is the AAFP’s position that the ASGE’s stance is not supported by clinical evidence and may reasonably be interpreted as more aligned with competitive marketplace concerns than patient access to quality care.
Section VI – Miscellaneous Issues

A. Public health implications

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 better access to family physicians than to other specialists. Improved access to EGD can lead to more efficient diagnosis and treatment as well as greater patient convenience.

B. Current research agenda

Research concerning EGD in primary care has predominantly comprised case series and descriptive studies that have shown family physicians can safely, accurately, and effectively perform EGD.

Although the findings from this type of research are helpful, evidence is needed from randomized, controlled trials and other more powerful study designs. The AAFP supports the need to conduct and publish research regarding the performance of EGD by family physicians. In particular, research is needed to document benefits and harms of the procedure, patient preferences, costs and savings, utilization and alternatives.

C. Relationships with other organizations

AAFP policy states, "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." Unfortunately, in the past, some specialty societies have 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. It would be ideal if the AAFP and other specialty organizations could work together to improve patient care by disseminating information to educate all physicians. The AAFP welcomes opportunities to partner with other groups that have members who perform EGD.

Section VII – References

10. American Academy of Family Physicians. Privileges, documentation of training and experience (reviewed and


(August Board 2002) (2017 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

Electrocardiography was introduced by Willem Einthoven with the first published electrocardiogram (ECG) in 1902. It is the most commonly used test for the diagnosis of heart disease, contributing significantly to the diagnosis and management of cardiac arrhythmias and acute myocardial ischemic syndromes, which account for the majority of cardiac catastrophes. An ECG is safe, easy to administer, and available at a minimal cost. 

Electrocardiograms are interpreted not only by cardiologists, but also by other specialists, including family physicians. Although computerized interpretation of ECG data is widely available and is improving, it is not reliable enough to obviate the need for physician over-reading and confirmation. Therefore, family physicians must maintain competence in ECG interpretation.

Section I – Scope of Practice for Family Physicians

According to the October 2016 AAFP Member Profile, 89% of active American Academy of Family Physicians (AAFP) members perform ECGs in the office, and it is well established that ECG interpretation is within the scope of family medicine. The diagnosis and management of cardiovascular disorders is routinely taught in family medicine residency programs. The AAFP’s recommended cardiovascular medicine curriculum guidelines for family medicine residents state: “Core cognitive ability and skill may be obtained through longitudinal or block rotations, or cardiology experiences in intensive care and cardic care units. Residents will obtain substantial additional cardiology experience throughout the three years of experience in the family medicine practice, on their family medicine inpatient service, and through internal medicine experiences. During this time, it would be a reasonable goal to accomplish proficiency in ECG interpretation and [cardiopulmonary resuscitation (CPR)].”

Section II – Clinical Indications

Electrocardiography is indicated for patients who present with chest pain, palpitations, dizziness, or syncope, and for those who have symptoms that may indicate risk of sudden death or myocardial infarction.

In 2001, the American College of Cardiology/American Heart Association/American College of Physicians-American Society of Internal Medicine (ACC/AHA/ACP-ASIM) Task Force on Clinical Competence released a statement on electrocardiography and ambulatory electrocardiography. This statement (which had not been updated as of September 2017) notes 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 who do not have symptoms of heart disease, hypertension, or other risk factors for the development of heart disease. The U.S. Preventive Services Task Force (USPSTF) states that for asymptomatic adults at low risk for coronary heart disease (CHD) events, the incremental information offered by an ECG is “highly unlikely to result in changes in risk stratification that would prompt interventions and ultimately reduce CHD-related events.” 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 order annual ECGs or any other cardiac screening for low-risk patients who do not have symptoms. This recommendation is based on evidence that shows false-positive tests are likely to lead to harm through unnecessary invasive procedures, over-treatment, and misdiagnosis, so potential harms of routine annual ECG screening exceed the potential benefit.

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 (ACGME) requires that family medicine residency training include specific subspecialty training to ensure competence in the care of the cardiology patient in family medicine, which would include training in the interpretation of ECGs. AAFP policy states that procedural skills training in the family medicine residency should comprise a number of components, including knowledge of clinical indications and contraindications, and performance under supervision. Specific to training for ECG interpretation, the ACC/AHA/ACP-ASIM Task Force on Clinical Competence states that physicians should gain basic knowledge of electrocardiographic technology, cardiac anatomy, and cardiac physiology, and learn how to recognize diagnostic patterns on a 12-lead tracing. The number of studies needed to obtain competence in ECG interpretation has not been established.

The depth of ECG experience a family medicine resident requires will depend on his or her expected practice needs, especially in terms of practice location, available facilities, and accessibility of consultants. Physicians who wish to undergo more extensive training may find a preceptor by contacting local hospitals to identify medical staff members who have expertise in ECG interpretation. Other resources for finding a preceptor include local family medicine residency programs, AAFP chapters, and medical societies.

Section IV — Testing, Demonstrated Proficiency, and Documentation

Testing a physician’s knowledge of indications for ECG and ECG interpretation is a part of the general testing for certification by the American Board of Family Medicine (ABFM). Primary certification and recertification examinations include questions on topics such as arrhythmia interpretation, diagnosis of ischemia/myocardial infarction, and structural issues (e.g., accessory pathways). The number of questions about ECG interpretation varies from examination to examination.

Maintaining competence in ECG interpretation requires ongoing practice. However, the amount of continuing experience in ECG interpretation needed to maintain proficiency has not been extensively studied. Proficiency in ECG interpretation may be determined by monitoring a physician’s interpretations or administering a test. It is the AAFP’s position that if local tests are utilized to establish current competence, the use of such tests should apply equally to all physicians, regardless of specialty.

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.

Section V - Credentialing and Privileges

The process for credentialing and delineation of family medicine privileges varies among organizations. It is the position of the AAFP that clinical privileges should be based on the individual physician’s documented training and/or experience, demonstrated abilities, and current competence. AAFP policy states, “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 [ECGs].”

The AAFP’s stance 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 patient protection and clinical privileges states, in part, “Concerning the granting of staff and clinical privileges in hospitals and other health care facilities, the AMA believes: (1) the best interests of patients should be the predominant consideration; (2) the accordance and delineation of privileges should be determined on an individual basis, commensurate with an applicant's education, training, experience, and demonstrated current competence. In implementing these criteria, each facility should formulate and apply reasonable, nondiscriminatory standards for the evaluation of an applicant's credentials, free of anti-competitive intent or purpose.”19

The Joint Commission's standards also require that the decision to grant or deny privileges, and/or to renew existing privileges, must be an objective, evidence-based process in which there are no barriers to granting privileges for a given activity to more than one clinical specialty. The Joint Commission Comprehensive Accreditation and Certification Manual for 2017 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 [MS.06.01.03].”20 All of the criteria regarding licensure, education, training, and current competence should be "consistently evaluated for all practitioners holding that privilege [MS.06.01.05]."20

The AAFP supports the establishment of a family medicine department in every hospital departmentalized by specialty.21 The department of family medicine should have the right to recommend directly to the appropriate committee all privileges that fall within the scope of family medicine, including ECG interpretation. Neither the assent nor the approval of any other department should be required.

Because privileges for family physicians often overlap those in other clinical departments, there may be some confusion about 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 of the department of cardiology. 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.21

Resources on hospital privileging, including information about avoiding privileging disputes and answers to frequently asked questions about hospital credentialing and privileging, are available from the AAFP.

Section VI - Miscellaneous Issues

A. Payment

The AAFP recommends that payment for the interpretation of ECGs be available for all eligible physicians who have competence in ECG interpretation, regardless of the physician's specialty.

B. Quality assurance

Family medicine departments should have an ongoing peer review process in place that monitors patient outcomes to ensure that family physicians maintain their competence in ECG interpretation.

C. Public health implications

Family physicians are 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.

D. Research agenda

The research agenda for ECG interpretation should focus on the following:

1. Documentation of the outcomes of ECG interpretation by family physicians
2. Effective quality improvement programs to improve ECG interpretation error rates
3. Continued research into training methods

E. Relationships with other organizations

The AAFP, the ACC, and the ACP should cooperate to develop quality improvement programs for ECG interpretation.

Section VII – References

14. Hagen M. American Board of Family Medicine, Senior Vice President. Personal communication, September 2017.


(March Board 2001) (2018 COD)
Electronic Cigarettes

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 medical home. 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) (2018 COD)
Emergency Department Call for Family Physicians (Position Statement)

See also

- Emergency Medical Care
- Emergency Medicine, Family Physicians in
- Family Physicians Delivering Emergency Medical Care - Critical Challenges and Opportunities (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

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 have a basic understanding of resuscitation and emergency procedures through their residency training. Those family physicians working in isolated areas are encouraged to seek additional training and develop competency. The American Academy of Family Physicians (AAFP) encourages all office-based family physicians to develop practice appropriate protocols and have equipment to handle 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. Appropriately utilized, emergency medical care provided in an office setting should stabilize the patient until transfer to the next level of care is available. Repeated, episodic emergency medical services should not be substituted for ongoing comprehensive care in a primary care setting. (1988) (2018 October BOD)

See also

- [Emergency Department Call for Family Physicians (Position Paper)](https://www.aafp.org/about/policies/all/emergency-care-content.pdflist.html)
- [Emergency Medicine, Family Physicians in](https://www.aafp.org/about/policies/all/emergency-care-content.pdflist.html)
- [Family Physicians Delivering Emergency Medical Care - Critical Challenges and Opportunities (Position Paper)](https://www.aafp.org/about/policies/all/emergency-care-content.pdflist.html)
- [Privileges, Emergency Care Services](https://www.aafp.org/about/policies/all/emergency-care-content.pdflist.html)
- [Good Samaritan Law](https://www.aafp.org/about/policies/all/emergency-care-content.pdflist.html)
- [Medical Identification](https://www.aafp.org/about/policies/all/emergency-care-content.pdflist.html)
Emergency Medicine, Family Physicians in

See also

- [Emergency Department Call for Family Physicians (Position Paper)](https://www.aafp.org/about/policies/all/emergency-medicine.content.pdflist.html)
- [Emergency Medical Care](https://www.aafp.org/about/policies/all/emergency-medicine.content.pdflist.html)
- [Family Physicians Delivering Emergency Medical Care - Critical Challenges and Opportunities (Position Paper)](https://www.aafp.org/about/policies/all/emergency-medicine.content.pdflist.html)
- [Privileges, Emergency Care Services](https://www.aafp.org/about/policies/all/emergency-medicine.content.pdflist.html)

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) (2017 COD)
Environmental Health and Climate Change

In recognition of the numerous and serious adverse health consequences resulting from pollution, greenhouse gas emissions from human activities, climate change and ozone layer depletion, the American Academy of Family Physicians (AAFP) recommends strong action on the part of all public and private institutions to reduce pollution of our land, atmosphere, and water. Pollution, human greenhouse gas emissions, and ozone depletion lead to numerous severe consequences, including climate change and poor health outcomes. Those consequences more often affect vulnerable populations.

The AAFP opposes any federal or state government actions to reduce public access to environmental health research data. The AAFP also opposes any actions taken by local, state, or national governments that weaken existing stream and air protections.

The AAFP will continue to work with other health care organizations to inform the public and policymakers about the harmful health effects of climate change. The AAFP will also highlight the immediate and long-term health benefits associated with decreased greenhouse gas emissions and clean air and water.

The AAFP recognizes that toxins and chemicals are the proximate cause of certain diseases, and pollution in water and air aggregates in human bodies through a variety of channels, including dermal contact, ingestion, inhalation, and bioaccumulation. The AAFP supports policies to research and manage toxic environmental exposures, particularly those that can cause irreversible damage to health, especially the health of members of vulnerable populations. (1969) (2018 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) (2017 COD)
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(www.ama-assn.org)

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, Forgoing**

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.

Evaluation of Family Medicine Specialty Certifying Board, Guiding Principles for the

See also

- AAFP Definition: Certification/Maintenance of Certification
- Professional Competence Evaluation
- Professional Self-Regulation, Competence, and Certification

Ideally, physicians, patients, and others should be able to evaluate specialty-certifying boards on the extent to which they demonstrate adherence to the following guiding principles:

A) Transparency at multiple levels of governance and finance.
B) Relevance of board certification to professional practice.
C) Defined opportunities for representation of family physician interests.
D) Certification procedures are not burdensome to physicians.
E) Board certification status encouraged to be used appropriately.

A) Transparency at multiple levels of governance and finance

1. Strong conflict-of-interest protections
   a) Qualifying knowledge-certifying activities should not be produced solely by the certifying board.

2. Transparent policies and procedures regarding membership, governance, and finances
   a) Members and governance should reflect the makeup of the group they certify (i.e., a group of peers).
   b) A governance structure composed substantially of physician members.

3. Nonprofit organizational structure
   a) Conforms to community standards of finances and reserves.
   b) Public and proactive reporting processes to diplomates and the public including sharing an annual, certified audit of all entities associated with the certifying entity.

B) Relevance of board certification to professional practice

1. Evaluation processes are based on accepted professional standards
   a) Relevant to a variety of provider settings and practices within the scope of family medicine.

2. Processes ensure that assessments are based on evidence
   a) Knowledge assessments are based on current evidence.
   b) Process in place to ensure timely review of all materials to correct inaccurate information.
   c) Assessments include a self-evaluative process for the physician
   d) A robust quality-control process is in place that ensures the accuracy and validity of all assessments.
   e) Ability to accommodate a variety of different assessment methods (i.e., no over-reliance on high-stakes testing).

3. Board certification as a quality indicator
a) Ongoing process of physician engagement in and quality improvement to the evaluation processes.
b) Board clearly and legitimately differentiates to the public a distinct value of board certification.
c) Board demonstrates that certification reflects physicians who deliver quality health care.

C) Defined opportunities for representation of family physician interests

1. Family physicians have significant input to board decisions

   a) There should be appropriate family physician membership on the certifying board.
   b) The certifying board should regularly survey its diplomates in an anonymous and confidential manner to secure frequent feedback for how the certification process can be improved. Such surveys should not be part of the completion of elements of the certification process.

D) Certification procedures are not burdensome to physicians

1. Process of certification as non-burdensome as possible in cost and time.

   a) Not excessively costly to members at any stage of their careers.
   b) Processes are not internally or externally redundant.
   c) Processes are not irrelevant to majority of physicians.

2. Includes an appeals process that provides members with an opportunity to review their evaluations for accuracy and affords the opportunity for reconsideration.

E) Board certification status must be used appropriately.

1. Board certification is promoted as voluntary and must not be used inappropriately as an absolute or sole criterion for purposes of credentialing, privileging, licensing, payment, or employment.

2) Certification standards of professionalism should not include conduct prior to starting medical training.

3) Certification standards of professionalism should focus only on conduct that is illegal or professionally unethical.

(April 2018 BOD)
Expansion of Residency Training Programs of 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) (2017 COD)
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) (2017 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's Role in Undergraduate Medical Education
- Performance Measures Criteria
- Visions and Principles of a Quality Measurement Strategy for Primary Care (Position Paper)

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)
Family Medicine, Specialist in

See also

- Role Definition of Family Medicine
- Family Medicine, Quality Health Care in
- Family Medicine Faculty Training
- Family Medicine's Role in Undergraduate Medical Education
- Family Physician, Definition

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. Successful completion of an ACGME-approved family medicine residency program, or a three-year AOA-approved postgraduate family medicine residency program, or
2. Maintenance of eligibility requirements for active membership in the AAFP, or
3. Certification by a recognized certifying board in the specialty of family medicine.

(1990) (2018 COD)
Family Medicine Clerkship

See also

- Family Medicine Department, Definition
- Preceptorships
- Family Medicine's Role in Undergraduate Medical Education
- 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's Role in Undergraduate Medical Education
- Family Medicine Faculty Training
- Privileges in Family Medicine Departments
- 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's Role in Undergraduate Medical Education
- 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 programs, and all family physicians who regularly teach family medicine residents or medical students maintain current certification by the American Board of Family Medicine. (1975) (2018 July BOD)
Family Medicine in American Health Care

See also

- Family Physician, Definition
- AAFP Mission Statement
- Family Physicians Workforce and Residency Education
- Family Physicians' Creed

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's Role in Undergraduate Medical Education
- 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 Medicine's Role in Undergraduate Medical Education

The AAFP recommends all medical schools incorporate exposure to family medicine as an integral part of the required curriculum during the preclinical and clinical years. The AAFP is committed to making every effort to:

1. Ensure that all medical students, by the time they graduate, understand the importance of family medicine in leading the health care system, advocating for patients, caring for communities, and achieving health equity;
2. Increase student choice of family medicine; and
3. Produce a diverse family medicine workforce that meets the health needs of underserved areas

This can be achieved through early exposure to family medicine, high-quality and innovative teaching methods, longitudinal clinical experiences spanning all years, family medicine presence within the faculty and senior leadership at medical schools, family physician-role models and mentors, and institutional recognition of the value of family medicine departments for their contributions to medical education.

The AAFP specifically recommends that all medical schools provide the following evidence-based components of a mandatory family medicine clerkship:

1. Completion by the end of the third year,
2. Length of at least four weeks but preferably greater than six weeks,
3. Exposure to the broad scope of family medicine,
4. Longitudinal continuity with preceptors from preclinical throughout clinical years, and
5. Promotion of family medicine as a calling.

(COE) (1973) (2018 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 Burnout, Well-Being, and Professional Satisfaction
(Position Paper)

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 important to the AAFP because family physicians suffer from significantly higher rates of burnout than physicians in most other specialties.\textsuperscript{1,2} Burnout can negatively affect 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.\textsuperscript{3,4} The literature shows that there is a high risk of physician burnout in the United States. A broad-based study that assessed U.S. physicians using the Maslach Burnout Inventory (MBI) showed that 54.4% of all physicians combined reported experiencing at least one symptom of burnout.\textsuperscript{1} The same study found a 63% burnout rate among U.S. family physicians. Further, the study found that only 35% of family physicians report being satisfied with their work-life balance. These striking findings bear out across medical specialties, career phases, and demographics.\textsuperscript{5}

Definition of Burnout
The following is a classic definition of burnout:

- “[Job burnout is] a psychological syndrome in response to chronic interpersonal stressors on the job. The three key dimensions of this response are an overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment.”\textsuperscript{6}

Common Drivers of Burnout
The importance of identifying and addressing the root causes of physician burnout cannot be overemphasized. Despite much research, definitive data on causes of physician burnout still may not exist.\textsuperscript{7} 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.\textsuperscript{8,9} These factors have varying impact at different stages of a physician’s career. Inability to resolve work-life conflict has the greatest impact on physicians early in their careers.\textsuperscript{9} Long hours, frequent call, frustration with administrative burden, and reimbursement issues strongly affect physicians in the middle of their careers.\textsuperscript{9}

In 2013, the American Medical Association (AMA) commissioned a study by the Rand Corporation to identify high-priority determinants of physician professional satisfaction.\textsuperscript{10} The authors reported that two important factors influencing professional satisfaction are the use of electronic health records (EHRs) and physicians’ perceptions of their ability to provide high-quality care. Other factors that affect physician professional satisfaction include the following:

- Autonomy and work control
- Practice leadership
- Collegiality, fairness, and respect
- Work quantity and pace
- Regulatory and professional liability concerns
- Work content, allied health professionals, and support staff

Effects of Burnout
Understanding of how physician burnout directly affects patient health outcomes continues to increase. 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. 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; middle-career physicians are also more likely to leave clinical practice. 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.

Data from recent annual Medscape physician burnout studies reveal an increasing gender gap in rates of burnout. Across all specialties, the burnout rate among female physicians (55%) is 10% greater than the burnout rate of their male peers (45%). The reasons for this disparity are unclear and may require additional study.

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, the fact that more than half of U.S. physicians experience symptoms of burnout could compromise their ability to be effective in leading and sustaining change. 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.

**Definition of Well-being**
The Centers for Disease Control and Prevention (CDC) states the following definition:

> "In simple terms, well-being can be described as judging life postively and feeling good."13

**Happiness at Work and Professional Satisfaction**
Well-being and professional satisfaction are not simply the absence of burnout, just as good health is not simply the absence of disease. The Medscape Lifestyle Report 2017 reveals that although 45% of family physicians report no symptoms of burnout, only 29% report being happy at work. In addition, although 77% of family physicians report that they would choose to be a physician again, only 67% of those physicians would choose family medicine as their specialty again.

**The Family Physician Ecosystem**
Each individual family physician uniquely experiences his or her professional role within the context of many variables. These interacting variables form a family physician ecosystem (Figure 1). Potential solutions to improve personal well-being and professional satisfaction must be customized based on the family physician’s experience of this ecosystem.

The following are the five influential elements of the family physician ecosystem:

1. **U.S. Health Care System Level** – The U.S. health care system is heavily regulated and primarily based on fee-for-service payment. Reporting and documentation requirements place a significant burden on family physicians but do not yield a proportional improvement in quality of care.
2. **Organization Level** – The majority of family physicians report that they are either employed or part of an organized medical staff. The values, requirements, and operational policies of an organization can influence professional satisfaction.
3. **Practice Level** – The characteristics and efficiencies of the practice environment and the care team can affect the family physician’s well-being.
4. **Individual Level** – Individual wellness habits and resilience capabilities can affect the family physician’s response to external stressors.
5. **Physician Culture Level** – A culture that elevates self-sacrifice—or even self-neglect—in the service of others can contribute to feelings of shame and guilt when the family physician is unable to achieve superhuman performance levels. Peer-to-peer support is often unavailable.
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 have 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.16 There is a growing trend among health care 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.17

Conclusion

Though burnout affects physicians across all specialties, family physicians experience higher-than-average rates, especially when compared to the general U.S. working population. At the same time, satisfaction with work-life balance is decreasing. 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 influences family physicians’ decisions about remaining in clinical practice, which affects patients’ access to high-quality care. Burnout also affects family physicians’ ability to lead changes at the practice and health care system levels.

The AAFP strongly believes that physician burnout is a health system, organization, practice, and physician culture problem, not just an individual concern. Therefore, the AAFP takes a systems-based approach to identifying and combating root causes of physician burnout at all levels of the family physician ecosystem. As a trusted partner for members interested in developing their personal resilience skills, the AAFP is committed to providing resources to support members’ well-being and professional satisfaction. These resources are available to all AAFP members, including students, residents, active members, and life members.

References


(2014 COD) (2017 COD)
Family Physician Workforce and Residency Education

See also

- Family Medicine in American Health Care
- Family Physician, Definition
- Family Physicians' Creed
- Family Medicine's Role in Undergraduate Medical Education
- 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 Delivering Emergency Medical Care - Critical Challenges and Opportunities (Position Paper)

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. Without their contribution, many parts of the country would be without adequate emergency medical care. While family physicians provide a significant portion of emergency care in rural, urban, and suburban areas, their abilities have been questioned by some within emergency medicine professional societies and organizations. Family physicians are trained to provide emergency medical care by way of residency and post-residency education, but they have been viewed as competitors and suboptimal alternatives, rather than colleagues. This perception of family physicians is unfortunate, since family and emergency medicine physicians are the only generalists who routinely see patients regardless of age, gender, or organ system.

The training environment for most of today’s emergency medicine residency programs includes ready availability of specialty consultants and advanced technology readily available to assist the physician with the assessment and care of patients. However, most rural emergency departments lack these resources, and physicians caring for patients in these settings must depend upon their own best clinical skills and judgment to a greater degree than in the typical urban center. Therefore, an argument can be made that the training breadth of the family physician is appropriate for the care of most patients presenting to emergency departments where the emergency physician is a “generalist with expertise in emergency medicine.”

Family physicians’ participation in the delivery of emergency care is consistent with a specialty grounded in local adaptability to meet the comprehensive care needs of the community and patients, as well as the integration of primary care principles to provide cost-effective care through optimization of available resources.

Urgent care medicine is also an important part of the emergency care safety net and is primarily provided by family physicians. Urgent care centers may serve to increase patients’ access to medical care, as well as to decrease the care burden for both emergency departments and primary care offices.

While many family physicians have made lifelong careers in providing emergency medicine, some are facing challenges and restrictions in their scope of practice. Overall, the integrity of the emergency medical safety net will be strengthened by collaborative efforts between family medicine and emergency medicine specialties. Family physicians must continue to provide high-quality comprehensive medical services to a diverse population regardless of setting. Competition should be replaced with cooperation, and family physicians’ contribution to the emergency medical care safety net serves a vital role in the U.S. health system.

Background

Emergency Medicine Workforce Statistics

At the end of 2013, there were 34,434 emergency physicians certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine, out of an emergency department workforce of 45,140, representing 76% of emergency physicians in the U.S. The number of emergency medicine residency programs and the

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number of emergency medicine graduates has steadily increased each year.\textsuperscript{10,11} Indeed, the rate of growth in emergency medicine has exceeded that in most specialties overall.\textsuperscript{12} However, it is unlikely that residency-trained EM physicians will be able to fill the workforce demand for several decades, if ever.\textsuperscript{13-15}

Some emergency medicine leaders feel that there is no longer a workforce shortage, but rather a maldistribution of residency-trained emergency physicians away from rural areas.\textsuperscript{16} Most emergency medicine training programs are in urban areas and emergency medicine residency-trained or board certified physicians are more likely to practice in urban settings (10.3 per 100,000 population) vs. large rural (5.3) or small rural (2.5) settings.\textsuperscript{9,13} However, newer data suggests that this maldistribution may extend beyond rural areas. For example, less than half of emergency physicians in the Veterans Health Administration have formal emergency medicine board certification.\textsuperscript{17} Non-emergency medicine residency-trained physicians, including family physicians, also play a significant role in the staffing of many urban and suburban emergency departments.\textsuperscript{1}

### The Evolution of Emergency Medicine as a Specialty

The birth of emergency medicine arose partly from the need for better trained physicians who could treat critically ill or multiple trauma patients.\textsuperscript{18} 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. As emergency medicine has matured as a specialty in the U.S., it has brought recognition and academic strength to a field that was previously considered to be the domain of moonlighters.

In 1979, when the American Board of Medical Specialties (ABMS) accepted the American Board of Emergency Medicine (ABEM) as a member board and thus established emergency medicine as a “primary specialty.” Family physicians, including several who were charter members of the American College of Emergency Physicians (ACEP), were among those who championed the cause and were actively involved in the advancement of emergency medicine as a specialty. In a similar way, American Board of Family Practice (ABFP) members were also involved in the developmental phase of the American Board of Emergency Medicine (ABEM), with the founding ABFP executive director serving on the board of ABEM for several years.\textsuperscript{20} Thousands of physicians with family medicine backgrounds accessed the ABMS emergency medicine board exam during the 1980s, via its “grandfathering” provisions.

### Rural Emergency Medicine by Family Physicians

Twenty-two percent of family physicians practice in communities with populations less than 50,000, while 20\% of the U.S. population live in such communities.\textsuperscript{21} Rural communities have emergency departments with fewer patients—roughly half what is necessary to support a residency-trained emergency physician—and lower overall revenue. Therefore, they often are unable to afford a full-time residency-trained emergency physician. Due to their broad scope of practice, including procedural and obstetrical skills, family physicians may have other sources of revenue, and can potentially staff low-volume emergency departments far more cost effectively. This can be a critical factor in deciding whether a community can afford residency-trained emergency medicine physicians, as well as other health providers.

Emergency department staffing in small community hospitals by family medicine physicians allows more efficient use of resources in the hospital and in the community. Family physicians can evaluate patients in the emergency department, admit patients to the hospital, and follow them to discharge as the attending physician. This is more economical and efficient for hospitals with small medical staffs.

Access to health care in rural communities depends on the number of primary care providers.\textsuperscript{22} Emergency care is an integral part of this relationship. Family physicians in rural areas typically care for their patients from the cradle to the grave, during acute and chronic illness, as well as life-threatening events. Patients in rural communities often have strong ties with their local family physicians and a desire to see them when presenting to the emergency room. In rural communities, confidence in medical care is directly related to the length of relationship between the provider and the patient.\textsuperscript{23} This is also evident by increased patient satisfaction and outcomes that are equivalent or better for medical
services when compared to urban or suburban communities.24

Urgent Care Medicine

Urgent care centers are part of the emergency medicine safety net with care that is primarily provided by family physicians. Urgent care has been a fast-growing sector of medical care since the mid-1990s, and family physicians are the foundation of this specialty. More than 20,000 physicians practice urgent care medicine, where the most common physician specialty is family medicine, followed by emergency medicine.25 There are equal numbers of family physicians providing urgent care as there are providing emergency care.26

The combination of primary care physician shortages and increased patient loads due to health care reform will likely create a need for more access to a level of medical care higher than a primary care office, but not requiring an emergency department. Urgent care centers can provide services to a diverse population of patients and help decrease care burdens for both emergency department and primary care offices.27,28

Due to the range of patient ages, gender, and chief complaints that potentially present to urgent care centers, family physicians are the ideal medical professionals to staff and administrate them. Furthermore, despite a long history of urgent care centers, there is still no consensus definition of “urgent care” and thus there exists a wide variability in the quality and scope of care provided at urgent care centers. The opportunity exists for family physicians to play a key role in not only expanding services and providing quality care, but also participating in the regulation process of urgent care clinics.

Lastly, there has been a growing interest in urgent care medicine among family physicians. Currently, there are four urgent care fellowships available to family physicians who wish to obtain more urgent care experience.29 Additional training may benefit a physician who wishes to open a primarily urgent care practice or assume organizational leadership, but is not a requirement to practice in an urgent care center.

Challenges

Credentialing, Competence, and Board Certification

Central to the issue of family physicians practicing emergency medicine are fundamental concerns over competency, job security, and board certification. Many family physicians have made careers in emergency medicine. In rural areas, family physicians are often the primary providers of emergency care. Today, there remains a shortage of board-certified, residency-trained emergency medicine physicians in certain geographic areas. At the same time, family physicians have been under recognized for their role in providing emergency care.

Some hospitals have utilized emergency medicine board certification as a strict criteria for staffing.30,31 In those situations, some competent family physicians who lack certification in emergency medicine may be excluded because they do not meet the established criteria. Specialty-neutral credentialing is not the norm in most hospital organizations.

Professional Recognition and Board Certification

The controversy surrounding certification and competency is linked to the process of certifying physicians and by which organization. The medical profession has a closely regulated structure for conferring certification to those seeking specialty recognition.32,33

The ABMS and its subsidiary boards, which include the ABFM and the ABEM, set the standards for certification processes and are widely recognized and accepted by organized medicine. The ABMS has granted specialty status to 24 allopathic specialties since 1933. The ABEM exam was first offered in 1980.34 From 1980 to 1988, there were two pathways for physicians to qualify for board examination: completion of a residency in emergency medicine or
satisfying the requirements of a “practice track” pathway. The prerequisites of this latter option were 7,000 hours and 60 months of emergency department practice experience, with a specified number of continuing medical education (CME) credits in emergency medicine. In 1988, the practice track pathway was terminated. Limited access to the ABEM examination through closure of the practice track created significant controversy among non-emergency medicine residency-trained practitioners during the years that followed. Some felt that this closure was arbitrary and premature. However the recognition of emergency medicine as a primary board of the American Board of Medical Specialties was dependent upon the closure of the ABEM practice track.

In 1994, a committee of the ABMS developed a proposal to revise the process of board certification. The intention was to recognize certification as a dynamic process, which “should permit movement of qualified individuals across specialties and sub-specialties.” It was proposed that physicians with knowledge, training, and/or experience in a given area should be given access to the examinations. Ultimately this proposal failed.

The American Osteopathic Association (AOA) has 18 primary certifying boards including the American Osteopathic Board of Emergency Medicine (AOBEM) that began offering certification examinations in emergency medicine in 1980.

The American Board of Physician Specialties (ABPS) was founded in 1950, and currently consists of 12 governing boards that certify 18 specialties and readily accepts qualified allopathic and osteopathic physicians. The ABPS originally came about when osteopathic physicians with allopathic residencies were excluded from both ABMS and AOA board certification. Unlike the ABMS, family medicine residency-trained physicians who have practiced emergency medicine for at least five years on a full-time basis and accumulated a minimum of 7,000 hours during that period are eligible to test with the Board of Certification in Emergency Medicine (BCEM) of the ABPS.

**Displacement by Replacement**

The care provided by experienced, non-emergency medicine, residency-trained physicians and legacy emergency physicians is important. As the emergency medicine specialty came to maturation, experienced family physicians were removed from job considerations based on restrictive emergency physician group hiring and specialty bias. Some hospitals have restrictive credentialing bylaws determined by specialty certification rather than previous work experience and demonstrated competence.

As employers and hospital credentialing bylaws have become more restrictive toward experienced, non-emergency residency-trained physicians, some employers have become more amenable to hiring advanced practicing clinicians who usually work under the immediate supervision of the emergency department physician, regardless of previous work experience of the advanced practice clinician. This has resulted in a rise in the use of nurse practitioners and physician assistants in the emergency medicine workforce. Practice oversight for these providers varies across emergency departments with some practicing independently.

Legacy emergency physicians began practicing emergency medicine prior to the 21st century and are supported by ACEP. ACEP has positioned itself in support of the legacy emergency physician not being forced out of the workforce based solely on their board certification. Rather, ACEP asserts that they should be subject to the same quality standards of a board-certified emergency physician. On the other hand, family physicians who began practice after the start of the 21st century are not as well supported by ACEP despite their years of emergency department experience and their commitment to providing high-quality care. Both groups of experienced family physicians are sometimes denied credentialing, regardless of their emergency department work experience, with some being replaced in their practice environment by less experienced emergency medicine residency trained providers.

**Education and Training**

**Emergency Medicine Curriculum for Family Physicians**
Emergency medicine is an integral part of family medicine training. Several resources outline critical knowledge areas to help ensure family physicians are thoroughly familiar with emergency medicine curriculum, and can be used by family medicine residency-training programs in education planning. These guidelines provide a useful template for educating family physicians and identifying critical elements that might not be adequately addressed in other curricular areas or residency rotations.

Since there is significant overlap between family medicine and emergency medicine residency training, as well as variation among family medicine residency experiences, it is important for family physicians who provide emergency care to address potential knowledge gaps. Knowledge areas that may benefit from additional training include pediatric emergencies, trauma management, airway management, and care of patients with acute myocardial infarction. Furthermore, while the use of point-of-care bedside ultrasound has several applications in family medicine, core ultrasound applications may not be as numerous when compared to emergency medicine. Elective months during residency should be geared toward attaining these skills.

By promoting a structured emergency curriculum in residency and identifying potential knowledge gaps, the family physician will be better prepared to provide high-quality emergency care, decrease risk to litigation, and increase the health and safety of the patient. Additional training by AAFP courses and advanced life support courses should also be considered.

Family Medicine Residencies

The Accreditation Council for Graduate Medical Education (ACGME) requirements for family medicine residents reflect values that are complementary to the importance of providing emergency care. For example, family medicine residents must demonstrate competence to independently manage patients of all ages in various outpatient settings; evaluate patients of all ages with undiagnosed and undifferentiated presentations; recognize and provide initial management of emergency medical problems; and perform medical, diagnostic, and surgical procedures essential for the area of practice. The current ACGME program requirements for family medicine include a greater level of specificity for experiences with acutely ill adults and children in emergency settings.

By the nature of their training, family physicians add value to the emergency care they provide in several ways. In many communities, hospital emergency departments are required to provide an enormous amount of primary care services that would ideally be provided in other settings. Family physicians are trained to care for patients with both acute and chronic conditions and “take a broad look at a patient with a problem, decide what’s appropriate to do and do it.” Since there are increases in the time between a decision to admit a patient from the emergency room to the hospital and the transfer of the patient to the hospital room, physicians staffing the emergency room increasingly find themselves needing to provide non-emergent care to patients who would otherwise require inpatient management. Family physicians practicing in the emergency room are well-suited to provide the ongoing care to these stabilized patients awaiting transfer to the inpatient care units. Family medicine training in obstetrical emergencies can also be advantageous, especially in resource-limited environments.

Training Considerations for Rural Recruitment

Many emergency medicine residencies are in primarily urban environments with a disproportionate number of graduates choosing not to practice in rural areas. While rural training experiences will likely increase the retention of graduates to rural areas, several obstacles remain. Studies have shown that patient volumes are similar for urban and rural emergency physicians; however, patient acuity and procedural volume remains a concern. Furthermore, the ACGME requirement that emergency medicine faculty hold ABEM certification may be an obstacle for rural emergency training sites since many rural emergency physicians are trained by primary care programs.

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**Combined Residencies**

In 1976, the year that the ABEM 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." It was not until 1993 when the ABFP explored a combined training program leading to dual-board certification.

After 30 years, collaboration between the specialties of family and emergency medicine reached fruition and joint training programs were approved by the ABFM and the ABEM in 2006. Joint training guidelines described an integrated five-year curriculum with equal emphasis on the two disciplines. In 2007, the Christiana Care Health System in Wilmington, Delaware, launched the first combined family medicine-emergency medicine joint training program. By the end of 2016, there were two joint programs in the country. Residents that are enrolled in such programs 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 continuing and comprehensive patient care in a family medicine center.

While combined residency (family medicine-emergency medicine) programs are a step in the right direction in terms of collaboration between the two specialties, few positions are available and are unlikely to make a significant impact on workforce and are unlikely to solve many of the issues facing rural areas. A study of graduates of combined residency programs in emergency medicine-internal medicine, internal medicine-psychiatry, and family practice-psychiatry shows these certified physicians tend to work in urban, academic centers rather than rural settings. Similar studies are not available for graduates of combined emergency medicine-family medicine residency programs.

**Fellowships Enhance the Core Curriculum**

Fellowships in emergency medicine were first developed in the 1990s for family physicians, as well as other primary care physicians in response to the need for additional training in emergency medicine in academic centers. Furthermore, several studies report that family medicine residency-trained emergency physicians may still desire additional training. One-year fellowships have been established as a logical extension of accredited family medicine residencies in West Virginia, North Carolina, Arkansas, Tennessee, Texas, and other states. As of 2015, there are eleven emergency medicine fellowships with a combined total of 37 fellowship positions. Emergency medicine fellowships have been successfully used as a pathway to credentialing in community hospitals and academic settings. They have also been used to enhance acute care skills prior to practice in frontier medicine, rural practice, and international missions. The advantages of these fellowships have been their flexibility and financial feasibility, ability to be self-funded due to the high need for workforce in rural areas, and their inclusion of graduated physicians. These fellowships have successfully modeled the rural reality of simultaneously staffing the office, the emergency department, and the hospital, as well as providing access to enhanced training for graduates of family medicine residencies who plan to practice in rural areas.

Emergency medicine fellowships will likely continue to remain an attractive option for family physicians who practice emergency medicine given that the fellowships allow graduates of the programs to enter practice in four years, compared to the five year requirement of joint family medicine-emergency medicine programs. While the joint training programs have an inherent academic legitimacy that both ACEP and ABEM will accept, several fellowship programs lead to accelerated board certification eligibility by ABPS if other requirements are met.

Fellowship opportunities are beneficial, not only because they provide more emergency patient and procedural exposure and may fulfill hospital credentialing requirements, but also because fellowship graduates have a greater tendency to practice in rural environments.
Certificate of Added Qualifications in Emergency Medicine is not an Option

According to the rules of the ABMS, primary certifying boards are prohibited from establishing subspecialties or Certificate of Added Qualifications (CAQ) in clinical domains where another major specialty already exists. Thus, since an ABEM is currently in existence, the ABFM cannot establish a CAQ in emergency medicine.

Unique Training for Rural and Remote Settings

A unique program has been developed for those family physicians who deliver emergency care in rural areas. The Minnesota chapter of the AAFP created an innovative Comprehensive Advanced Life Support (CALS) course in 1996. The CALS curriculum includes material from all the major advanced life support programs. A team-based approach involving emergency medical services (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. This course is supported by both AAFP and ACEP in efforts to improve rural emergency care. An ACEP policy statement described CALS as a valuable educational experience and may be considered as an equally acceptable alternative to other advanced life support and/or trauma life support courses.

The CALS project promises to strengthen the preparation of family physicians, other physicians, and health care providers who currently practice in rural areas, and who desire 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 the specialties of family medicine and emergency medicine.

A Path Forward

Institute of Medicine (IOM) now known as the National Academy of Medicine (NAM) Report Endorses Family Physicians in Emergency Medicine

In 2006, the IOM report entitled “The Future of Emergency Care in the United States Heath System” described the condition of emergency medicine in our nation and gave 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 quality of care 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 the emergency care workforce (including prehospital emergency medical services as well as the multiple professions that provide care at the hospital) and rural emergency medicine.

The IOM report stands as a challenge to the current paradigms expressed by many health care experts in emergency medicine. The report concludes that “coordinated, regionalized, and accountable” solutions will require change in a number of the ways that emergency care is structured in the U.S. 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 certified by ABFM rather than ABEM, family physicians 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.

AAFP and Other Family Medicine Organizations Strongly Support the Role of Family Physicians in Emergency Medicine

The American Academy of Family Physicians (AAFP) has long-supported its members who practice emergency
medicine. In 1995, the AAFP developed and has since updated its policy about emergency care services, which currently states, “Family physicians, through their 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.” Additionally, the AAFP published a set of core curricular guidelines on acute and emergency care for residents in family medicine residency programs.

Recognizing flaws in a fragmented U.S. health system, leaders of seven family medicine organizations formed the Future of Family Medicine project. The group released a report in 2004 calling for a New Model of practice that is grounded in the values of personalized, patient-centered care, coupled with the application of new technologies and systems to meet the health care needs of society in a changing environment. The model included enhanced educational opportunities and a “basket of services” individualized to meet the needs of the community in emergency and acute care services. The report recognized the strength of family physicians for their adaptability and diverse scope of practice. The report also acknowledged that implementing the New Model of practice may be challenged by those with vested interests in maintaining the status quo.

In 2006, the AAFP Board of Directors approved and the Congress of Delegates adopted and later updated a policy statement on emergency medicine addressing the standard of care for credentialing and workforce issues. It parallels the recommendations from the Institute of Medicine (IOM) report, and provides a foundation for defining family physician’s role in emergency care in the 21st century. The statement reads as follows:

> 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.

> Specialty 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.

In 2010, the first AAFP member interest group was formed in emergency medicine and urgent care. This interest group gives physician members a forum to discuss emergency medicine-related issues that they face on a daily basis. The group continues to hold annual meetings at the Family Medicine Experience (FMX).

Family Medicine for America’s Health (FMAHealth) was launched in 2013 by the AAFP, AAFP Foundation, American Board of Family Medicine, Association of Departments of Family Medicine, Association of Family Practice Residency Directors, North American Primary Care Research Group, and Society of Teachers of Family Medicine to “position family medicine with new strategic and communication plans to create better health, better health care, and lower cost for patients and communities (the Triple Aim).” As a part of the exploration of the scope of practice for family physicians, a document was developed that defined the family physicians’ role in health care delivery. These expectations include providing timely, cost-effective care; integrating care for both acute and chronic illnesses; collaborating with national stakeholders to reduce health disparities; and ensuring that the country has a well-trained primary care workforce for the future through the expansion and transformation of training. Among other statements, the document describes the importance of family physicians’ role in providing emergency care, their ability to provide

https://www.aafp.org/about/policies/all/critical-challenges.content.pdflist.html[4/24/2019 3:02:52 PM]
comprehensive medical care with the capacity to handle the needs of most patients, and their ability to adapt care to the unique needs of their patients and communities.87

A Model of Collaboration - The Canadian Health System

The Canadian health system may provide a helpful model for the U.S. since emergency care in Canada is provided by a heterogenous group of clinicians. In Canada, there are three pathways for a physician to practice emergency medicine. First, similar to the U.S., residency-trained family physicians, which provide a majority of care in rural areas, provide emergency care.88,89

Second, the College of Family Physicians of Canada (CFPC) offers a two-year residency training program in family medicine with the option of an additional year of training in emergency medicine to obtain the Canadian College of Family Physicians - Emergency Medicine (CCFP-EM) certification. The CFPC supports cross training in emergency medicine for family physicians, and there is widespread acceptance of this pathway within the medical community.

The third pathway is the Royal College of Physicians and Surgeons of Canada (RCPSC) five-year emergency medicine residency program with certification as a Fellow of the Royal College of Physicians of Canada (FRCPC). The objective of this program is to prepare physicians for academic careers involving teaching, research, and administration in emergency medicine.89 The first qualifying exam was offered in 1983, and grandfather eligibility through a practice track existed through 1987. During this period, many physicians became double-board certified in family medicine and emergency medicine.

While there is ongoing debate regarding having a single, conjoint emergency medicine certification, no agreement could be reached concerning the details of such a training program.90-92 Most institutions do not differentiate between graduates from either colleges. While the RCPSC program aims to produce academically-oriented emergency physicians, physicians from both colleges work mainly in urban areas and share the same patient mix and responsibilities. Furthermore, while Canada also has more than one organization governing certification in emergency medicine, both the CFPC and RCPSC continue to collaborate on clinical practice and quality of care issues. The collaborative efforts between both groups provide a model for cooperation that could be considered by medical associations and certifying boards in the U.S.

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 varied emergency environments, such 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 Network93 includes more than 300 family physicians in 45 states with integration of an electronic medical record (EHR) 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 who 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 IOM for emergency care research, since it “involves many disciplines and cross-cutting themes.” As academic cooperation increases between the specialties on the residency training level,66 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. Evidence-based research for acute care is a strength of 21st century family medicine.

A small database exists on the unique aspects of emergency care that is provided by family physicians, but more research opportunities are necessary 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 topics for investigation include rural emergency care delivery, the provision of “first-hour” emergency care in family physician offices, trauma care in remote areas, and emergency and urgent care procedural skills. One successful 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.47

Conclusions

Providing comprehensive emergency medical services to a diverse population requires a cooperative relationship among a variety of health professionals.57,94 Delivering quality, comprehensive emergency care requires that emergency medical care and workforce issues be based on “best practice” models that include all necessary and contributing specialties and disciplines.57 In the 21st century, competition should be replaced with cooperation. More collaboration is needed between the AAFP and ACEP, and the ABFM and ABEM to ensure emergency department credentialing and job security is based on the quality of care delivered by the emergency physician.

Policies should be advanced that recognize and support the critical role of family physicians in emergency medicine in most communities around the U.S.

The most important objective of the family physician must be to provide 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 AAFP will continue to support the greater flexibility and wide scope of practice of family physicians, especially in areas where there is a workforce shortage.

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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, Global Surgical
- 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) (2018 October BOD)
Fees to Physicians for Referrals to Other Health Care Providers

See also

- Consultations and/or Policies on Referrals
- Fees, Global Surgical
- 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

- Fee-splitting
- Fees to Physicians for Referrals to Other Health Care Professionals

The American Academy of Family Physicians (AAFP) 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, after 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.

The AAFP believes the global period for all surgical services should be zero days. All surgical services with a longer global period, such as 10 or 90 days, should have their global period reduced to zero days and be revalued accordingly. Use of a zero-day global period facilitates more accurate valuation of surgical services. (1984) (2018 December BOD)
Fellowship, Definition

See also

- Certificates of Added Qualification (CAQ)

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 (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:

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) (2017 COD)
Fluoridation of Public Water Supplies

See Also

- Dental Services
- Oral Health
- Oral Health Education and Advocacy

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) (2018 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
- Oral Health
- Oral Health Education and Advocacy

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)
Generic Drug Pricing - AAFP Legislative Stance

See also

- Drugs, Generic
- Drug Identification
- Drugs, Therapeutic Substitution
- Drugs, Prescribing

Genital Surgeries in Intersex Children

The American Academy of Family Physicians (AAFP) opposes medically-unnecessary genital surgeries performed on intersex children.

Many intersex children are subjected to genitalia-altering surgeries in infancy and early childhood without their consent or assent. The surgery can lead to decreased sexual function and increased substance use disorders and suicide. Scientific evidence does not support the notion that variant genitalia confer a greater risk of psychosocial problems.

The risk of neoplasia in intersex individuals has not been verified, and genitalia-altering surgeries should not be offered to minimize this risk.

Genital surgeries should only be recommended for intersex infants and children for the purpose of resolving significant functional impairment or removing imminent and substantial risk of developing a health- or life-threatening condition. (2018 July BOD) (2018 COD)
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) (2018 COD)
Graduate Medical Education Financing Policy

**Principle 1:** Provide an adequate number of family medicine residency positions to allow capacity for meeting the "25% by 2030” goal for U.S. medical school graduates making a career choice of family medicine. This results in a goal of “10,000 by 2030” for PGY-1 family medicine GME positions and the need for ongoing support for the duration of training for those positions. (new)

Support for Principle 1: Effective health care systems have a physician workforce comprised of roughly 50% primary care and 50% subspecialty. The current U.S. physician workforce is 33% primary care. To achieve the overall goal of 50% primary care, it is imperative that at least 25% of U.S. medical school graduates choose family medicine by 2030. Based on the following information, the AAFP estimates a need for roughly 10,000 PGY-1 positions in family medicine by 2030 to meet workforce and capacity demands:

- The Association of American Medical Colleges (AAMC) reported that there were 21,338 matriculants (MS-1) to Liaison Committee on Medical Education (LCME)-approved U.S. medical schools in 2017, which represents a 1.5% increase from the year before.
- The American Osteopathic Association (AOA) reported that there were 7,197 matriculants (MS-1) to Commission on Osteopathic College Accreditation (COCA)-approved U.S. medical schools in 2017, which is a 6.9% increase over the year before.
- According to the 2017 AAFP residency census, 3,658 medical school graduates matriculated into Accreditation Council for Graduate Medical Education (ACGME)-accredited family medicine residency programs as first-year residents in 2016. If the current rate of international medical graduates (IMGs) who are training in U.S. family medicine residencies is maintained, the AAFP anticipates that this number of PGY-1 residency positions will roughly need to triple by 2030.

**Principle 2:** Establish accountability for federal GME payments to correct the historical maldistribution of federal GME financing by ensuring new positions are allocated to mitigate rural/urban and other geographic and specialty imbalances to reduce health professional shortage and medically underserved areas. (new)

Support for Principle 2: It is important to address the current maldistribution of the physician workforce because it is contributing to lower health care quality and health disparities. The type and location of GME training is predictive of eventual practice location. There is an opportunity to collaborate with stakeholders at the federal, state, and community levels to identify and share what is working well currently and to identify what would work if additional or redistributed investments through GME payment models were available. One successful example is the Teaching Health Center Graduate Medical Education (THCGME) model. In addition, because current federal policy is often a barrier to development of new rural residency programs, it is important to advocate for the federal government to further study how its GME investments are contributing to the health and socioeconomic status of people living and working in underserved rural and urban communities. There is also a need for development of an entity to create and monitor GME financing strategies to accomplish national workforce goals. This entity should establish accountability measures that would be utilized as a condition for sustained GME payments.

**Principle 3:** Create new funding collaborations between federal, state, and nongovernmental stakeholders investing in primary care GME to positively impact factors such as health disparities, primary care access, workforce maldistribution, health equity, infant mortality, and social determinants of health. (new)

Support for Principle 3: Many states have had success developing and supporting new primary care residency programs. In 2015, 42 states made Medicaid GME payments. Some of these initiatives used waivers, matching funding, and targeted programming to reduce maldistribution of physician workforce in the state. Creating and supporting the conditions to measure and share data on these programs was a critical element. In 2017, 110 participants from 33 states participated in the GME Initiative’s States Initiative Summit to identify ways to engage community stakeholders in investing in primary care residency training; leverage Medicaid GME; and utilize unique state funds and other assessments (e.g., tobacco taxes, hospital/insurance assessments, other grant programs). Many hospitals and health systems have committed to expanding family medicine GME as a foundational approach to addressing workforce...
concerns and population health. Fostering private funding streams for family medicine GME expansion may be necessary to augment public funding. Therefore, identifying and communicating successful innovations in GME financing are important complements to optimizing current federal investment in GME. Any newly created or local funding support should be additive and supplemental, not meant to replace or decrease federal support.

**Principle 4: Make permanent and increase funding to the Teaching Health Center Graduate Medical Education (THCGME) program to ensure stability, growth, and long-term sustainability of the program. (new)**

Support for Principle 4: The THCGME program was created under the Patient Protection and Affordable Care Act (ACA) and reauthorized through fiscal year 2019 to increase the number of primary care residents who train in community-based ambulatory patient settings. It is important that this program be permanently funded within the Medicare GME system and not be subject to periodic reauthorization and appropriated funding. Currently, the Health Resources and Services Administration (HRSA) awards funds to eligible teaching health centers for the purpose of covering both direct and indirect GME costs for new or expanded community-based primary care residency programs. The U.S. Department of Health and Human Services (HHS) is required by law to establish formulas for determining separate Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payment formulas for the THCGME program. As of June 2018, HHS had not yet established rules on such payment formulas. Instead, it has been making payments using an interim annual payment rate of $150,000 per resident, with reductions when appropriated funding levels do not allow the full per-resident amount (PRA). Regarding the DGME payment formula, the statute provides that DGME payments must be equal to the product of the updated national PRA and the average number of full-time equivalent (FTE) residents in teaching health centers’ residency programs. Regarding the IME payment formula, the statute provides that HHS must evaluate the indirect teaching costs needed to support primary care residency programs in qualified teaching health centers and ensure that the aggregate payments for indirect and direct costs do not exceed the total amount appropriated for the THCGME program in each fiscal year. The payment rate for THCGME recipients may fluctuate over time, depending on available appropriations, the number of eligible applicants, and the number of FTE residents supported. THCGME awards can supplement GME payments from other federal sources, including Medicare, Medicaid, and the Children's Hospitals Graduate Medical Education (CHGME) program, but recipients generally cannot use funds to pay for the same portion of resident time that has been counted toward funding in these other GME programs. To maintain GME program stability and sustainability, it is imperative for THCGME funding to be predictable, secure, and reliable.

**Principle 5: Modernize GME financing by replacing Indirect Medical Education (IME)/Direct Graduate Medical Education (DGME) payments with a per-resident payment (PRP). (new)**

Support for Principle 5: Modernizing GME payment methodology is necessary to make strategic investments that support a more equitable, rational physician workforce and support the development of training at non-hospital sites. Consistent with the IOM’s 2014 recommendation to replace rigid statutory formulas that were developed in an era when hospitals were the central site for physician training, the AAFP advocates for combining IME and DGME financing streams into a single payment, with funds distributed as a national per-resident payment. The PRP should be evidence based, transparent, and predictable.

**Principle 6: Support existing and expanded funding for family medicine residencies by refocusing existing Medicare GME funding to first-certificate residency programs. (carryover)**

Support for Principle 6: If there is limited support for increasing the overall funding for additional GME positions for family medicine training, then an existing revenue source must be identified for first-certificate residency programs. A logical solution is to shift funding from existing fellowship training programs. The number of ACGME-accredited subspecialty fellowship programs increased by more than 30% from academic year 2003-2004 to academic year 2012-2013, and the number of fellows in subspecialty training increased by 40% during that time. Limiting the outsized growth of fellowships and other subspecialty training will temper increasing costs to the system that do not substantially benefit population health or achieve the Triple Aim. Shifting funding from existing fellowship training will allow for the development of additional first-certificate residency program positions. At least half of new positions should be in the primary care specialties of family medicine, general internal medicine, and general pediatrics. At least half of new primary care specialty positions should be in family medicine (i.e., 25% of all newly funded first-certificate residency
program positions). The AAFP anticipates that there will be increased emphasis on innovation, use of GME outcome metrics to guide improvement, and redesigned training in first-certificate residency programs.

(July 2018 BOD)
Graduated Driver's License

See also

- Distracted Driving
- 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 (in person or online) 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 "Team-Based Care" supports practice teams led by a physician. 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. The provider credentials of the NPP should be clearly and easily identifiable by the patient at the time of the visit.

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.

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 give appropriate directions are given, understood and executed to ensure patient safety. These directions may take the form of pre-approved written protocols, in person patient reviews, over the phone consultations, or by some other means of electronic communication as appropriate.

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 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 regarding 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 comply 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,
Gun Violence, Prevention of (Position Paper)

SEE ALSO:

- Prevention of Gun Violence (Policy Statement)
- Violence (Position Paper)
- Violence as a Public Health Concern
- Violence in the Media and Entertainment

Introduction

Gun violence is a national public health epidemic that exacts a substantial toll on the U.S. society. Gun violence includes homicide, violent crime, attempted suicide, suicide, and unintentional death and injury. According to the Centers for Disease Control and Prevention (CDC), more than 38,000 deaths from firearms (including suicides) occurred in the United States in 2016,1 and nearly 85,000 injuries from firearms occurred in 2015.2 That’s an average of 105 deaths and more than 230 injuries from firearms each day.1,2

In addition to the thousands killed or injured, myriad families must also cope with the consequences of this violence. In terms of the financial toll, although the estimates vary, it’s generally held that gun violence expenses—medical charges, loss of income, daily care/support, and criminal justice expenditures—cost the U.S. economy approximately $229 billion annually.3

Gun violence should be considered a public health issue, not a political one—an epidemic that needs to be addressed with research and evidence-based strategies that can reduce morbidity and mortality. Gun violence affects people of all ages and races. Family physicians care for victims of gun violence and their families every day. These physicians, who witness the substantial impact firearm-related violence has on the health of their patients, families, and communities, have the power to help improve the safety and wellbeing of those groups.

The complexity and frequency of firearm violence, combined with its impact on the health and safety of Americans, suggest that a public health approach should be a key strategy used to prevent future harm and injuries. This approach focuses on three elements: scientific methodology to identify risk and patterns, preventive measures, and multidisciplinary collaboration.4 The AAFP encourages this public health approach and supports research that identifies which policies and interventions effectively reduce morbidity and mortality, while also respects the Constitutional right to bear arms.

Call to Action

The American Academy of Family Physicians joined the American Academy of Pediatrics, American College of Physicians, American College of Obstetricians and Gynecologists, and the American Psychiatric Association urging the president and Congress to take the following three concrete steps to address gun violence:

- Label violence caused by the use of guns as a national public health epidemic.
- Fund appropriate research as part of the federal budget.
- Establish constitutionally appropriate restrictions on the manufacturing and sale, for civilian use, of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity.5

This call to action from physician groups emphasizes the need to treat gun violence as a public health epidemic.

Family physicians can further address gun violence in their practices and communities by following these office- and community-based steps.

Office-based:
• Know the rates of gun violence in your area to help understand the impact on your patient population ([http://www.gunviolencearchive.org/charts-and-maps(www.gunviolencearchive.org)]).6
• Ask patients and their families if there are guns in the home. If “yes,” discuss safe storage of firearms and ammunition. Encourage participation in gun safety classes.
• The AAFP recommends screening for depression in the general adult population, including pregnant and postpartum women ([https://www.aafp.org/patient-care/clinical-recommendations/all/depression.html](https://www.aafp.org/patient-care/clinical-recommendations/all/depression.html)).7
  
  o Patients who screen positive should undergo additional assessment that considers severity of depression and comorbid psychological problems, alternate diagnoses, and medical conditions. Patients with depression should be treated with antidepressant medication and/or psychotherapy.

• The AAFP recommends that clinicians screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services ([https://www.aafp.org/patient-care/clinical-recommendations/all/domestic-violence.html](https://www.aafp.org/patient-care/clinical-recommendations/all/domestic-violence.html)).8
  
  o The presence of guns in the home increases the risk that a woman will die due to an IPV-related homicide eight-fold.9

**Community-based:**

• Know the rates of gun violence in your area to better understand the impact on your community ([http://www.gunviolencearchive.org/charts-and-maps(www.gunviolencearchive.org)]).6
• Participate in programs that address violence in your community.
• Communicate with your local, state, and federal officials about gun violence as a public health concern. These conversations should specifically address:
  
  o Funding research to identify effective measures to increase the safety of firearms;
  o Gun safety legislation;
  o Strict enforcement of current gun laws;
  o Constitutionally-appropriate restrictions on the manufacture and sale, for civilian use, of large-capacity magazines and firearms; and
  o Appropriate funding for mental health services.

**Gun Violence: A Public Health Epidemic**

Gun violence is a public health epidemic and should be treated accordingly. While mass shootings are horrific and capture the attention of the media, they are only part of the gun-violence picture—more than half of all suicides are firearm-related,10 and firearms are used in more than 50% of female homicides.3,11

Similarly to females, firearm-related deaths are a particular threat to children in the U.S. They are the third-leading cause of death in children overall,1 and the U.S. accounts for more than 90% of all firearm deaths among children in developed, high-income nations.12

Public health professionals are trained to create and test interventions to reduce death and injury. However, limited federal funding is available to research this leading cause of death. Introduced in 1996, the Dickey Amendment prohibits federal funding allocated to the Centers for Disease Control and Prevention (CDC) be used to advocate for or promote gun control, which essentially ended all CDC funding research on gun violence or gun control measures.13

Appropriate research funding is the first step to understand gun violence and is essential to develop programs to prevent premature death from guns. An inconsistent collection of epidemiologic data is another impediment to this research. Currently, not all U.S. states report surveillance data to the National Violent Death Reporting System.14 International Classification of Disease (ICD) codes are often used to collect data on a national scale, but do not provide the same level of detail. Creating a comprehensive data collection surveillance system will provide public health researchers with comprehensive and consistent information to study gun violence.

An example of such a system in place with data to study a public health issue is research on motor vehicle accidents. The number of deaths caused by motor vehicle accidents is comparable to gun violence, but motor vehicle deaths have declined significantly over the past decade despite more motorists on the road. Extensive research has improved motor vehicle safety with multiple evidence-based interventions contributing to decreased mortality. Implementation of vehicle safety features, stricter enforcement of traffic laws, and public awareness campaigns effectively addressed high morbidity and mortality associated with motor vehicles.

The National Highway Traffic Safety Administration (NHTSA) operates with a budget of more than $1 billion annually, and is committed to the continued improvement of the safety of motor vehicles and motorists. Research and development for the agency alone had a budget of nearly $146 million in 2017.

Similarly, almost all other leading causes of death, whether accident or disease, receive substantially more funding for research than gun violence. One study found that, “in relation to mortality, gun violence research was the least-researched cause of death and the second-least funded cause of death after falls.” When a similar approach to research on motor vehicle accidents is suggested for gun violence, it is often considered political, instead of an evidence-based, data-driven approach to prevent morbidity and mortality.

As whole-person health care providers, family physicians see the effect of gun violence on their patients and in their communities. Using a public health perspective, family physicians can incorporate evidence-based strategies to treat their patients and guide their communities on this important issue. With that in mind, the AAFP:

- Continues to oppose legislation that would prohibit the CDC and other agencies from conducting and distributing research on gun violence as a public health problem;
- Advocates for systems to allow accurate reporting of surveillance data; and
- Encourages the evaluation and implementation of evidence-based research and approaches that addresses gun violence to improve the health and lives of all patients.

Suicide

In 2016, almost 45,000 individuals committed suicide in the U.S. Suicide accounts for nearly 60% of all firearm-related deaths in the U.S., with men overwhelmingly choosing firearms as their primary method to commit suicide. Alarming, suicide was the second-leading cause of death for adolescents ages 15-19, with firearms as the leading method of suicide (50.7%) in this age group.

Firearms are the most lethal method of attempting suicide. Between 85 to 91% of firearm suicide attempts result in death, compared to 3% or less for other common ways of attempting suicide. Suicide is often an impulsive decision. The majority of those who survived a suicide attempt reported that less than one hour had passed between the time they decided to commit suicide and when they took action. The use of a firearm to commit suicide rarely allows for intervention or reconsideration, so increased access to firearms is associated with increased rates of completed suicide. Evidence suggests unsafe gun storage may also pose a higher risk for committing suicide using a firearm. The impulsive nature of suicide, in combination with often times easy access to guns, can result in a completed suicide—one that might have been preventable if another method had been attempted.

Opportunities for Prevention

Reducing the availability of firearms is one of the most effective mechanisms for suicide prevention. Waiting periods for purchasing handguns, mandatory background checks, gun locks, and restrictions on open-carry policies are also associated with a reduction in suicide by firearm.

Waiting periods may allow for a “cooling off” time for individuals to reconsider suicide. Background checks limit access by creating a second barrier at the point of purchase. Safely securing guns places a barrier on immediate access and open-carry regulations decreases exposure to firearms. These mechanisms have been shown not only to decrease
suicide by firearm, but also to decrease overall rates of suicide (by any method).\textsuperscript{20}

In addition to decreasing access to firearms, increased access to mental health services is associated with a decrease in overall rates of suicide.\textsuperscript{19} The majority of patients with mental health issues access the health care system through primary care physicians.\textsuperscript{21} Appropriate access to primary care and payment for mental health services are critical to care for individuals with depression, substance abuse, and other mental illnesses, and can ultimately prevent attempted suicide through firearms and other means.

**Domestic Violence**

Among developed nations, the U.S. has the most gun violence against women. Women are nearly 16 times more likely to die by firearm when compared to other developed nations.\textsuperscript{12} The majority of these deaths are the result of intimate partner violence (IPV). For example, in 2015, more than 3,500 women and girls were victims of homicide. More than half of those deaths were related to IPV.\textsuperscript{11} These rates are even greater in subgroups defined by race. Non-Hispanic black and American Indian/Alaskan Native women have the highest rates of IPV-related homicide.\textsuperscript{11}

Compared to homes without guns, households with guns are associated with a nearly three-fold increase for the risk of homicide occurring in the home.\textsuperscript{22} There is a nearly eight-fold increased risk associated with gun ownership and homicide when the perpetrator is the intimate partner or a relative of the victim.\textsuperscript{22} If the gun owner has a history of domestic violence, the risk of homicide is 20 times higher.\textsuperscript{22} Women who are physically abused by current or former partners are seven times more likely to be murdered if the partner owned a handgun compared to women whose partner does not own a handgun.\textsuperscript{9}

**Opportunities for Prevention**

A proven strategy to protect women from IPV-related homicides includes reducing the availability of firearms. The AAFP recommends screening all women of childbearing age for IPV, and referring women who screen positive for IPV to intervention services.\textsuperscript{8} A step that family physicians can take after a positive assessment for IPV is to refer female patients to organizations which have resources for crisis intervention and counseling, and finding safe housing, medical care, and legal advocacy.\textsuperscript{11}

Intimate partner violence is higher in communities experiencing severe disadvantage, such as poverty and low-social cohesion.\textsuperscript{23} System-level changes to reinvest in communities of poverty can reduce violence of many forms, including IPV-related homicide. Legislative policy change is an essential component to the reduction of IPV-related homicide.

Restricting firearm purchases for individuals convicted of domestic violence-related crimes or under a domestic violence-related restraining order is an effective way to prevent IPV-related homicide.\textsuperscript{24} States with systems to screen for restraining orders prior to firearm purchases have an 8-19\% reduction in all IPV homicides and a 9-25\% reduction in the rate of IPV homicide with a firearm.\textsuperscript{25} However, these safeguards must apply to all purchases to be effective. Currently, federal law only requires background checks for firearm purchases with licensed dealers.\textsuperscript{19} Firearms purchased through unlicensed sellers and at gun shows, commonly referred to as the “gun-show loophole,” do not require a background check, allowing for individuals with a history of domestic violence unfettered access to guns. States requiring universal background checks on handgun sales from all sources experienced a 47\% reduction in victims of IPV-related firearm homicide.\textsuperscript{26}

**Homicide and Violent Crime with a Firearm**

In 2016, there were more than 14,400 homicides with a firearm, accounting for nearly three-quarters of all homicides.\textsuperscript{1} In contrast to IPV, the majority (80\%) of homicide victims are men.\textsuperscript{1}

In the U.S., individuals are 25 times more likely to be killed by a firearm than in other high-income nations.\textsuperscript{12} Disparities exist across racial and ethnic lines, as well. Non-white individuals are more likely to die by homicide than whites. For individuals 10-29 years, homicide is the leading cause of death in non-Hispanic blacks and Hispanics.\textsuperscript{27}
This is substantially higher than non-Hispanic whites, where homicide is the fifth-leading cause of death.\textsuperscript{27}

Opportunities for Prevention

Not surprising, a lack of research has resulted in a scarcity of evidence regarding prevention of homicide and violent crime. Limited evidence suggests that reducing access to illegal guns through programs that have demonstrated success can reduce homicide and violent crime rates. One program implemented in Baltimore used a system of “hot-spotting,” where detectives were placed in areas at high risk for gun violence. Between 2007 and 2012, areas of “hot spotting” experienced a 12-13\% reduction in homicides and an 18-20\% reduction in shootings.\textsuperscript{28}

Background checks may also contribute to decreased rates of both homicide and overall violent crime.\textsuperscript{19} Moderate evidence suggests a decrease in violent crime with mental health background checks.\textsuperscript{19} However, much of this data is reported voluntarily by states and may vary depending on which conditions prohibit gun ownership.\textsuperscript{19} It is important to note that there is evidence that certain policies may actually increase violent crime. There is moderate evidence that stand your ground laws increase rates of homicide, and some evidence that states with concealed carry laws see increased rates of violent crime.\textsuperscript{19}

Mass Shootings

Given no standard definition of “mass shooting,” data on the subject, as well as mass murder is inconsistent. After the 2012 shooting at Sandy Hook Elementary School in Newtown, Connecticut, the U.S. Congress defined “mass killing” as “3 or more killings in a single incident.”\textsuperscript{29} This definition does not include information about the weapon(s) used, the number of perpetrator(s), or the location of the shooting. Mass murder is defined by the Federal Bureau of Investigation (FBI) as a “multiple homicide in which four or more victims are murdered, within one event, and in one or more locations in close geographical proximity.”\textsuperscript{29} This does not include injuries, nor is this a formal definition used for data collection purposes. Developing standard definitions through consensus among researchers will be crucial for quality, consistent research regarding gun violence.

Mass shootings account for only a small portion of gun violence deaths, but generally garner media attention due to the public and horrific nature of the incidents. In recent years, mass shootings have, by and large, been perpetrated by men using assault-style, semi-automatic weapons, often modified to mimic fully-automatic versions via high-capacity magazines and “bump stock” technology. These shootings have occurred in public places, such as schools, nightclubs, churches, and music venues.

Opportunities for Prevention

While a lack of research hinders the development of evidence-based strategies to prevent mass shootings, even small changes—banning modification devices, such as bump stocks and high-capacity magazines—could potentially reduce the number of injuries and deaths that occur.

Congress’s 1994 assault weapons ban, which included 18 types of assault weapons, weapons with military-style features, and weapons with high-capacity magazines (10 or more bullets), lapsed in 2004. In that 10-year period, “gun massacres” (six or more gun deaths) declined compared to the decade prior.

From 2004-2014, after the assault weapons ban lapsed, the number of gun massacre deaths during the ban (89) increased more than three times (302). Also, the number of gun massacre incidents during the ban (12) nearly tripled (34) during the same 10-year period.\textsuperscript{30}

Unintentional Death and Injury by Firearm

Unintentional deaths and injuries by firearms are largely preventable. In 2016, 495 people died from unintentional firearm incidents.\textsuperscript{1} Of those, 127 (25.7\%) were children and adolescents (0-19 years).\textsuperscript{1} Most of those deaths were among two age groups: 15-19 years (53 deaths) followed by 0-4 years (23 deaths).\textsuperscript{1} Young adults (20-24 years) had the most deaths by age group, with 68 unintentional firearm deaths.\textsuperscript{1}

Unintentional injury by firearm also disproportionately affects adolescents and young adults. Of the 17,311
unintentional injuries by firearm in 2015, nearly 8,000 (50%) occurred in individuals between 15-29 years.\(^2\) The rate of unintentional injury by firearm was the highest among individuals between 20-24 years (21.9).\(^2\)

**Opportunities for Prevention**

Research suggests clinical interventions and public health campaigns focused on safe storage are effective at preventing unintentional injuries and deaths by firearms.\(^1\) One study found that family physicians and pediatricians who ask patients (mostly those with children) about access to firearms, and are counseled on safe storage and provided a free safe storage device, it results in increased safe storage behaviors.\(^1\) Another study, following the same protocol without providing a free safe storage device, also found improvements in safe storage of firearms. Safe storage of firearms decreases immediate access to guns, especially for children.\(^1\) Child access prevention (CAP) laws are designed to protect children by legally prosecuting adults who intentionally or carelessly create situations in which children have unsafe and negligent access to guns.\(^1\)

These laws often mandate safe storage of firearms, and some states stipulate that firearms must be unloaded when stored.\(^1\) CAP laws also prohibit providing children with unsupervised, reckless access to firearms.\(^1\) Strong evidence suggests CAP laws decrease firearm-related self-injuries (intentional and unintentional) among all ages, and decrease unintentional firearm injuries and death among children.\(^1,\)\(^3\)\(^1\)\(^9\) Evidence also suggests that classifying violations of CAP law as felonies may further reduce unintentional death and injuries by firearms among children.\(^1\)

**Policy Strategies to Address Gun Violence**

Other potential avenues to address gun violence are consistent with common prevention strategies employed in other public health interventions. Two of the most effective public health strategies employed to reduce tobacco use—price increases and taxation—have proven effective deterrents to initiating tobacco use and encouraging the decline and cessation of tobacco use.\(^3\)\(^2\) Applying this economic strategy to the purchase of firearms could potentially reduce gun ownership, and as a result, decrease gun violence.

For example, background checks for ammunition purchases, limits on ammunition purchases, and identification requirements for firearms, have been shown to reduce firearm deaths.\(^3\)\(^3\) Reinstating the 1994 federal assault weapons ban could decrease access to dangerous semi-automatic weapons. Requiring microstamping—microscopic, laser-generated engravings on guns and ballistic materials—contribute to a higher solve rate for homicides and other violent crimes.\(^3\)\(^4\)

**Call for Research**

The AAFP calls for increased research funding on gun violence, and identifying key areas that must be addressed. These areas could begin to be addressed by answering the following questions:

- What specific counseling (regarding gun safety and given by physicians) reduces the likelihood of gun violence?
- Does gun safety training reduce gun violence?
- What policies and interventions (including legal remedies and prevention strategies) reduce gun violence?
- What are the most effective interventions for securing public venues to minimize the risk of mass shootings and minimize resulting casualties?

**AAFP Efforts to Address Firearm Safety and Violence**

Family physicians frequently find themselves on the frontlines on public health issues and discussions. This role provides them an opportunity to address and guide conversations about public health issues, such as gun violence, in both the exam room and their communities. By advancing policies that promote safety and discourage violence, family physicians are instrumental in the gun violence debate.

To assist family physicians in this effort, the AAFP has policies and advocacy efforts relating to violence to help equip family physicians as they serve the needs of their patients. The AAFP recognizes violence as a public health concern, and the impact of violence has on immediate and long-term health outcomes. The AAFP acknowledges that violence
occurs in the context of a broad range of human relationships and complex interactions. These encompass social, cultural, and economic risk factors, including but not limited to, the influence of the media, substance abuse, interpersonal violence, fragmentation of family life, and the increased availability of weapons.

Moreover, the AAFP recognizes that violence disproportionately affects vulnerable populations, such as women, children, lesbian, gay, bisexual, transgender, questioning, and intersex individuals, as well as those living in poverty, among other populations. The AAFP has outlined multi-faceted issues surrounding violence in position papers, and describes both the challenges and opportunities for family physicians to address the health consequences, as well as to help prevent a continued cycle of violence.

- Violence Position Paper: This paper discusses the incidence and prevalence of violence, the impact it has on health, causes of violence, and the family physician’s role in preventing violence and serving patients who have been impacted by violence (www.aafp.org/about/policies/all/violence.html).
- Violence as a Public Health Concern: This policy discusses the AAFP’s stance on violence as a public health concern (www.aafp.org/about/policies/all/violence-public-health.html).
- Firearms and Safety Issues: This policy covers the AAFP’s stance on firearms, guns, and violence as a public health issue (www.aafp.org/about/policies/all/weapons-laws.html).
- Prevention of Gun Violence: This policy discusses the AAFP’s stance on background checks as a mechanism to prevent gun violence (www.aafp.org/about/policies/all/prevention-gun-violence.html).

**Summary**

As clinicians, family physicians can help prevent gun violence in their practice and within their communities by proper screening and treatment of depression, screening for IPV, referring patients to appropriate services, and talking with patients about the safe storage and handling of guns.

Outside of the exam room, family physicians can help prevent suicide and intentional injuries and deaths by advocating for gun violence research funding and gun control legislation at the community, state, and federal levels. To gain a better understanding of gun violence and potential solutions, it is essential that the U.S. Congress implements research funding to create evidence-based strategies to combat and prevent gun violence.

Gun violence in the U.S. is a public health epidemic. Using comprehensive, interdisciplinary approaches, and working in collaboration with other public health professionals, family physicians can play an imperative role in the reduction of gun violence.

**References**

30. Ingraham C. It’s time to bring back the assault weapons ban, gun violence experts say. The Washington Post. 
31. Dowd MD, Sege RD. Firearm-related injuries affecting the pediatric population. Council on Injury, Violence, 
34. Giffords Law Center to Prevent Gun Violence. Microstamping & ballistics. http://lawcenter.giffords.org/gun-

(2018 COD)
Hate Crimes

See also

- Violence (Position Paper)
- Violence, Harassment and School Bullying
- Violence as a Public Health Concern
- Intimate Partner Violence
- Violence, Illegal Acts Against Physicians and Other Health Professionals
- Violence in the Media and Entertainment (Position Paper)

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) (2018 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 is a Right

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)
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 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
- Health Care is a Right
- Homelessness

Goal

To ensure health care coverage for everyone in the United States through a foundation of comprehensive and longitudinal primary care.

The intent of this policy document is to give the American Academy of Family Physicians (AAFP) and its Board of Directors the needed advocacy flexibility to consider all options that might come before federal and state governments and the American people in working to achieve the goal of health care coverage for all – a goal based upon AAFP policy which recognizes that health is a basic human right for every person and that the right to health includes universal access to timely, acceptable and affordable health care of appropriate quality.

Introduction

The health care system in the United States is uncoordinated and fragmented and emphasizes intervention rather than prevention and comprehensive health management. Health care costs continue to increase at an unsustainable rate and quality is far from ideal.\(^{i,ii}\)

Over the past two decades, policies implemented through the Children’s Health Insurance Program (CHIP) and the Patient Protection and Affordable Care Act (ACA) have extended access to affordable health care coverage to millions of previously uninsured, non-Medicare eligible adults and children. The uninsured population reached a historic low of 8.8% under the implementation of these policies.\(^{iii}\) The greatest gains in coverage have occurred among our most vulnerable populations and young adults. However, the rollback of some provisions of these policies has increased the percentage of those uninsured to 15.5%,\(^{iv}\) close to what it was one decade ago when our uninsured rate was nearing 17%, with nearly 50 million people uninsured.\(^{v}\)

Ensuring that all people in the United States have affordable health care coverage that provides a defined set of essential health benefits (EHB) is necessary in order to move toward a healthier and more productive society. Additionally, our health care system must begin to account for and address social determinants that have a profound impact on individual and population health outcomes and costs, such as socioeconomic status, housing and occupational conditions, food security, and the environment. 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.”\(^{vi}\)

Any successful health system reform designed to achieve health care coverage for all must re-emphasize the centrality of primary care, reinvigorate the primary care infrastructure in the United States, and redesign the manner of primary care delivery and payment. Compelling research demonstrates 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 so that they are more accessible, promote prevention, proactively support patients who have chronic illnesses, and engage patients in self-management and decision-making, health care quality improves along with the cost efficiency of care.\(^{vii}\)
Family medicine and primary care are the only entities charged with longitudinal continuity of care for the whole patient. The patient and primary care physician relationship and its comprehensiveness have the greatest effect on health care outcomes and costs over the long term. However, the current United States health care system fails to deliver comprehensive primary care because of the way primary care has been, and is currently, financed.

According to the Center for Evaluative Clinical Sciences at Dartmouth (now called the Dartmouth Institute for Health Policy and Clinical Practice), U.S. states that rely more on primary care have lower Medicare spending (inpatient reimbursements and Part B payments); lower resource inputs (hospital beds, intensive care unit [ICU] beds, total physician labor, primary care labor, and medical specialist labor); lower utilization rates (physician visits, days in the ICU, days in the hospital, and patients seeing 10 or more physicians); and better quality of care (fewer ICU deaths and a higher composite quality score).

The patient-centered medical home (PCMH) is one approach to providing comprehensive advanced primary care (APC) for children, youth, adults, and the elderly. It is a model of health care that facilitates a partnership between an individual patient, the patient’s personal physician, and, when appropriate, the patient’s family or caregiver. Each patient has an ongoing relationship with a personal primary care physician trained to provide first-contact, coordinated, 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.

Fundamental change is required to shift the direction of the U.S. health system toward one that covers all people and emphasizes comprehensive and coordinated primary care. Current resources must be allocated differently, and new resources must be deployed to achieve these desired results. Payment policies by all payers must change to reflect a greater investment in primary care to fully support and sustain primary care transformation and delivery. Workforce policies must be addressed to ensure a strong cadre of the family physicians and other primary care physicians who are so integral to a high-functioning health care team. Congress and/or state legislatures must enact comprehensive legislation to achieve this change. If such legislation only addresses the uninsured and fails to fundamentally restructure the system to promote and pay differently and better for family medicine and primary care, any solution will not reach its full potential to achieve the Quadruple Aim of better care, better health, smarter spending, and a more efficient and satisfied physician workforce.

**Key Elements of the Framework**

- Everyone will have affordable health care coverage providing equal access to age-appropriate and evidence-based health care services.
- Everyone will have a primary care physician and a medical home.
- Insurance reforms that have established consumer protections and nondiscriminatory policies will remain and will be required of any proposal or option being considered to achieve health care coverage for all. Those reforms and protections include, but are not limited to, continuation of guaranteed issue; prohibitions on insurance underwriting that uses health status, age, gender, or socioeconomic criteria; prohibitions on annual and/or lifetime caps on benefits and coverage; required coverage of defined EHB; and required coverage of designated preventive services and vaccines without patient cost sharing.
- Any proposal will reflect at least a doubling of the percentage of health care spending invested in primary care. This investment must result in a payment model for primary care that supports and sustains primary care medical home transformation and reduces the current income disparity between primary care and subspecialty care to ensure an adequate primary care physician workforce.
- Federal, state, and private funding for graduate medical education will be reformed to establish and achieve a national physician workforce policy that produces a primary care physician workforce sufficient to meet the nation’s health care needs. Additionally, U.S. medical schools will be held to a higher standard in regard to producing the nation’s needed primary care physician workforce.
- A defined set of visits and services to a primary care physician will not be subject to cost-sharing.
- In any system of universal coverage, the ability of patients and physicians to voluntarily enter into direct contracts for a defined or negotiated set of services (e.g., direct primary care [DPC]) will be preserved. Additionally, individuals will always be allowed to purchase additional or supplemental private health insurance.
To achieve health care coverage for all, the AAFP supports bipartisan solutions that follow the above referenced principles, are supported by a majority of the American people, and involve one or more of the following approaches, with the understanding that each of these have their strengths and challenges:

- **A pluralistic health care system approach** to the financing, organization, and delivery of health care is designed to achieve affordable health care coverage that involves competition based on quality, cost, and service. Such an approach involves multiple for-profit and not-for-profit private organizations and government entities in providing health insurance coverage. Such an approach to universal health insurance coverage must include a guarantee that all individuals will have access to affordable health care coverage.

- **A Bismarck model approach** is a form of statutory health insurance involving multiple nonprofit payers that are required to cover a government-defined benefits package and to cover all legal residents. Physicians and other providers operate independently in a mix of public and private arrangements.

- **A single-payer model approach** that is clearly defined in its organization, financing, and model of delivery of health care services would be publicly financed and publicly or privately administered, with the government collecting and providing the funding to pay for health care from physicians and other providers who work independently or in private health systems.

- **A public option approach** that is a publicly administered plan directly competing for customers with private insurance plans could be national or regional in scope. Physicians and other providers would continue to operate independently.

- **A Medicare/Medicaid buy-in approach** would build upon existing public programs by allowing individuals to purchase health care coverage through these programs. In such a scenario, there must be at least Medicaid-to-Medicare payment parity for the services provided to the patients of primary care physicians.

As noted in the AAFP’s *Discussion Paper on Health Care Coverage and Financing Models*, which was commissioned by the AAFP Board of Directors in 2017, each of these options for achieving health care coverage for all has its strengths and challenges, which need and deserve to be debated by the American people and their elected officials and representatives. These include, but are not limited to, the following important issues:

- Level of administrative and regulatory burden for physicians, clinicians and other health care providers, and patients/consumers
- Impact on overall health care costs to government, employers, and individuals
- Level of patient, consumer, physician, and clinician satisfaction
- Level of tax burden
- Impact on the timely delivery of health care services (wait times) and delays in scheduling elective health care services
- Clarity of the financing model and levels of payment to physicians, clinicians, and other health care providers
- Inclusion of family physicians on payment, delivery, and other health care decision-making boards
- A description of and clarity on a core set of essential health care benefits available to all, especially primary and preventive care, management of chronic illnesses, and protections from catastrophic health care expenses
- Impact on the equitable availability and delivery of health care services
- Impact on quality and access
- Determination of whether there are global budgets and price/payment negotiations
- Need for a clear and uniform definition of a “single-payer health care system”

**Comprehensive Primary Care**

Advanced primary care embodies the principle that patient-centered primary care is comprehensive, continuous, coordinated, connected, and accessible for the patient’s first contact with the health system. APC aims to improve clinical quality through the delivery of coordinated, longitudinal care that improves patient outcomes and reduces health care spending. The AAFP believes APC is best achieved through the medical home model of practice. We define a

primary care medical home as one that is based on the Joint Principles of the Patient-Centered Medical Home and has adopted the five key functions of the Comprehensive Primary Care Plus (CPC+) initiative, which establishes a medical practice that provides comprehensive care and a partnership between patients and their primary care physician and other members of the health care team, as well as a payment system that recognizes the comprehensive work of providing primary care. The key functions of a primary care medical home are:

1. Access and Continuity
2. Planned Care and Population Health
3. Care Management
4. Patient and Caregiver Engagement
5. Comprehensiveness and Coordination

Benefits

All proposals or options to provide health care coverage for all will be required to cover a defined set of essential health benefits. At a minimum, these would include items and services in the following benefit categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

In addition to requiring coverage for EHB, all proposals or options will ensure that primary care is provided through the patient’s primary care medical home. To foster a longitudinal relationship with a primary care physician, all proposals or options will provide the following services independent of financial barriers (i.e., deductibles and co-pays) if the services are provided by the patient’s designated primary care physician:

a. Evaluation and management services
b. Evidence-based preventive services
c. Population-based management
d. Well-child care
e. Immunizations
f. Basic mental health care

Affordability

To achieve the goal proposed in this paper: “to ensure health care coverage for everyone in the United States through a foundation of comprehensive and longitudinal primary care,” it will not be sufficient to focus on health care coverage and primary care alone. There will need to be an effort aimed at identifying and reducing the costs of health care services including the administrative costs of delivering those services.

A health care system that is comprehensive and prioritizes primary care must also emphasize the cost and affordability of care. This is important not only for consumers, but also for the decision-making of physicians, clinicians, payers, and government agencies. Affordability is a critical component in efforts to reform the United States health care system.

- Prevention & Public Health – there should be increased investment in preventive care, specifically those preventive services that have been proven to reduce the prevalence of preventable diseases (e.g., access to free vaccines and screening programs). A focus on reducing preventable diseases likely would reduce or, at minimum defer, future high-cost spending for preventable diseases. In addition, there should be an increased focus on
identifying societal and environmental factors that contribute to increased health care spending.

- **Transparency** – an increased investment in primary care and the medical home allows health plans to not only reduce the costs of treating high-risk patients but improve the quality of health services.\textsuperscript{xii} This increased investment should be supported by aggressive efforts to establish price transparency for all health care services. Such transparency likely will contribute to reducing excessively high health care costs by informing the public about their costs of care and creating more competition in the health care industry.

- **Consolidation** – consolidation in the health system is cause for concern when it comes to affordability. Although consolidations between health systems may allow for reductions in internal costs, such as operating expenses, they create a less competitive market which leads to higher health care costs and insurance premiums.\textsuperscript{xii}

- **Site-Neutral Payment Policies** – for many health care services, current payment policies often are highly variable depending on the site of service (payment higher for the same service performed in a hospital versus an ambulatory surgery center versus a physician’s office for example) despite no significant differences in quality or outcomes of care. Such payment policies contribute to excessive spending in our current system. In addition, such payment policies incentivize consolidation, decrease competition between providers of care, and facilitate over-utilization of high-cost health care services. This issue could be addressed effectively through site-neutral payment policies and the elimination of some facility fees.

- **Administrative Costs** – a share of the overall costs of health care in United States health care is due to high administrative costs. Much of these high administrative costs is due to complexities in billing which is exasperated by multiple payers. Countries with lump-sum budgets and fewer health care payers have seen lower costs in administrative spending.\textsuperscript{xiii} Of all hospital spending in the United States, 25% is dedicated to administrative costs--- nearly $200 billion. In comparison, Canada dedicates only 12% of hospital spending to administrative costs, while England spends 16% on administrative costs. Additionally, no link has been found between higher administrative costs and higher quality care.

- **Pharmaceutical & Biologics** – advances in pharmaceuticals and biologics have improved the health of millions of people, decreased the prevalence of preventable diseases, and allowed for chronic diseases to maintained over a prolonged period of time. These advances have extended life expectancy for millions of people, especially those with chronic diseases and some cancers. These advances should be celebrated for the positive impact they have had on millions of people. However, the escalating costs of pharmaceuticals and biologics places these interventions and treatments out of reach for far too many people. Policies should be established that allow purchasers of health care, including Medicare, to negotiate the costs of prescription drugs. Additionally, there should be greater flexibility in the design of formularies that allow for increased use of generic and bio-similar products.

### Payment

The AAFP believes all primary care physicians should be compensated in a manner that is consistent with the AAFP’s comprehensive payment model for family medicine and primary care, the Advanced Primary Care Alternative Payment Model (APC-APM). The AAFP believes the APC-APM is a foundational element of a greater investment in primary care that is essential to a better system of care in the United States.

The model builds on previous programs and years of research showing the benefits of movement away from fee-for-service (FFS) payment and increased support for population-based care. It better supports small and independent practices and reduces administrative burden in the health care system.

**Key Components of the APC-APM**

For any health care system to achieve its goals, there will be a need for greater investment in primary care. The AAFP strongly supports increased investment in primary care as part of any U.S. health care system.
Family physicians, other primary care physicians, and primary care teams provide comprehensive primary care through two distinct functions: direct patient care and non-face-to-face care, which we label as “population-based care.” The AAFP has concluded that traditional FFS payment is largely incongruent with these core functions. The APC-APM, which is outlined in Figure 1, is better designed to recognize the value of these complementary, yet distinct, functions.

The APC-APM establishes a payment model built on the realization that high-quality primary care is delivered through both direct patient care and the population-based services that are provided by the primary care team. Additionally, we believe the revenue cycle for primary care must move to a prospective payment model with a retrospective evaluation for performance and quality. Therefore, our model establishes prospective payments for a direct patient care global payment, a population-based global payment, and a performance-based incentive payment.

Building on our belief that primary care should remain comprehensive, the APC-APM maintains an FFS component as a means of driving comprehensive care at the primary care level. The presence of this FFS component recognizes that a comprehensive primary care practice will provide episodes of care that are beyond the scope of the direct patient care global payment.

We believe the APC-APM will support a greater investment in primary care and will allow primary care practices of all sizes and in any location to achieve and sustain success through its simplified payment structure and dramatic reduction in administrative burden. More importantly, we believe patients will achieve better outcomes and have a more favorable experience through this model.

Figure 1. Key Components of the APC-APM Payment

Summary

This framework offers important policy options for the AAFP to move the United States toward a primary care-based health care system in which all people have appropriate and affordable health care coverage, are provided a medical home, and have primary care-oriented benefits. This can be achieved only if Congress and/or state legislatures act to ensure that these policy objectives are implemented. All people in the United States must have appropriate and affordable health care coverage, but this is not sufficient by itself. A fundamental change in the health care system to move toward a primary care-based system is essential to achieve 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. The United States will only achieve the type of health care system that our people need, and our nation deserves through a framework of health care coverage for all that is foundationally built on primary care.

References


(1989) (July 2018 BOD)
Health Care is a Right

See Also

- Health Care
- Health Care for All

The American Academy of Family Physicians recognizes that health is a basic human right for every person and that the right to health includes universal access to timely, acceptable and affordable health care of appropriate quality. (2017 COD)
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) (2018 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

Related Information

- The EveryONE Project

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**


(2014 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

The American Academy of Family Physicians (AAFP) believes that health care facilities should emphasize healthy behaviors, including access to healthy nutrition, opportunities for physician activity, and a smoke-free environment for their employees and patients. Healthy nutrition options should be in all dietary offerings, including on-site cafeterias, vending machines, snack carts, and gift shops. Healthy options should be prominently displayed, while fast food, high sugar beverages, and other unhealthy options should be limited. Whenever possible, health care facilities should use local environmentally-sustainable food. Family medicine training programs should, therefore, promote and support institutional policies to provide well-balanced food options for trainees during work hours.

Further, the AAFP believes that high-quality nutrition should extend to all workplaces that offer food to their employees and to the public at on-site cafeterias and vending machines. (2005) (2017 COD)
Helmet Laws

See also

- Protective Equipment for Recreational and Competitive Sports Activities
- Motor Vehicle Occupant Protection
- Motorized Recreational Vehicles

The American Academy of Family Physicians (AAFP) recommends the use of helmets when riding motorcycles, bicycles, all-terrain vehicles, scooters, skate boards, and while skating (ice, roller, or in-line) and using city bike and scooter share programs. The AAFP supports legislation requiring appropriate helmet use and urges constituent chapters to support the enactment or preservation of state helmet laws when riding motorcycles, bicycles, all-terrain vehicles, scooters, skate boards, and while skating (ice, roller, or in-line). The AAFP acknowledges the potential public health benefits of bike and scooter share programs and encourages the safe use of these transportation methods. The AAFP recognizes these programs often do not include readily-accessible helmets, and therefore health benefits should be weighed accordingly. (1981) (March 2019 BOD)
Hearing Loss, Deafness, and the Hard-of-Hearing

See Also

- Culturally Sensitive Interpretive Services - AAFP Legislative Stance
- Discrimination, Patient

The American Academy of Family Physicians (AAFP) encourages all family physicians to become knowledgeable about prevention, evaluation and treatment of deafness and hearing loss in patients of all ages. The AAFP recommends the following:

- Counsel patients to prevent all forms of hearing loss.
- Refer patients who are deaf and hard of hearing for hearing assistive devices and hearing-ear dogs, if desired.
- Ask patients who are deaf or hard-of-hearing their preferred method of communication.
- Provide American Sign Language (ASL)-fluent interpreters experienced in medical interpretation, if requested, available, and financially feasible. To ensure clear and complete communication, an ASL interpreter is preferable to a family member interpreting for a patient.
- Provide a means of booking appointments and accessing private health information through appropriate language assistance and accommodations.
- Provide visual aids and online resources to facilitate patient education.

Home Health Care

See also

- Medical Home
- Essential Community Provider
- Ethics and Advance Planning for End-of-Life Care
- Hospice Care
- Long-Term Care
- Continuity and Coordination of Care Long-Term Care Facilities
- 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) (March 2019 BOD)
Homelessness

See also

- Essential Community Provider
- Medically Underserved
- Medical Schools, Service to Minority, Vulnerable and Underserved Populations
- Health Care for All
- Community and Migrant Health Centers

The American Academy of Family Physicians (AAFP) supports Housing First programs that offer rapid access to permanent, affordable housing integrated with health care and supportive services. Housing First is a model defined by the U.S. Department of Housing and Urban Development (HUD) as a method to ‘quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers.’ Preconditions and barriers can include but are not limited to sobriety, treatment, or service participation requirements.

Housing is health care. Access to safe and affordable housing is a social determinant of health. Homelessness may exacerbate existing health conditions and lead to the development of new health conditions. Persons who are homeless frequently experience co-occurring severe physical, psychiatric, substance use, and social problems that affect both individuals and families. Health care services are more effective when a patient is housed, and maintaining housing is more likely when comprehensive primary health care services are available. Effective strategies to end homelessness must consider this complexity of health conditions and disability faced by persons who are homeless.

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, Documentation of Training and Experience
- Hospital Medical Staff and Other Health Care Organizations, Board Recertification
- 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. All medical staff members should recognize that overlap occurs among specialties and that no one department ‘owns’ or has exclusive rights to any particular privileges.

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) (2018 October BOD)
Hospital Medical Staff and Other Health Care Organizations, Board Recertification

See Also

- Hospital Medical Staff, Board Certification for Membership
- Hospital Medical Staff, Liaison Between Governing Boards and Certificate/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

The AAFP believes that physicians who are elected or appointed by a medical staff to a hospital board of trustees or governing board, 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) (2018 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) (2017 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) (2018 October BOD)
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 without regard to financial barriers 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. The rationale to deny a transfer must be clearly articulated to the attending physician involved in the referral. (1986) (2017 COD)
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)

Other resources:

1. www.PolarisProject.org(www.PolarisProject.org)
2. http://211.org/services/human-trafficking(211.org)

(2016 September BOD) (2017 COD)
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)
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

See Also

- Clinical Recommendations
- Payment, Physician
- Immunization Exemptions

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

- Decriminalization of Possession of Marijuana for Personal Use

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)
Implicit Bias

AAFP Resources

Addressing Implicit Bias in Health Care Delivery

Use this PowerPoint presentation, from The EveryONE Project, to help facilitate an in-service or lunch-and-learn session with your practice team.

Download Now

The American Academy of Family Physicians (AAFP) recommends educating physicians about implicit bias and strategies to address it to support culturally appropriate, patient-centered care and reduce health disparities.

Implicit bias, defined as, ‘the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner,’ is a contributing factor to health disparities. Family physicians should make efforts to explore their own implicit biases to identify unconscious decisions and actions that may negatively affect the communities they serve. (2018 July BOD) (2018 COD)
Incarceration and Health: A Family Medicine Perspective (Position Paper)

Executive Summary

Family physicians have an interest in advancing policies that improve the health of all people, with a special focus on the most vulnerable members of our communities. Incarcerated individuals and those detained in immigration facilities are disproportionately affected by chronic health conditions, mental illness, and substance abuse. However, they tend to receive inadequate health care before, during, and after incarceration or detention, further exacerbating their disadvantage.

The American Academy of Family Physicians (AAFP) supports policies that mitigate health disparities, such as improved access to substance abuse treatment, reproductive health care, and mental health services. Furthermore, as incarceration and detention are themselves detrimental to health, the AAFP supports reducing sentences for nonviolent and drug possession offenders and ending detention for those seeking legal asylum in the United States.

The AAFP supports efforts to address issues surrounding the current bail system and to reduce negative health outcomes of individuals in correctional facilities awaiting trial. Interventions that could improve the health of incarcerated individuals include delivering improved health care services in correctional and detention facilities and improving coordination of services following release.

Family physicians can promote the health of individuals who are incarcerated by working or volunteering in correctional or detention facilities; aiding them during the transition to their communities by supporting collaborations between prison or detention facilities and community health services; promoting integrated models of care; and supporting more linkages to housing, employment, and mental health support.

Positive Actions Family Physicians Can Take

- Learn about the unique needs of incarcerated or formerly incarcerated individuals and their families. Resources include the American College of Correctional Physicians (http://societyofcorrectionalphysicians.org), the National Commission on Correctional Health Care (www.nche.org), and the Center for Prisoner Health and Human Rights (www.prisonerhealth.org).
- Advocate for individuals who are incarcerated or who have been incarcerated and their families to have adequate access to mental health and evidence-based substance abuse treatment services, including medication-assisted treatment for opioid use disorders.
- Advocate to prevent unnecessary incarceration by diverting eligible people from the justice system to substance abuse and/or mental health treatment.
- Advocate against detention of those seeking asylum and against separation of parents and children in immigration detention centers, and promote policies for humane treatment of families detained as a result of seeking safe haven in the U.S.
- Partner with legislators on other policy issues related to prisoner health, such as eliminating racial disparities in the bail system, sentencing, commuting sentences of nonviolent drug offenders, and facilitating health insurance enrollment processes after release.
- Be aware of tools and resources for addressing health disparities and apply them as appropriate in their practices and communities.

Defining the Problem

The U.S. has the highest incarceration rate in the world.1 In 2016, the corrections system in the U.S. had approximately 6.6 million people under its supervision, including people in prison or jail and people on probation or parole.2 From 1978 to 2016, there has been a nearly fivefold increase in the number of people under the jurisdiction of state or federal correctional authorities in the U.S.3 While the increased incarceration rate has contributed to a proportion of the decreased crime rate, the majority of the drop in crime is a result of other factors. One analysis suggests that 25% of the decline in violent crime in the 1990s was due to increased incarceration. It suggested that the remaining 75% was due to other factors, such as economic growth, changes in drug markets, strategic policing, and community responses to crime.4 Moreover, increased incarceration has not resulted in a significantly safer or crime-free society.4

Two factors contributed to the increased incarceration rate. The first was court cases that “deinstitutionalized” mental health patients by ruling that they be moved from inpatient facilities to outpatient care.5 Much of the inpatient care was viewed as dehumanizing, and some experts theorized that new and better drugs would allow most mental health patients to be treated as outpatients. However, as inpatient populations dropped, additional funding was not allocated for outpatient treatment. As a result, large numbers of inpatients were released without adequate care, housing provisions, or social support.6 Many went untreated and became homeless and prone to being arrested for substance abuse, petty theft, and disruptive behavior. A 2009 study found that 14.5% of men and 31% of women in jail suffered from serious mental illness.7 By comparison, the National Survey on Drug Use and Health reported that 3-4% of adults in the general population suffered from serious mental illness from 2008 to 2014.8

A 2015 case study of the New York City jail system showed that among the most frequently incarcerated population, most were charged with misdemeanors such as trespassing, non-payment of transit fares, and low-level theft, and comparatively few were involved in assaults.9 Among this frequently incarcerated population, 19% of prisoners had serious mental illness and 51.5% were homeless. The study suggested that providing adequate housing, health care, and social support to this group would be far less expensive than incarcerating them and would result in better health outcomes.9

The second factor contributing to the incarceration rate has been the war on drugs that was instituted in the early 1980s. This campaign has resulted in harsh, lengthy sentences for possession of even small amounts of illegal drugs.10 From 1980 to 2016, the number of individuals incarcerated for drug offenses increased from nearly 41,000 to more than 450,000—more than a tenfold increase.10 In addition, the lack of treatment and follow-up for drug use and abuse during and after incarceration is likely associated with increased recidivism,11 as well as an increased rate of death due to overdose.12 Racial disparities in drug-related arrests and convictions are evident. For example, although there are only negligible differences in reported drug use between black and white populations, black individuals are more likely to be arrested for drug possession or use.13 In 2015, the percentage of non-Hispanic black or African-American individuals in federal prison for drug offenses was almost twice the percentage of whites.14
For some inmates, incarceration may have a positive health impact in the short term by providing housing; making meals available; reducing access to drugs, alcohol, and cigarettes; and giving some access to health care. However, this protective effect is temporary because individuals lose these benefits once they are released. In fact, studies have documented a twelfe-fold increase in all-cause mortality in the first two weeks after individuals were released from prison when compared to all other populations.

**Health Issues During Incarceration**

Inmates in correctional facilities have significantly higher rates of disease than the general population, and correctional facilities are often an ill-equipped provider for the medically underserved. This population tends to suffer in greater numbers from infectious disease, mental health problems, and substance use and addiction. Their health can also be affected negatively by factors in their environment, such as violence or overcrowding.

**Infectious Disease**
Infectious disease is more prevalent among incarcerated populations than in the general population. Compared to the general population, individuals living in correctional facilities are approximately three times more likely to have HIV or AIDS and are more likely to have hepatitis and tuberculosis. Access to screening and evidence-based treatment for HIV is not consistently available in many prisons. Rates of other sexually transmitted infections (STIs), such as chlamydia, gonorrhea, and syphilis, are also higher in individuals who are incarcerated. In correctional facilities, STI rates are higher in women than men.

**Mental Health and Substance Abuse**
It is estimated that greater than 65% of individuals who are incarcerated meet the Diagnostic and Statistical Manual (DSM)-IV criteria for alcohol or other drug dependence or abuse. Unfortunately, only 11% of individuals who have a substance use disorder receive drug treatment while incarcerated. For this reason, individuals who have chronic addictions have a higher risk of going through withdrawal while in custody and then overdosing when they return to the community.

Since 2000, the rate of deaths from drug overdoses in the U.S. has increased 137%, including a 200% increase involving opioids. Opioids, primarily prescription pain relievers and heroin, account for the majority of drug overdoses in the U.S. While these deaths were initially related to prescription opioids, beginning in 2016, illicit forms of opioids (e.g. heroin and fentanyl) became the main source of deaths due to overdoses. With an increase in illicit drug use, there may be an increase in the number of individuals incarcerated with opioid use disorders. Evidence-based treatment of substance use disorders improve health outcomes and reduce the spread of infectious diseases. Additionally, treatment of substance use disorders of inmates has been shown to reduce mortality and recidivism.

**Violence and Self-harm**
Intentional and accidental injuries to individuals who are incarcerated, corrections officers, and correctional facility staff are common. In one survey, more than 32% of people in state correctional facilities reported being injured since their admission. Suicide has been the leading cause of death in local jails every year from 2000 to 2014, accounting for nearly one-third of all deaths in local jails during that period.

**Health Outcomes Across the Life Span**
At any point, between 6 and 10% of women who are incarcerated are pregnant. One study found that 43% of pregnant women entering jail in Rhode Island had conceived within one year of release from a prior incarceration. Among those women, 50% had conceived within 90 days of a prior release. Providing contraceptive services to these women during incarceration increases the likelihood they will initiate birth control compared to providing those services only in their communities. However, most state prison health providers fail to use best practices and established standards when caring for pregnant women. Among women who enter prison during the first trimester of pregnancy and deliver at term, the number of prison prenatal care visits appears to be positively associated with infant birth weight.

Compared to the general adolescent population, incarcerated youth have higher morbidity and mortality rates. Priority health care needs in this population include dental health, reproductive health, and mental health. Two-thirds of boys and more than four-fifths of girls who are incarcerated meet the criteria for at least one mental health disorder. The most prevalent include disruptive disorders, substance abuse, anxiety disorders, and mood disorders (e.g., depression). Injuries and exposure to violence also contribute to the poor health seen in this population. Juvenile incarceration likely correlates with poor health and a lower social functioning status across an individual’s lifetime.

From 1990 to 2009, the number of inmates older than 55 years of age more than tripled. This increase has economic consequences. Older adults have higher rates of chronic conditions, including hypertension, diabetes, and heart disease. As they age, there will be more people in the prison population with cognitive impairment and physical disabilities that will make them vulnerable to injury and poorer health outcomes. Mostly due to health care costs, this translates to older people in prison being the most expensive group. Many prisons and jails are poorly equipped to meet the needs of elderly inmates who have chronic medical conditions and disabilities.

**Effects of Incarceration on Families**
As the number of people incarcerated increases, more and more families have to deal with having someone from the household in jail or prison. For children, having an incarcerated parent may have negative health and social consequences. Parental incarceration has been associated with increased drug use during late adolescence for males and females in the U.S.. A 2012 meta-analysis showed that children who had an incarcerated parent consistently had higher rates of antisocial behavior. Some subgroups of children also showed issues with poor school performance and mental health problems. Another study found that men who had been incarcerated contributed nearly $1,300 less to their children per year than men who had never been incarcerated. This decrease can put a significant strain on families that are already struggling financially. Additional financial burdens for families include the traveling costs and lost wages associated with visiting loved ones incarcerated far from their communities.
The impact of incarceration can begin prior to sentencing as people in poverty are often incarcerated while pending trial due to their inability to pay the cash bond, regardless of their potential threat to society, severity of their crime, or innocence. In 2014, more than 60% of people who were incarcerated were awaiting trial. African-American defendants are disproportionately affected by the cash bail system as they often receive higher bail amounts than white defendants who commit similar crimes. Pre-trial incarceration can last weeks, and sometimes months to years placing individuals at risk of losing necessities like housing, employment or custody of their children while awaiting trial. Many families cannot afford to post bail and subsequently lose income, implementing barriers to meeting basic needs, including housing and food.

### Privatization of Prison Services

In some states, prison services have been handed over to private companies, which also assume responsibility for health care services inside the correctional institution. Comparative effectiveness studies on health outcomes in private and state-run prisons are not available; however, published anecdotal reports have shown poor quality care at multiple private prisons across the country. These reports have shown an increase in inmate mortality; gross deficiencies in care; and allegations of increased risk of serious harm, preventable injury, amputation, disfigurement, and death due to conditions at correctional facilities.

As a result, multiple court cases have been brought against private prisons.

### Immigration Detention Centers

U.S. Immigration and Customs Enforcement (ICE), under the direction of the U.S. Department of Homeland Security, oversees the detention of immigrants in more than 200 county jails and for-profit prisons in the U.S. An average of more than 350,000 people immigrating to the U.S. are detained in the centers per year. They are primarily individuals taken into custody by ICE while their cases for deportation are being processed. In recent years, several reports from watchdog groups, such as the American Civil Liberties Union (ACLU) and Human Rights Watch, have documented numerous cases of inadequate medical care at immigration detention centers.

The detention of immigrants has negative physical and mental health implications for adults and children alike. Detention has been associated with anxiety, depression, post-traumatic stress disorder (PTSD), self-harming behavior, sleep disturbances, and social withdrawal. In many instances, detained individuals have already experienced traumatic events in the country of origin from which they sought a safe haven. The AAFP opposes the separation of family units, and in particular the separation of minor children from parents/guardians in immigration facilities. In instances where separation cannot be avoided, family members should have the ability to communicate frequently and receive updates on the status of legal proceedings.

Women, especially pregnant women, held in immigration detention facilities have poor access to medical care. Advocates also point to major concerns of sexual assault and physical violence to women in ICE custody. Immigration detention facilities must adhere to women’s health standards including prenatal care, preventive services and contraception, and should be held to that standard in a transparent and public facing manner, as do other federally-funded public health facilities such as community health centers and health departments.

### Health Issues After Incarceration

More than 650,000 individuals were released from prison in 2015. This transition, or reentry to society, may be a very stressful period for the individuals, their families, and communities. Individuals released from prison must find housing, employment, and access to health care, in addition to reintegrating themselves with their families and communities.

Studies have shown that individuals who have been incarcerated have higher rates of morbidity and mortality than the general population. As a population, people in prison exhibit a high burden of chronic and noncommunicable diseases (e.g., hypertension, diabetes, and asthma), as well as communicable diseases (e.g., hepatitis, HIV, tuberculosis), mental health problems, and substance abuse disorders. A representative sample of individuals released from correctional facilities noted that most had at least one physical health, mental health, or substance abuse problem, and nearly 40% of men and more than 60% of women in this population had multiple health conditions. Upon reentry into society, prompt and continuous management of these conditions often falls by the wayside as individuals who have been incarcerated face challenges enrolling in health insurance coverage, finding a primary care physician, making health care appointments, and refilling prescriptions.

Barriers to health care contribute to an individual’s particularly high vulnerability to morbidity and mortality the first few weeks after release.

Rates of hospitalization are higher in individuals who have been incarcerated than in the general population. One study reported that approximately 1 in 12 individuals is hospitalized for an acute condition within 90 days of release from correctional facilities. Another study demonstrated a higher risk of death among individuals released from prison—particularly in the first two weeks—compared to the general population during the same period. Researchers noted that the adjusted relative risk of all-cause mortality within the first two weeks after release from prison was 12.7 times the risk of nonincarcerated individuals.

The adjusted relative risk of death was higher for women than men. Drug overdose, cardiovascular disease, homicide, and suicide were the leading causes of death.

The use of mental health and substance abuse treatment services decreases significantly following release from prison. Additionally, one survey noted that for men and women who received treatment for physical health conditions during their incarceration, treatment rates dropped dramatically within 8-10 months after their release. The trend was similar for mental health treatment. For men, more than 60% were treated for mental health issues while in prison but only 53% received treatment 8-10 months after their release. For women, 57% were treated for mental health issues while incarcerated, but only 42% received treatment 8-10 months after their release. Studies have also found delays in linkage to HIV treatment services after release from prison. Lack of insurance is one reason for the decrease in service utilization by individuals in the first year after their release from correctional facilities.

Many of these individuals rely on hospital emergency departments for episodic care for acute problems. The absence of continuity of care after incarceration leads to increased morbidity for patients who have chronic conditions, particularly those who are HIV-positive.

### Policy Implications

The AAFP supports policies that mitigate health disparities, such as improved access to substance abuse treatment, reproductive health care, and mental health care, preventive services and contraception, and should be held to that standard in a transparent and public facing manner, as do other federally-funded public health facilities such as community health centers and health departments.
services. Furthermore, as incarceration and detention are themselves detrimental to health, the AAFP supports reducing sentences for nonviolent and drug possession offenders and ending detention for those seeking legal asylum in the U.S. Due to increased incarceration time for many individuals, the AAFP calls for a review and changes to the cash bail system, as it increases the risk of both short- and long-term negative health outcomes, exacerbates socioeconomic disparities, and is racially biased.

The AAFP advocates for individuals who are incarcerated or detained to have access to comprehensive medical services including mental health care and reproductive health care. Reproductive health services should include evidence-based prenatal care, preventive services, as well as, contraception during incarceration and at the time of release. Other services and items should be made readily available, such as medication and counseling to treat and prevent sexually transmitted infections and should include integration of routine HIV prevention strategies including Pre-Exposure Prophylaxis (PrEP) medication, condoms, education, and frequent screening for HIV and other sexually transmitted infections. Access to evidence-based treatments for substance use disorders should be provided by correctional health facilities. Facilities should publicly report quality and safety performance on key metrics such as those that are consistent with the Unified Data System maintained by the Health Resources and Services Administration (HRSA) as a condition of federal funding.

The health and well-being of children of immigrant parents should be protected. Children should not be placed in settings that do not meet basic standards for their physical and mental health. Children should not be separated from a parent or primary care giver who is detained in an immigration facility, as this separation poses great risks in terms of emotional trauma, safety, and diminished overall well-being. Federal policy should mandate access to medical services for all individuals, particularly pregnant women and children, who are in detention centers. Private prisons and immigration detention centers should report on quality and safety performance on key metrics such as those that are consistent with the Unified Data System maintained by the Health Resources and Services Administration (HRSA) as a condition of federal funding.

Individuals who have been incarcerated have significant health care needs and face multiple barriers to obtaining health insurance and access to care. These challenges affect not only the formerly incarcerated individuals, but also their families and communities, many of which are disadvantaged, and experience health inequities born out of complex social determinants of health. Achieving the goals of improving the health of former prisoners, easing their transition back into the community, and preventing future reincarceration will require interventions on multiple levels. Successful interventions should encompass system-wide strategies at the community and policy levels, including the following:

- Reentry processes that begin prior to release
- Establishment of community-based collaborations
- Integrated models of care, and linkages to housing, employment, substance misuse and abuse support, and mental health support

Successful reentry programs must be culturally competent and consider racial and ethnic disparities, as well as the needs, resources, and strengths of diverse groups and communities. Models of chronic care and individual case management in the first few weeks after release from prison were shown to be effective in increasing the use of primary care and decreasing emergency department usage following release from prison. These models should be made widely available.

References


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(2017 April BOD) (March 2019 BOD)
Independent Physician Associations (IPAs) Definition

See also

- Payment, Physician

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:

- 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.

Independent Practice

Family medicine physicians have appropriate training and competency to care for patients in a wide array of practice models and environments. The American Academy of Family Physicians (AAFP) supports physician and patient choice. The AAFP understands family physicians that own or work in a small and/or independent practice environment have unique needs and may need specific and targeted support to be successful. Education, resources, and services that are developed for use in a small and/or independent practice environments can often be modified to work in larger and/or more integrated practice environment. Often the reverse is less applicable. The AAFP provides education, resources, and services specific to family physicians in independent practice. The AAFP also advocates for public and private payer policies and rules that support family physicians that choose to work in an independent practice environment. (2017 COD)
Information Technology Used in Health Care

The American Academy of Family Physicians recommends that Congress:

- Use federal incentives to support a system of “Connected Patient Centered Medical Homes,” electronically connecting 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 upward payment adjustments to physicians who can demonstrate that they use Electronic Health Records (EHRs) for care coordination, disease management, referrals, e-prescribing, and for communications with patients and other doctors. Conversely, physicians without an HIT system should not be penalized with negative payment adjustments.
- Extend targeted 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 uniform standards for portability and interoperability to the exchange of health information. 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) (2017 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

See also

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

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\(^1\) yet ranking consistently low in quality measures compared to other industrialized nations.\(^2\) 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.\(^3\)-\(^5\) 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.”\(^6\) This is paralleled with a growing awareness of the social,\(^7\) environmental,\(^8\) and community\(^9\) 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),\(^10\) 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.\(^11\) 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\(^12\) and The Future of the Public’s Health in the 21st Century\(^13\) developed momentum that led to the most recent release of the IOM’s Primary Care and Public Health: Exploring Integration to Improve Population Health,\(^14\) 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,\(^15\) 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.\(^16\),\(^17\) 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” 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.

**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.\textsuperscript{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.\textsuperscript{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,\textsuperscript{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.\textsuperscript{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.

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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**


(2015 COD)
Intimate Partner Violence

See also

- Violence (Position Paper)
- Violence as a Public Health Concern
- Violence in the Media and Entertainment (Position Paper)
- Violence, Harrassment and School Bullying
- Child Abuse
- Hate Crimes
- Human Trafficking

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:


(2002) (March 2019 BOD)
Laboratories, Physician Office

See also

- Laboratory Technicians
- Laboratories Sharing Data

The AAFP believes clinical laboratory procedures performed in physician offices offer timely diagnostics that can improve patient care. For this reason, the AAFP supports appropriate payment of clinical laboratory services performed in physician offices. These physician office laboratories should participate in a recognized laboratory accreditation program and an approved proficiency testing program to ensure the accuracy of diagnostic tests and laboratory results. (1988) (2018 COD)
Laboratories Sharing Data

See Also

- Laboratory Technicians
- Laboratories, Physician Office
- Data Stewardship

The American Academy of Family Physicians supports seamless exchange of laboratory data between the laboratory and any member of the care team, when requested. The data should be shared through the practice’s usual preferred method of receiving results at no further cost to the practice. (2017 COD)
Laetrile

Scientific evidence has shown that Laetrile has no place in a treatment regimen for cancer patients. (1977) (2018 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

- 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) (2018 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) (2018 COD)
Licensure

See also

- Certification/Maintenance of Recertification, Definitions
- Professional Competence Evaluation
- Licensure/Relicensure, Definitions
- Licensure, Restricting Physician Licensure

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) (2018 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) (2018 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 federal health care mandates. (2008) (2018 COD)
Long-Acting Reversible Contraceptives

See also

- Over-the-Counter Oral Contraceptives
- Reproductive Decisions
- Women's Health Care
- Contraception Methods for Medicare Patients
- Contraceptive Advice
- Coverage, Patient Education, and Counseling for Family Planning, Contraceptive Methods, and Sterilization Procedures
- Reproductive and Maternity Health Services

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)
Long-Term Care

See also

- Home Health Care
- Continuity and Coordination of Care Long-Term Care Facilities
- Aging
- Elder Mistreatment
- Primary Care
- Ethics and Advance Planning for End-of-Life Care

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.

Managed Care Reform

See also

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

The American Academy of Family Physicians (AAFP) supports managed care reform that ensures patients receive access to high-quality health care, clear information, and fair treatment from their health plans. The AAFP believes managed care organizations (MCOs) should protect the primary care physician's ability to act as the patient's advocate.

Below are provisions that the AAFP believes are essential to include when advocating for comprehensive managed care reform:

The AAFP supports:

- A requirement that MCOs promote, measure, and maintain care quality improvements in comprehensive managed care programs, consistent with AAFP policy on “Performance Measures Criteria;”
- A requirement that MCOs provide physicians with timely and actionable data on quality and costs, especially if the physician is responsible for the total cost of care for their patients;
- A requirement that MCOs limit prior authorization and provide a streamlined prior authorization process that is efficient for patients and their physicians; the process should not limit physicians’ ability to prescribe or refer based on their specialty;
- A requirement that information be provided before and at the time of enrollment to all plan enrollees in a uniform and easy-to-understand format; the information should include covered and excluded benefits, out-of-pocket expenses (i.e., deductibles, co-pays, and co-insurance) in providers, experimental benefits, and other important plan provisions;
- A requirement that MCOs have just and equitable appeals process in place enabling meaningful and prompt access and providing timely resolutions for patients and their physicians;
- A requirement that MCOs utilize a prudent layperson standard enabling patients to secure emergency care out of plan without prior authorization;
- A requirement that MCOs honor the right of each physician and other health care providers to communicate freely with all patients;
- A requirement that MCOs have a policy protecting physicians who advocate on behalf of their patients for needed medical benefits;
- A requirement that MCOs have a policy ensuring "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 plans governed under the Employee Retirement Income Security Act of 1974 (ERISA) 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 appropriate liability caps in federal court which will ensure MCOs recognize their responsibility to guarantee patients have timely access to needed medical care;
- A requirement that MCOs have formularies that are consistent with AAFP policy on "Patient-Centered Formularies;"
- The inclusion of family physicians in any definitions of women's and children's health care providers to ensure access to all qualified physicians;
- Recognition of an accurate definition of primary care, consistent with the AAFP definitions of "Primary Care" and "Family Medicine;"
- A requirement that MCOs must regularly update their provider directories to ensure patient coverage, while minimizing administrative burdens, and make it available to physicians and patients;
- A requirement that MCOs must furnish physicians with a fee schedule showing what they will be paid for services, provided by that physician under the plan, before negotiating with the physician to become or continue as a healthcare provider under the MCO;
Recognition of the importance of advanced primary care functions consistent with the Joint Principles of the Patient-Centered Medical Home, as developed by the AAFP and others, by encouraging patients to visit primary care physicians as their usual source of care and providing payment that reflect the value primary care physicians bring to the health care system;

- The use of a uniform provider contract template;
- First dollar coverage for preventive services by MCOs, consistent with AAFP policy on "First Dollar Coverage for Preventive Care;" and
- Adequacy of primary care and specialist networks (especially with regard to the number of available physicians and geographic availability).

(March 2001) (2017 COD)
Marijuana Possession for Personal Use

See also

- Substance Abuse and Addiction
- Impaired and Clinically Deficient Physicians
- Tobacco and Smoking
- Tobacco: Preventing and Treating Nicotine Dependence and Tobacco Use (Position Paper)

The American Academy of Family Physicians (AAFP) opposes the recreational use of marijuana. However, the AAFP supports decriminalization of possession of marijuana for personal use. The AAFP recognizes the benefits of intervention and treatment for the recreational use of marijuana, in lieu of incarceration, for all individuals, including youth.

The AAFP also recognizes that several states have passed laws approving limited recreational use and/or possession of marijuana. Therefore, the AAFP 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.

(1989) (March 2019 BOD)
Maternal/Child Care (Obstetrics/Perinatal Care)

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 currents 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) (2017 COD)
Maximizing Representation of Racial and Ethnic Subpopulations in Data

The American Academy of Family Physicians (AAFP) affirms the importance of collecting accurate information on race and ethnicity in health and demographic surveys, such as those conducted by the United States Census. Comprehensive indicators of race and ethnicity, beyond five broad racial groups and two ethnicities (Hispanic/Not Hispanic), are essential to capture information on groups which may be disproportionately affected by socioeconomic, health, and other disparities. Without specific indicators, these populations may not receive adequate consideration in budgeting processes and resource allocations, resulting in further disadvantage. The AAFP supports collecting data on race and ethnicity that includes specific ethnic groups within each race based upon broader similarities such as country/continent of origin, language, and religious background.

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 medically necessary health services for all Medicaid recipients.

All Medicaid coverage should include a uniform range of mandatory services and state-approved optional services. Medicaid payment for services should be fair and adequate, and at least at Medicare rates, in compliance with the "equal access" provision of the Medicaid statute.

All Medicaid programs should include provisions whereby the homeless and medically uninsurable are covered, and to accomplish this, states, should expand Medicaid to avoid coverage gaps.

The AAFP endorses the principle that peer review systems and utilization review systems will promote uniform quality of care to all Medicaid beneficiaries. (1983) (2018 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
- Vision and Principles of a Quality Measurement Strategy for Primary Care (Position Paper)

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) (2017 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) (2018 COD)
Medical Necessity for the Hospitalization of the Abused and Neglected Child

See also

- Child Abuse

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)
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

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 Medicare Advantage plan payment to physicians to be at least at the level of traditional Medicare fee-for-service or higher;

(l) Supports a performance bonus based on evidence-based performance measurement; and

(m) Supports development of alternative payment models to assure fair payment for primary care services.

(1973) (2017 COD)
The AAFP, at all times, supports rigorous pre- and post-market testing of drugs, devices, and biological agents. Testing should ensure safety as well as benefit measured by health outcomes of value to patients. Previously approved agents should be available for research or scientifically supported clinical use for "off label" indications. The selection of appropriate agents in treatment of an individual should take into consideration the scientific evidence alongside the patient's values and preferences in a shared decision-making process. (1977) (2018 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

EXECUTIVE SUMMARY

Mental illness is highly prevalent in the United States and is associated with an increased risk of morbidity and mortality. There are significant gaps in the provision of mental health care services in the U.S., especially related to vulnerable populations. Family physicians are well-equipped to provide mental health services and are one of the primary sources for mental health care in the U.S. The American Academy of Family Physicians (AAFP) supports the following:

- Family physicians are well-prepared to provide many mental health services and should continue to lead and participate in these services to improve access, quality, and outcomes.
- Family physicians should work with behavioral and mental health professionals whenever possible to ensure the best care for their patients. This can range across a continuum, including collaboration and partnerships, co-locating services, or even full integration within one single care plan.
- Graduate medical education in family medicine emphasizes the direct link between physical and mental health, and should continue to offer behavioral and mental health training as part of the core curriculum.
- Family physicians should educate themselves about mental health practices, including staying up-to-date on screening recommendations for mental health; behavioral health and primary care integration models; trauma-informed care, telemedicine and telepsychiatry; and mental health disparities and high-risk populations.
- Family physicians should advocate for the elimination of the stigma that accompanies poor mental health, as well as support policies that improve access to behavioral and mental health services.
- Advocating for the maintenance and expansion of state, federal, and private insurance funding of mental health care services for all.
- Advocating for the establishment of payment mechanisms that: adequately reimburse primary care physicians for providing mental health care services; and allows adequate funding of mental health care services provided in co-located practices to ensure its continued availability in the primary care physician’s office.
- The development of new treatment strategies to increase the number of patients who receive appropriate treatment and follow-up through both primary care and mental health specialty care providers, and through the use of new technologies, such as telehealth.

BACKGROUND

Mental illness, which includes a range of mental health conditions that affect one’s mood, thinking, and behavior, is one of the most pervasive causes of disease and disability worldwide. The prevalence of mental illness has important public health ramifications, affecting roughly 20% of all adults, and is the leading cause of disability in the U.S., accounting for 18.7% of years of life lost to disability and premature mortality. While mental illness is common in all parts of society, there are disparities, with American Indian and Alaska Natives (28.3%) experiencing higher rates than white (19.3%), black (18.6%), Hispanic (16.3%), or Asian (13.9%) adults. Mental illness has a substantial economic impact, accounting for $179 billion in health care spending in 2014, which is projected to increase to $238 billion in 2020.

Challenges exist for providing high-quality mental health care services in the U.S., mainly arising from the fragmentation of medical care and mental health care. Mental health services are not distributed evenly throughout the U.S. and many communities lack access to these services. Roughly two-thirds of primary care physicians are unable to
Family medicine, which promotes the integration of the behavioral and physical models of illness, serves a vital role in providing mental health care services. Transformations within primary care, most notably the patient-centered medical home (PCMH), have called for reintegration of mental health care into routine comprehensive care through a team-based approach. Integration can take place across a continuum, including collaboration and partnerships, co-locating services, or full integration within one single care plan. The current lack of integration is a barrier to improving the quality, outcomes, and efficiency of care delivery for those struggling with both mental and physical illness.

This paper explores the various issues family physicians face regarding mental health and mental health care services, clarifies the family physician’s role, and provides direction to the AAFP to advocate for a better system for addressing mental health in the U.S. The paper covers topics related to: incorporating mental health care services in primary care; health disparities and high-risk populations; tobacco use as a risk factor for excess morbidity and mortality in the population experiencing mental illness; and payment.

ROLE OF THE FAMILY PHYSICIAN

While psychiatric and other mental health professionals can play an important role in the provision of high-quality mental health care services, primary care physicians are the main providers for the majority of patients. Most people with poor mental health will be diagnosed and treated in the primary care setting. Mental illness also complicates other medical conditions, making them more challenging and more expensive to manage. Together, this makes mental health an important issue for primary care physicians.

Family physicians are well-positioned to address their patient’s mental health issues. The behavioral sciences and mental health are central tenets of the specialty of family medicine, and family physicians receive high-quality training in these areas. The Residency Review Committee of the Accreditation Council for Graduate Medical Education (ACGME) for Family Medicine has stringent standards for education in family medicine residencies for mental health, including that residency programs: have faculty dedicated to the integration of behavioral health; teach residents to diagnose, manage, and coordinate care for common mental illnesses and behavioral issues in patients of all ages; require that residents demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, and their application to patient care; and structure their curriculum so that behavioral health is integrated within student’s total educational experience.

INCORPORATING MENTAL HEALTH SERVICES IN PRIMARY CARE

Screening for Mental Illness
Screening for mental illness is not new to family medicine but has more recently been linked to quality metrics and payment. Screening for mental illness can be an important strategy for decreasing morbidity, as well as preventing adverse maternal and child health outcomes associated with perinatal depressive symptoms, postpartum depression, or maternal suicide. While important, screening in a busy practice can seem overwhelming, but practices can leverage technology, empower staff, and utilize wellness visits to complete this screening.

Family physicians should be aware of screening recommendations for their patients, recognizing that identification of mental health issues is integral to ensuring appropriate treatment and reduction of complications. Mental health clinical recommendations and guidelines developed or endorsed by the AAFP are outlined on the AAFP’s website.

Primary Care and Behavioral Health Integration
Integrating mental health into primary care settings, as well as the blending of primary and preventive medicine into
traditional mental health settings, represents a more holistic approach to treatment than the traditional consultative and referral models. Integrating primary care and mental health services increases access for patients by making mental health services available in their regular primary care clinics. When integrated into primary care, mental health providers can impact the care of more patients than in the specialty mental health referral sector. In the primary care setting, mental health providers take on a more consultative and team-based role and focus on helping primary care providers treat mental health disorders. In this context, mental health providers typically reach more patients, and have shorter and more problem-focused encounters than in the context of traditional specialty mental health.

**Collaborative Care – A model for Primary Care and Mental Health Integration**

The Collaborative Care Model, supported by various organizations including the American Psychiatric Association, is a model for the successful integration of primary care and behavioral and mental health. At its core, the idea of collaborative care is anchored in team-based care, often in the context of a medical home, and steered by primary care physicians. It involves behavioral health specialists and consulting mental health professionals delivering evidence-based care that is patient-centered. Evaluations of this model of care are ongoing, particularly in the adult population.

The collaborative care model includes four core elements: 1) team driven, 2) population focused, 3) measurement guided, and 4) evidence based. These four elements, when combined, can allow for a fifth guiding principal to emerge—accountability and quality improvement. Collaborative care is team-driven, led by a primary care clinician with support from a “care manager” and consultation from a psychiatrist who provides treatment recommendations for patients who are not achieving clinical goals. Other mental health professionals can contribute to the Collaborative Care Model. Collaborative care is population focused, using a registry to monitor treatment engagement and response to care. Collaborative care is measurement guided with a consistent dedication to patient-reported outcomes and it utilizes evidence-based approaches to achieve those outcomes. Care remains patient centered with proactive outreach to engage, activate, promote self-management and treatment adherence, and coordinate services.

**Telemedicine and Telepsychiatry**

Telemedicine is the process of providing health care from a distance using technology. Telepsychiatry, a subset of telemedicine, involves either direct or indirect interaction between a psychiatrist and the patient, where a psychiatrist supports a primary care physician and other health care providers. Several telehealth models exist for providing mental health services. A promising model is Project ECHO (Extension for Community Healthcare Outcomes). A model such as this seeks to enhance access to mental health and substance-use disorder treatment via remote and telehealth training and practice support for primary care clinicians, particularly in rural and underserved areas. Telemedicine for mental health is a growing interest in primary care and telehealth initiatives for mental health care are expanding rapidly. While the research is limited on this topic, there are a growing number of studies assessing the benefits, comparative effectiveness with face-to-face visits, and cost comparisons. Family physicians who wish to integrate mental health care services in their practice, but have limited access, should consider learning more about this topic.

**Trauma-informed Care**

An estimated 60% of adults in the U.S. have experienced a traumatic event at least once in their lives. Exposure to trauma, such as intimate partner violence, sexual abuse, rape, neglect, terrorism, war, natural disasters, and street violence predisposes those affected to poor physical and mental health outcomes.

Trauma-informed care, an approach to engaging individuals with a history of trauma that recognizes their traumatic experiences, and how it affects their lives, is a promising practice that may facilitate healing and help prevent the consequences of exposure to trauma. The principles of trauma-informed care include: realizing that there is a high prevalence of trauma and it has serious effects; recognizing the signs and symptoms of trauma; responding to the high prevalence by integrating knowledge about trauma into practices, procedures, and policies; and avoiding retraumatizing individuals by using best-practices in screening and history taking.

While still in its infancy in family medicine, trauma-informed care is gaining support and evidence of its benefits are accumulating. Family physicians who have learned about trauma-informed care have increased measurements of “patient-centeredness” after completing a continuing medical education (CME) course. Family physicians will
undoubtedly hear more about trauma-informed care and should take advantage of training opportunities in its principles and practice.35

HEALTH DISPARITIES AND HIGH-RISK POPULATIONS

Health Disparities
While mental health conditions can affect everyone, regardless of culture, race, ethnicity, gender or sexual orientation, some populations experience those conditions at a higher rate.

- American Indian and Alaska Natives (28.3%) experience higher rates of mental illness than white (19.3%), black (18.6%), Hispanic (16.3%), or Asian (13.9%) adults.1
- Individuals from the lesbian, gay, bisexual, transgender, and questioning (LGBTQ) community are two or more times as likely as heterosexual individuals to have a mental health condition1 and LGBTQ youth are two to three times more likely to attempt suicide than heterosexual youth.1
- Nearly one-fifth (18.5%) of the veterans who returned from serving in either Iraq or Afghanistan suffer from either major depression or post-traumatic stress disorder.36
- The prevalence of mental illness is similar for individuals living in either rural or metropolitan areas, but the mental health care needs are more often unmet in rural communities due to inadequate services.37

Disparities in mental health illness and mental health care are related to coverage and availability of care, quality of care, rates of health insurance, stigma, cultural insensitivity, racism, bias, homophobia, discrimination in treatment settings, and language barriers.1

College Students
Approximately 20 million students are enrolled in U.S. colleges and universities.38 Mental health concerns, such as non-suicidal self-injury and serious suicidal ideation, have risen in this population over the past several years.39 According to the Center for Collegiate Mental Health’s 2017 Annual Report, 52.7% of students attended counseling for mental health concerns; 34.2% took a medication for mental health concerns; 9.8% were hospitalized for a mental health concern; 27% purposely injured themselves without suicidal intent; and 34.2% seriously considered attempting suicide, with 10% making a suicide attempt.39 In fact, some data suggest that suicide may be the most common cause of death in college students.40

Attention-deficit/hyperactivity disorder (ADHD) is another prevalent disorder in college students that family physicians may encounter. ADHD’s prevalence is estimated to be between 2-8% among college students, and this condition is frequently associated with other psychiatric comorbidities and increases individuals’ risk of psychosocial and substance-use problems.41

TOBACCO USE – A RISK FACTOR FOR EXCESS MORBIDITY AND MORTALITY
Tobacco use is prominent among individuals living with mental illness. Thirty-six percent of adults with any mental illness use tobacco products, compared with 25.3% for adults without a mental illness.42 In addition, people who have any mental illness are only half as likely to quit smoking compared to individuals without a mental illness.43 One study found that nearly half of all deaths were tobacco-related for persons who received substance abuse services, or who received both substance abuse and mental health services.44 Therefore, addressing tobacco addiction among individuals living with mental illness is an important strategy for decreasing preventable mortality and morbidity among individuals living with a mental illness.

The AAFP has position papers that detail substance abuse and addiction (http://www.aafp.org/about/policies/all/substance-abuse.html) and tobacco prevention and cessation (http://www.aafp.org/about/policies/all/nicotine-tobacco-prevention.html).
PAYMENT

Historically, primary care physicians have encountered barriers to receiving full reimbursement for office visits for mental health diagnoses. This limitation in reimbursement interfered with the family physician’s ability to offer comprehensive care and management of mental health conditions, as well as the ability to integrate, from a business perspective, with behavioral health services. However, new coverage policies adopted by the Centers for Medicare & Medicaid Services (CMS) are more promising and may incentivize primary care physicians to provide treatment for mental and behavioral health conditions. These policies, effective January 1, 2017, emphasize collaborative care, where primary care physicians are expected to work in partnership with a behavioral health care manager, and consult with mental health specialists. While targeting populations with Medicare, these policies may also encourage private insurers to offer similar options and may incentivize more family physicians to offer behavioral and mental health care to other populations.

Health care for all people with mental illness should be “affordable, nondiscriminatory, and includes coverage for the most effective and appropriate treatment.” Coverage for mental illness should be equal in scope to coverage for other illnesses and all clinically-effective treatments appropriate to the needs of individuals with mental illness should be covered.

CONCLUSION

Family physicians play an important role in the provision of mental health care services in the U.S. and are well trained to provide many types of mental health care services. It is imperative that family physicians work to integrate with mental and behavioral health care providers to better meet their patients’ needs when possible. A variety of models and resources exist to assist them with filling the existing gaps in the provision of mental health care services in the U.S., especially related to vulnerable populations. In this manner, family physicians can work to meet both the physical and mental health care needs of their patients.

REFERENCES:


9. deGruy FV, Etz RS. Attending to the whole person in the patient-centered medical home: the case for incorporating


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, and payment for licensed behavioral health providers should be part of a patient's medical benefits when those services are delivered by licensed behavioral health providers under the supervision of a primary care physician in an integrated behavioral health model. (1998) (2018 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) (2017 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 American Academy of Family Physicians (AAFP) believes that all people should have access to essential health care services, regardless of their immigration status. Migrant and seasonal workers provide essential services in the U.S. and their health and well-being should be important to physicians and the public. The AAFP encourages family physicians to become aware of the health and health care issues faced by seasonal and migrant workers and solutions that address their unique needs and situations. (1980) (March 2019 BOD)
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) (2018 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

- Distracted Driving
- Driver Education
- Graduated Driver's License
- 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)
Motorized Recreational Vehicles

See also

- Motor Vehicle Occupant Protection
- Helmet Laws
- Protective Equipment for Recreational and Competitive Sports Activities

The American Academy of Family Physicians (AAFP) recommends that family physicians become familiar with the potential dangers associated with the use of motorized recreational vehicles (including mini-bikes, all terrain vehicles, snowmobiles and personal watercraft) and be aware of state laws related to age restrictions. Family physicians should be able to advise patients about their safe use, including information about appropriateness based on physical and emotional development, recognizing that some states legally allow children under 12 years to operate vehicles that place them at risk for injury or death. The AAFP also supports laws establishing speed limits, separation of motorized recreational vehicles from non-motorized vehicles and prohibiting the operation of such vehicles while under the influence of alcohol or other mind-altering drugs. (1973) (March 2019 BOD)
The AAFP:
(a) supports the objectives of the National Health Service 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) (2018 COD)

The American Academy of Family Physicians advocates for reauthorization and appropriate funding of the National Health Service Corps (NHSC) and for reinstitution 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) (2013 July BOD)
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. (2002) (2018 COD)
Naturopathic Practice

See also

- Non-Physician Providers, Family PhysicianTraining 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) (2017 COD)
Needle Exchange Programs and Safe Injection Sites

The AAFP supports effective harm reduction strategies to prevent the spread of HIV, Hepatitis C, and Hepatitis B; reduce the risk of death from opioid overdose; and engage individuals in treatment for substance use disorders. Needle exchange programs and safe injection sites reduce the transmission of disease, do not increase the rate of substance use, and increase the likelihood that individuals will enter drug treatment programs. Such strategies may also provide additional health and preventive services to vulnerable and high risk populations. Physicians should be knowledgeable about their states' statutes regarding such harm reduction strategies. (July 2016 BOD) (March 2019 BOD)
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) (2018 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
- 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:


(B1994) (2016 COD)
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) (March 2019 BOD)
Nurse Midwives, Certified

See also

- AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants
- Team-Based Care
- Non-Physician Providers, Family Physician Training With
- Nursing Profession
- Payment, Non-Physician Providers
- Maternal/Child Care (Obstetrics/Perinatal Care)

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)
Nurse Practitioners

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) (2018 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)
Obstetric Ultrasound Examination (Position Paper)

Overview and Justification

Obstetric care is an integral part of many family physicians’ scope of practice and an important component of family medicine residency training. Maternity care in rural and underserved communities is disproportionately provided by family physicians, so their ability to perform obstetric ultrasound examination improves patients' access to care. Patients also benefit from more rapid diagnosis and treatment, and enhanced continuity of 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. The primary objective must be the highest standard of obstetric care, regardless of specialty.

In addition to improved access and continuity of care, potential benefits of obstetric ultrasound examination performed by a family physician include the following:

- Availability of clinical information at the time of patient contact in rural or underserved areas
- Immediate assessment of urgent clinical problems
- Sensitivity and specificity of ultrasound examination performed by a physician who knows the patient
- Reductions in time and cost
- The likelihood that primary care allows more time than referral care for educational interaction with the patient

Family physicians who perform obstetric ultrasound examination must guard against potential drawbacks, including the following:

- Potential for misuse of the technology, particularly nonmedical uses
- Risk that easy availability will lead to overutilization
- Patients’ unrealistic expectations related to outcomes or the power of the technology
- Possibility that increasing technological complexity will require additional training
- Possibility that increasing volume will lead physicians to delegate examinations to ultrasound technicians, thus distancing physicians from their patients
- Possibility that other clinical duties may not allow time for ultrasound examinations in the physician's schedule
- Ongoing interspecialty conflicts regarding the utilization of this technology

Section I – 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 that obstetric ultrasound examination is within the current scope of family medicine:
According to the AAFP Member Census (as of December 31, 2017), 8 percent of AAFP members offer obstetric ultrasound imaging in their practice. The AAFP’s recommended curriculum guidelines for maternity care state that family medicine residents should demonstrate the ability to independently perform limited obstetric ultrasound examination (i.e., fetal position, amniotic fluid index, placental location, and cardiac activity) as a core skill. The guidelines also recommend additional experience for family medicine residents who are planning to practice in communities without readily available obstetric-gynecologic consultation and who will need to provide a more complete level of obstetric-gynecologic services. These advanced skills include clinical assessment of gestational age; ascertainment of accurate dating with ultrasound, if indicated; and ultrasound-guided amniocentesis during the second trimester and third trimester.

The Society of Teachers of Family Medicine (STFM) Group on Hospital Medicine and Procedural Training includes basic prenatal ultrasound (i.e., amniotic fluid index, fetal presentation, and placental location) on its list of core procedures for family medicine that all residents must be able to perform independently by graduation. Advanced prenatal ultrasound (i.e., dating and anatomic survey) is listed as a procedure that family medicine residents must have exposure to and be given the opportunity to be trained to perform independently by graduation. A task force of Council of Academic Family Medicine (CAFM) member organizations and experienced faculty and program directors published a consensus statement for procedural training in family medicine residency that includes basic obstetric ultrasound (i.e., amniotic fluid index, fetal presentation, and placental location) as a procedure that all graduates of U.S. family medicine programs should be adequately trained to perform.

In the United States, there are approximately 40 family medicine fellowships in obstetrics. Physicians in these programs are trained to perform obstetric ultrasound examination, and many subsequently practice in rural and/or underserved areas.

Obstetric ultrasound examination appropriately enhances the diagnostic and therapeutic capabilities of family physicians. Applications in family medicine can be divided into the following general areas:

- First trimester diagnostic pregnancy care
- Second or third trimester diagnostic pregnancy care
- Ultrasound-guided procedures (e.g., amniocentesis)
- Emergency care of acutely ill patients in labor and delivery, in the emergency department, and in the office

Every family physician who delivers infants can make use of ultrasound examinations for a limited number of applications that often arise suddenly and can have significant impact on patient care. These applications—which include assessment of fetal life, fetal number, fetal presentation, quantity of amniotic fluid, and placental location—are readily learned by family physicians and are included as an option in the AAFP-sponsored Advanced Life Support in Obstetrics (ALSO®) courses. Modern obstetric care benefits from the availability of ultrasound equipment in, or readily accessible to, the labor and delivery area for these purposes.

Section II – Clinical Indications

The American Institute of Ultrasound in Medicine’s (AIUM’s) practice parameter for the performance of obstetric ultrasound examination lists indications for first-trimester ultrasound examination (Table 1) and second-/third-semester ultrasound examination (Table 2).

Table 1. Indications for First-Trimester Ultrasound Examination

First-trimester ultrasound examination is indicated for the following:
1. Confirm presence of intrauterine pregnancy
2. Evaluate:
   a. Suspected etopic pregnancy
   b. Pelvic pain
   c. Maternal pelvic masses and/or uterine abnormalities
   d. Suspected hydatidiform mole
3. Identify cause of vaginal bleeding
4. Estimate gestational age
5. Diagnose or evaluate multiple gestations
6. Confirm cardiac activity
7. Use as adjunct to procedures such as chorionic villus sampling, embryo transfer, and localization and removal of an intrauterine device
8. Assess for certain fetal anomalies (e.g., anencephaly) in high-risk patients
9. Measure nuchal translucency when screening for fetal aneuploidy


Table 2. Indications for Second- and Third-Trimester Ultrasound Examination

Second- and third-trimester ultrasound examination is indicated for the following:

1. Screen for fetal anomalies
2. Evaluate:
   a. Fetal anatomy
   b. Fetal growth
   c. Vaginal bleeding
   d. Abdominal or pelvic pain
   e. Cervical insufficiency
   f. Suspected multiple gestation
   g. Significant discrepancy between uterine size and clinical dates
   h. Pelvic mass
   i. Suspected hydatidiform mole
   j. Suspected ectopic pregnancy
   k. Suspected fetal death
   l. Suspected uterine abnormalities
   m. Fetal well-being
   n. Suspected amniotic fluid abnormalities
   o. Suspected placental abruption
   p. Premature rupture of membranes and/or premature labor
   q. Abnormal biochemical markers
   r. Fetal condition in late registrants for prenatal care
3. Estimate gestational age
4. Determine fetal presentation
5. Use as adjunct to:
   a. Amniocentesis or other procedure
   b. Cervical cerclage placement
   c. External cephalic version
6. Conduct follow-up evaluation of:
   a. Fetal anomaly
   b. Placental location for suspected placenta previa
7. History of previous congenital anomaly
8. Assess for findings that may increase the risk for aneuploidy

Under the Choosing Wisely campaign—a national effort to reduce waste in the health care system and avoid unnecessary or harmful tests and treatment—ACOG recommends that physicians should not perform prenatal ultrasounds for non-medical purposes (e.g., solely to create keepsake videos or photographs).5 ACOG’s recommendation states: “While obstetric ultrasound has an excellent safety record, the U.S. Food and Drug Administration [FDA] considers keepsake imaging as an unapproved use of a medical device. The American Institute of Ultrasound in Medicine also discourages the non-medical use of ultrasound for entertainment purposes. Keepsake ultrasounds are not medical tests and should not replace a clinically performed sonogram.”5

In a standard first-trimester obstetric ultrasound examination, the uterus, cervix, adnexa, and cul de sac region should be examined.13,14 The presence, size, location, and number of gestational sac(s) should be evaluated, and gestational sac(s) should be examined for the presence of a yolk sac and embryo/fetus. When an embryo/fetus is present, crown-rump length and cardiac activity should be documented.

For ultrasound examinations performed in the second trimester and the third trimester, the American College of Radiology (ACR), the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), the Society for Maternal-Fetal Medicine (SMFM), the Society of Radiologists in Ultrasound (SRU), ACOG, and AIUM have adopted the following uniform terminology: standard, limited, and specialized (Table 3).13,15,16

Table 3. Classification of Second- and Third-Trimester Ultrasound Examination

A. Standard Examination13,14
A standard obstetric ultrasound examination includes:

- Evaluation of fetal presentation and number
- Evaluation of amniotic fluid volume
- Evaluation of cardiac activity
- Evaluation of placental position
- Evaluation of fetal biometry
- Anatomic survey
- Examination of maternal cervix and adnexa, as clinically appropriate and when technically feasible

B. Limited Examination13,14
A limited examination is performed to answer a specific clinical question (e.g., to verify fetal presentation in a patient who is in labor or to confirm fetal heart activity in a patient experiencing vaginal bleeding), but it does not replace a standard examination.

C. Specialized Examinations13,14,17
Specialized examinations are typically performed starting at 32 weeks of gestation but may be done earlier if there are multiple risk factors or particularly worrisome problems. A specialized anatomic ultrasound examination is performed when an anomaly (e.g., fetal growth restriction) is suspected based on the history, laboratory abnormalities, or the results of a limited or standard examination. A biophysical profile (BPP) is a specialized examination that combines ultrasound examination and fetal heart rate monitoring to evaluate the amount of amniotic fluid, and fetal heart rate, breathing, body/limb movements, and muscle tone. A BPP is typically recommended when there is an increased risk of problems that could result in pregnancy complications or lead to stillbirth. Other specialized examinations include fetal Doppler ultrasound, fetal echocardiogram, or additional biometric measurements.

Section III – Training Methodology
Family physicians can acquire skills for performing obstetric ultrasound examination during their family medicine residency training or a post-residency fellowship. Obstetric ultrasound examination courses organized and presented by family physicians and sponsored by the AAFP have been offered since 1989. Other organizations also offer training through accredited continuing medical education (CME) activities and workshops. Most physicians who have a base of knowledge in maternal-fetal anatomy and physiology can rapidly learn basic (limited) applications of obstetric ultrasound examination, including assessment of fetal life, fetal number, fetal presentation, quantity of amniotic fluid, and placental location. However, learning advanced applications require significant additional study and supervised practice.

Key elements of standard ultrasound examinations in the first trimester and second and third trimesters have been defined, with very little disagreement, by the AIUM, ACOG, and ACR. Existing training methodologies address these elements. In the ideal situation, a physician would engage in a preliminary period of extensive reading, followed by a basic course that includes didactic and experiential activities. This would be followed by practice that is supervised either directly or through an audit of recorded scans. The efficacy of these methodologies has been established by direct examination of scanning capabilities, written tests, objective measurements of acquired basic data, comparison of patient outcomes, and comparison of family physicians' results to those of other providers.

Section IV – Testing, Demonstrated Proficiency, and Documentation

The ACOG practice guideline on ultrasound in pregnancy states the following qualifications for competence in obstetric ultrasound examination: “Physicians who perform, evaluate, and interpret diagnostic obstetric ultrasound examinations should be licensed medical practitioners with an understanding of the indications for such imaging studies, the expected content of a complete obstetric ultrasound examination, and a familiarity with the limitations of ultrasound imaging. They should be familiar with ultrasound safety and the anatomy, physiology, and pathophysiology of the pelvis, pregnant uterus, and fetus. All physicians who perform or supervise the performance of obstetric ultrasonography should have received specific training in obstetric ultrasonography.”

For family medicine residents, longitudinal curricula in obstetric ultrasound examination will allow for acquisition of skill. An individual physician's proficiency typically depends on factors such as time committed, patient volume, and enthusiasm. The International Society of Ultrasound in Obstetrics and Gynecology (ISUOG) concurs, noting that the optimal amount of training and the minimum number of supervised examinations required for competence in obstetric ultrasound examination can vary greatly according to the learner’s predisposition.

The AAFP recommends that family physicians document all significant training and experience so that this information can be reported in an organized fashion, if necessary. Documentation should demonstrate the physician’s understanding of the technology, ability to perform the ultrasound examination, and ability to interpret findings. Any family physician who intends to perform obstetric ultrasound examinations is advised to keep a record of the following:

- Courses taken, including the number of hours of formal learning involved
- Number of directly supervised examinations performed
- Total number of examinations performed
- Types of examinations performed (e.g., standard examinations, labor and delivery scans, emergency department scans, ultrasound-guided procedures)

In addition, the AAFP acknowledges that documentation of outcomes is important to demonstrate proficiency and support credentialing. In the case of obstetric ultrasound examination, specific outcomes that are most likely to be scrutinized include the following:

- 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 V – Credentialing and Privileges

Office practice of obstetric ultrasound examination is currently unregulated in the sense that an office-based physician who has ultrasound equipment can use it as he or she sees fit. However, facility accreditation may be required by some payers before payment is issued. The AIUM and ACR both offer ultrasound facility accreditation. The accreditation system is open to any practice, regardless of specialty, and is based on meeting standard examination content, documentation, procedure volume, and maintenance standards. A study of the AIUM accreditation program found that practices had improved case study scores and compliance with published minimum standards and guidelines for the performance of obstetric ultrasound examinations after three years of accreditation.

Obstetric ultrasound services provided in hospitals range from standard examinations to emergency department and labor and delivery applications. 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 non-radiologists access to the radiology department equipment. Therefore, it becomes an interspecialty issue involving family physicians, OB/GYNs, and radiologists.

Since most family physicians who perform obstetric ultrasound examination do so in their office, this may not often pose a significant problem. However, if an office practice and its equipment are owned by a hospital, the radiology department may try to assert its sovereignty over office imaging practice, including plain radiography and diagnostic ultrasound, thus infringing on family physicians' office-based practices. Family medicine residencies could also be affected if they are denied ultrasound equipment based on a radiology department's objections.

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. This general policy applies to performing obstetric ultrasound examinations in the family medicine practice. The AAFP’s policy on interspecialty support in clinical procedures states, "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."

Section VI – Miscellaneous Issues

A. Quality assurance

Ensuring the quality of CME in ultrasound examination is important. The AAFP Prescribed credit mechanism is one means of ensuring that courses offered by the AAFP or other professional organizations meet quality standards.

B. Public health implications

Family physicians are the first—and sometimes the only—point of contact for many patients within the health care system. Expanding and improving family physicians' use of obstetric ultrasound examination could improve access to care for patient populations in need.

C. Financial implications

The general financial implications of expanding family physicians' use of obstetric ultrasound examination include the cost savings associated with improved access to care. 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 comprehensive services.

D. Research agenda

The research agenda for obstetric ultrasound examination should focus on clearly defining competency-based measures...
and analyzing outcomes of examinations performed by family physicians.

Section VII – References


http://www.aafp.org/dam/AAFP/documents/medical_education_residency/program_directors/Re


5. Choosing Wisely®. Don’t perform prenatal ultrasounds for non-medical purposes, for example, solely to create keepsake videos or photographs.


7. American Academy of Family Physicians. AAFP Member Census, December 31, 2017. Table 12: Clinical procedures performed by physicians at their practice.


13. American Institute of Ultrasound in Medicine. AIUM practice guideline for the performance of obstetric ultrasound


Officers' Protocol

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)
Oral Health

See Also

- Dental Services
- Fluoridation of Public Water Supplies
- Oral Health Education and Advocacy

The American Academy of Family Physicians (AAFP) recognizes the importance of oral and dental health, and the impact it has on individual and community wellness. Compromised oral health is associated with cardiovascular disease, diabetes, premature birth, and low-birth weight. The AAFP encourages its members to be aware of the serious disparities surrounding oral health, and to advocate for and engage in strategies that address the underlying social determinants of oral health, including advocating for sufficient water fluoridation.

The AAFP recommends primary care physicians prescribe oral fluoride supplementation starting at six months for children whose water supply is deficient in fluoride, as well as apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.

The AAFP recommends physician education in oral condition screening and management, as well as the consequences of poor oral hygiene on overall health. The AAFP encourages collaboration of family physicians with dental health practitioners to provide comprehensive medical care. (April 2018 BOD) (2018 COD)
Oral Health Education and Advocacy

See Also

- Dental Services
- Fluoridation of Public Water Supplies
- Oral Health

The American Academy of Family Physicians recommends increasing educational and advocacy efforts that support the identification and treatment of oral health problems in the primary care setting. Oral health concerns are important throughout life and require a coordinated effort between family physicians and their dental colleagues to ensure overall dental health. (2017 COD)
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 beliefs, 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

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:

Paid Sick Leave

The American Academy of Family Physicians believes that all employers should offer paid sick leave to their employees. This leave should be available to use when an employee or their family member is unwell. Employees should be protected from retaliatory action when using sick leave. (April 2018 BOD) (2018 COD)
Pain Management and Opioid Misuse: A Public Health Concern (Position Paper)

Chronic Pain Management and Opioid Misuse: A Public Health Concern
Parental Leave During Residency Training

1. Any parental leave plan utilized by a family medicine residency program must:
   1. Safeguard the health of the parent and child,
   2. Assure that the resident fulfills all educational requirements, and
   3. 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:
   1. 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](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](https://www.aobfp.org).
   2. 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:
   1. Expectant mothers must be allowed the same sick leave or disability benefits as other residents.
   2. Expectant partners and adoptive parents should be allowed the same leave or disability benefits as other residents.
   3. The category of leave credited (sick, vacation, parental, short-term) should be specified.
   4. Whether leave is paid or unpaid should be specified.
   5. 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.
   6. 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.
   7. 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.
   8. Efforts should be made to schedule the most demanding rotations.
   9. earlier in the pregnancy, allowing for the least strenuous rotations to be performed around the time of the resident's EDD.
   10. 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.
   11. 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.
   12. Residents taking parental leave must be able to return to the residency within a reasonable period of time without loss of training status.
   13. 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.
13. 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.
14. The mechanisms available for making up time, or extending or delaying training should be verified.
15. It should be verified if the extended training or make-up time will be paid.
16. 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
- 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) (2018 October BOD)
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 bioequivalancy 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 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 Referrals

See also

- AAFP Mission Statement

The American Academy of Family Physicians (AAFP) supports physicians and patients in making personal and professional choices regarding their access in healthcare.

Patients

Patients should have reasonable freedom to select their physicians, other providers, and healthcare settings. Importantly, whenever making a choice, patients and caregivers 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.

Physicians

Physicians should have reasonable freedom in the context of patient values, evidence-based care, quality, and value, to determine where and how to provide ethical medical care and where to refer patients. (1985) (2018 October BOD)
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.

Pay-For-Performance

See also

- Performance Measures Criteria
- Data Stewardship
- Payment, Physician
- Public Reporting of Physician Performance, Guiding Principles
- Tiered and Narrowed Physician Networks
- Transparency
- Value-Based Insurance Design
- Payment for Non Face-to-Face Physician Services
- Payment, Care Management Function
- Physician's Right Relative to Imposed Administrative Costs
- Vision and Principles of a Quality Measurement Strategy for Primary Care (Position Paper)

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
- Virtual 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
- Public Reporting of Physician Performance, Guiding Principles
- Tiered and Narrowed Physician Networks
- Transparency
- Payment, Non-Physician Providers
- Physician's Right Relative to Imposed Administrative Costs
- Independent Physician Associations (IPAs) Definition
- Vision and Principles of a Quality Measurement Strategy for Primary Care (Position Paper)

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 physician/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 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. Each physician should be able to explain the basis for his/her charges. 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;
7. Costs of maintaining an appropriate facility for providing the service; and
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 that 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 account for 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. 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 Fees").

18. There should be "equal pay for equal work" and no discrimination in physician payment in any form, including but not limited to, that based on 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
- Public Reporting of Physician Performance, Guiding Principles
- Pay-For-Performance
- Payment, Physician
- Family Medicine, Quality Health Care in
- Tiered and Narrowed Physician Networks
- Transparency
- Health Care Costs, Methods for Reducing
- Vision and Principles of a Quality Measurement Strategy for Primary Care (Position Paper)

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) (2018 COD)
Pharmacists (Position Paper)

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.1 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.2 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 to assure continuity of the patient's medical 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. Although pharmacists should not independently diagnose, they are qualified to deal with issues of medication use, medication tolerability, patterns of medication use, assessment of therapeutic response, and dosing adjustments. 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.

**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**

3. The American Academy of Family Physicians, "Team-Based Care" Policy.
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) (2018 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 American Academy of Family Physicians (AAFP) recognizes that regular physical activity is essential for healthy growth and development and encourages that all children and adolescents accumulate at least 60 minutes of moderate to vigorous aerobic physical activity every day.

Regular physical activity is correlated with numerous health benefits, including improved cardiovascular health and reduced risk of obesity. Additionally, regular physical activity has been shown to improve cognitive and academic performance and promote psychological well-being.

Family physicians can be leaders in promoting regular physical activity in their patients and communities by partnering with individuals, families, and schools. The AAFP recognizes that interventions must go beyond individual behavior-change strategies, and address the environmental factors that influence opportunities to engage in healthy activities. The AAFP encourages its members to become aware of the conditions in their communities that promote or hinder healthy activities and to partner with individuals, families, and schools to reduce barriers to engaging in physical activity. (2006) (2018 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) (2018 December BOD)
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)
Physician Dispensing of Drug Samples

See also

- Drugs - Identification
- Drugs, Physician Dispensing
- Drugs, Prescribing
- Drugs, Therpeutic Substitution
- Medication, Device, and Biologic Agents Testing and Selection

The American Academy of Family Physicians (AAFP) 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) (2018 October BOD)
Physician Expert Witness in Medical Liability Suits

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 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 Remediation Education

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 that physicians with gaps in educational and clinical skills are being identified by various means. To address these gaps, the AAFP believes that a prescriptive, remedial educational program based upon a comprehensive, individualized assessment is essential, as is documentation of achievement of competence at completion of the program. (COCPD) (1996) (2018 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 implement best in class advocacy tactics to develop effective long-term relationships with legislators at the state and federal levels, leveraging support of the FamMedPAC and state and territorial family medicine PACs for further member engagement with legislators.

The Academy will continue to work with political parties and candidates to educate them on the importance of family medicine physicians and raise awareness of the fundamental role of the family medicine in the health care delivery system and the need to increase the number of family physicians. (1972) (2018 COD)
Population Health

See Also

- Poverty and Health - The Family Medicine Perspective (position paper)
- Social Determinants of 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. 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.

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.

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. These effects are mediated through individual- and community-level mechanisms. For individuals, poverty restricts the resources used to avoid risks and adopt healthy behaviors. 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. 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.

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.

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). 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.

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. 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 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 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.25
- 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.

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REFERENCES


(2015 COD)
Pre- and Post-Operative Care

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) (2018 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

See also

- Reproductive Decisions
- Reproductive Decisions, Training in
- Reproductive and Maternity Health Services
Poland and significant racial and ethnic disparities persist within the United States.\(^{17}\)

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.\(^{2}\) Additionally, until they are pregnant, many women of child bearing age do not seek care for themselves or may not have access to care.\(^{18}\) 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.\(^{16, 18}\)

In 1990, Jack and Culpepper identified seven barriers to preconception care\(^{19}\):

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.\(^{19}\)

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.\(^{20}\) However, a majority of women did not recall receiving any preconception counseling.\(^{20}\) In addition, while the majority of preconception counseling is important,\(^{21}\) most neither provide nor recommend counseling for their patients of childbearing age.\(^{22}\) 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%.\(^{23}\)

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.\(^{24}\) 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 ages 18-44.\(^{25, 26}\) They also play a major role in providing ambulatory primary care services to children and men.\(^{25}\) 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.\(^{27}\)
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.\(^{27}\)

**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.

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,\(^{29}\)
- Counseling to help choose a contraceptive method
- Prompt provision of the contraceptive method selected by the patient (preferably on site; if necessary).\(^{30}\)

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.\(^{31, 32}\) 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.\(^{29}\) 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.\(^{33}\) 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.\(^{34}\) 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 encephalocele. 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 [BM] 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>
<thead>
<tr>
<th>Questions/Care Considerations:</th>
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<tr>
<td><strong>Reproductive Planning</strong></td>
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<tr>
<td>Discuss reproductive goals and issues at each visit</td>
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<tr>
<td>When pregnancy is desired, discuss medications, health conditions, and activities that may affect fertility</td>
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<tr>
<td><strong>Folic Acid</strong></td>
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<tr>
<td>All women of reproductive age should be advised to take folic acid and to consume a balanced, healthy diet of folate-rich foods. Women at high risk for NTDs should take higher levels of folic acid</td>
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<tr>
<td><strong>Contraception</strong></td>
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<tr>
<td>When pregnancy is not desired, discuss safe sex and effective contraceptive methods</td>
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<tr>
<td>Offer a full range of contraceptive methods and provide appropriate contraceptive counseling that is tailored to each patient’s preference</td>
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<tr>
<td>Counsel women on the importance of birth spacing</td>
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<tr>
<td><strong>Family and Genetic History</strong></td>
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<tr>
<td>Assess pregnancy risks on the basis of maternal age, maternal and paternal health, obstetric history, and family history</td>
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<td><strong>Weight</strong></td>
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<tr>
<td>All women with a BMI greater than or equal to 30 kg/m² or less than 18.5 kg/m² should be counseled about infertility risk and risks during and after pregnancy.</td>
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<tr>
<td><strong>Chronic Disease Management</strong></td>
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<tr>
<td>Hypertension: Women of reproductive age should have blood pressure checks during routine care. If diagnosed with hypertension, they should be counseled on lifestyle changes and medications that are safe in pregnancy.</td>
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<tr>
<td>Diabetes: Women who have diabetes should be counseled about the importance of glycemic control.</td>
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<tr>
<td>Depression/Anxiety Disorders: Women of reproductive age should be screened for depression and anxiety disorders and counseled about potential risks of untreated illness. Medications should be prescribed/adjusted prior to conception, if appropriate.</td>
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<tr>
<td>Assess for use of teratogenic medications and optimize risk profile of medications</td>
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<tr>
<td><strong>Social and Behavioral History</strong></td>
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<tr>
<td>Assess social history, lifestyle, and behavioral issues that may affect pregnancy</td>
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<tr>
<td>All women of childbearing age should be screened for alcohol consumption, tobacco use, and drug use.</td>
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<tr>
<td><strong>Immunizations</strong></td>
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<tr>
<td>Immunization status should be reviewed annually and updated as indicated.</td>
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<tr>
<td><strong>STIs</strong></td>
</tr>
<tr>
<td>For all women of childbearing age and their partners, assess STI risk, provide counseling and immunizations as indicated to prevent acquisition of STIs, and provide indicated STI testing and treatment.</td>
</tr>
<tr>
<td><strong>Physical/Sexual/Emotional abuse</strong></td>
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<tr>
<td>All women of reproductive age should be screened for</td>
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current, recent past, or childhood physical, sexual, or emotional interpersonal violence and referred to appropriate resources when needed.

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, undescended 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\textsuperscript{67-69} 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.\textsuperscript{62, 63} In addition, a growing body of literature that suggests 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.\textsuperscript{70} 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.\textsuperscript{71}

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.\textsuperscript{62, 64} 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.\textsuperscript{72-74}

Table 2 - General Recommendations for Preconception Interventions for Men

<table>
<thead>
<tr>
<th>Reproductive Planning</th>
<th>Male reproductive health issues should be an integral part of every wellness visit.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assess the man’s understanding of reproduction and his reproductive plan.</td>
</tr>
<tr>
<td></td>
<td>When a partner’s pregnancy is desired, discuss medications, conditions, and activities that may affect fertility</td>
</tr>
<tr>
<td></td>
<td>Conduct a physical examination looking for signs or conditions that may affect fertility</td>
</tr>
<tr>
<td>Contraception</td>
<td>When a partner’s pregnancy is not desired, discuss effective contraceptive methods</td>
</tr>
<tr>
<td>Family and Genetic History</td>
<td>Assess family history and genetic susceptibility</td>
</tr>
<tr>
<td>Social and Behavioral History</td>
<td>Assess social history, lifestyle risk factors (Including smoking, substance abuse, and unsafe sex), and behavioral issues</td>
</tr>
<tr>
<td></td>
<td>Assess for occupational hazards that may affect fertility</td>
</tr>
<tr>
<td>STIs</td>
<td>Assess STI risk, provide counseling, and immunizations as indicated to prevent acquisition of STIs, and provide STI testing and treatment</td>
</tr>
<tr>
<td>Physical/Sexual/Emotional Abuse</td>
<td>Beginning in adolescence, consider screening for and counseling to avoid intimate partner violence and coercive relationships and promote respectful and consensual sexual relationships</td>
</tr>
</tbody>
</table>

\textit{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


Pre-payment and Post-payment Audits

See also

- Coding and Payment

The AAFP believes indiscriminate use of pre-payment and post-payment audits is a significant business disruption for the physician office and creates an inappropriate culture of mistrust. 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. The AAFP recommends 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) as preferable to broad pre-payment or post-payment audits. (2014 COD) (2018 October BOD)
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 calls all members to prioritize role modeling and teaching throughout their careers and practice, including providing clinical preceptorships and shadowing experiences for both medical students and premedical students. The AAFP highly values family medicine preceptors, and it strongly supports clinical experiences for students at all stages of training. This training should emphasize high-quality, continuous, compassionate, and coordinated care demonstrating the breadth of family medicine. Evidence shows that early, consistent, longitudinal mentorship and preceptorship increases student choice of family medicine as a career. Furthermore, the AAFP will continue to serve as an advocate for students, preceptors, departments, and institutions in the creation and maintenance of such preceptorships. (1980) (2018 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

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 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 (Policy Statement)

See also

- Gun Violence, Prevention of (Position Paper)
- Violence (Position Paper)
- Violence as a Public Health Concern

The American Academy of Family Physicians (AAFP) supports primary prevention strategies to reduce the injuries and deaths associated with gun ownership and violence. The AAFP believes that federal and state policies can balance the right to own firearms with health, safety, and societal well-being. Appropriate gun violence research funding and public health surveillance are essential prevention strategies. Physicians play an important role in counseling patients about injury prevention, including safe storage practices. Counseling is important for raising awareness for at-risk patients, particularly for pediatric and adolescent patients, and individuals who experience suicidal ideation. Family physicians should oppose state “gag rule” bills that aim to discourage this important doctor-patient communication.

The federal National Instant Criminal Background Check System (NICS) requires federally-licensed gun sellers to conduct background checks for each purchase. Background checks 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. Physicians should be aware that women who are domestic violence victims are at high risk for potential gun violence.

Stronger gun trafficking and straw purchase laws could help reduce gun violence by discouraging those who are legally able to buy guns from diverted weapons to criminals and those living in jurisdictions with restrictive firearm ownership requirements. The AAFP also supports reinstating the ban on the sale of assault weapons and high capacity magazines. (2013 COD) (2018 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) (2017 COD)
Primary Care

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 "undiagnosed" 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 Administrative Simplification

The regulatory framework with which primary care physicians must comply is daunting and often demoralizing. Standardization is not required among public or private payers, and many physicians participate with 10 or more payers. Physicians are forced to learn and navigate the rules and forms of each payer. Thus, physicians spend countless hours reviewing documents and checking boxes to meet the requirements of health insurance plans. This is time that physicians could better spend caring for patients.

The regulatory framework for physician practices has driven operating costs up and caused reduced face time with patients. The administrative and regulatory burden is one of the top reasons independent practices close and is a leading cause of physician burnout. Despite the good intent of underlying health care policies, the burden has expanded to an untenable level and is a significant barrier to achieving the Quadruple Aim.

The American Academy of Family Physicians has developed the following prioritized list of principles on administrative simplification. Adherence to these principles will ensure that patients have timely access to treatment while reducing administrative burden on physicians.

1. Prior Authorization
   Physicians strive to deliver high-quality medical care in an efficient manner. The frequent phone calls, faxes, and forms physicians and their staff must manage to obtain prior authorizations (PAs) from prescription drug plans and durable medical equipment suppliers, and others impede this goal.

   Principles:
   - Activities requiring prior authorization (PA) must be justified in terms of financial recovery, cost of administration, workflow burden, and lack of another feasible method of utilization control.
   - Rules and criteria for PA determination must be transparent and available to the prescribing physician, at the point of care. If a service or medication is denied, the reviewing entity should provide the physician with the criteria for denial. For medications, it should provide alternative choices to eliminate a guessing game.
   - PA for imaging services should be eliminated for physicians with aligned financial incentives (e.g. shared savings, etc.) and proven successful stewardship.
   - There should be a goal of eliminating PA for durable medical equipment (DME), supplies, and generic drugs.

   Transitional steps include:
   - Limiting and reducing the number of products and services requiring PA
   - Adopting a standardized form and process for PA among all payers
   - Requiring payers and pharmacy benefit managers (PBMs) that design PA specifically to save the payer or PBM money rather than benefit the patient to pay physicians for their time, as decided by the 2008 Merck-Medco v. Gibson court case
   - Requiring payers to pay physicians for PAs that exceed a specified number of prescriptions or are not resolved within a set time period
   - Prohibiting payers from requiring repeated PAs for effective medication management for patients with chronic disease and PA for standard and inexpensive drugs

2. Quality Measures and the Need for Measure Harmonization
Quality measures have proliferated in the past 15 years, leading to a significant compliance burden for physicians. Most of the measures are disease-specific process measures, rather than more meaningful evidence-based outcomes measures. With many family physicians submitting claims to more than 10 payers, the adoption of a single set of quality measures across all public and private payers is critical.

Principles:

- Quality measures should be focused on improving processes and outcomes of care in terms that matter to patients.
- Quality measures should be based on best evidence and reflect variations in care consistent with appropriate professional judgment.
- Quality measures should be practical given variations of systems and resources available across practice settings.
- Quality measures should not separately evaluate cost of care from quality and appropriateness.
- Payers should take into account the burden of data collection, particularly in the aggregation of multiple measures.
- Payers should provide transparency for methodology used to rate or rank physicians.
- All payers (Medicare, Medicaid, Veterans Administration, commercial insurers, ERISA plans, and any third-party administrator plan) should implement the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure parsimony, alignment, harmonization, and the avoidance of competing quality measures.
- Quality measure feedback reports should be simplified and standardized across all payers to make them more actionable.
- Quality measures should be updated regularly or when new evidence is developed. As new quality measures are adopted, sponsoring entities should sunset other quality measures.
- Physicians should not be accountable for quality measures that they do not have the control over nor authority to improve.

3. Certification and Documentation

Physicians want to efficiently order what their patients need to manage their disease conditions in a way that maintains their health. The current procedures surrounding coverage of medical supplies and services impede this goal and add no discernible value to the care of patients.

Principles:

- The physician’s order should be sufficient. Physicians should not have to sign multiple forms from various outside entities for patients to receive needed physical therapy, home health, hospice, or Durable Medical Equipment (DME), including diabetic supplies.
- Physicians should not be required to recertify DME supplies annually for patients with chronic conditions.
- Authorization for supplies should be generic so that physicians are not required to fill out a new form every time a patient switches brands, including but not limited to diabetic supplies.
- Authorization forms should be universal across payers. Data within the forms should be standardized to allow for automated EHR extraction and population of forms.
- Physicians should not be required to attest to the patient’s status when the service is provided by another licensed health professional as is the case with diabetic footwear.

4. Medical Record Documentation

Documentation burdens have increased dramatically, despite adoption of Electronic Health Records (EHRs). Documentation requirements for public and private payer programs and initiatives have escalated. Further, the Centers for Medicare and Medicaid Services (CMS) Documentation Guidelines for Evaluation and Management (E/M) Services, established 20 years ago, do little to support patient care, and serve more as a framework to help physicians justify their level of billing (e.g. level 3, 4, or 5) than to help physicians diagnose, manage, and treat patients. Adherence to the guidelines consumes
a significant amount of physician time, and does not reflect the workflow of primary care physicians. The guidelines were drafted for use with paper-based medical records, and do not reflect the current use and further potential use of electronic health records and team-based care. The guidelines negatively impact the usability of EHR software programs.

Principles:

- As part of the Medicare Quality Payment Program, documentation guidelines for E/M codes 99211-99215 and 99201-99205 must be eliminated for primary care physicians.
- Changes must be made to the outdated E/M documentation guidelines and the Medicare Program Integrity Manual. The changes should include the acceptability of medical information entered by any care team member related to a patient's visit. This standard should be applied by all Medicare contractors, Medicaid, marketplace policies, and private payers.
- The primary purpose of medical record documentation should be to record essential elements of the patient encounter and communicate that information to other providers. The use of templated data and box-checking should be viewed as administrative work that does not contribute to the care and wellbeing of the patient.
- EHR vendors, physicians, and workflow engineers must collaborate to redesign and optimize EHR systems.

(2018 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)
Prior Authorizations

The American Academy of Family Physicians (AAFP) believes prior authorizations should be standardized and universally electronic throughout the industry to promote conformity and reduce administrative burdens. Prior authorizations create significant barriers for family physicians to deliver timely and evidenced-based care to patients by delaying the start or continuation of necessary treatment. The very manual, time-consuming processes used in prior authorization programs burden family physicians, divert valuable resources away from direct patient care, and can inadvertently lead to negative patient outcomes.

The AAFP believes family physicians using appropriate clinical knowledge, training, and experience should be able to prescribe and/or order without being subjected to prior authorizations. The AAFP further believes that a physician's attestation of clinical diagnosis or order should be sufficient documentation of medical necessity for durable medical equipment. In rare circumstances when prior authorizations are clinically relevant, the AAFP believes they should be evidenced-based, transparent, and efficient to ensure timely access and ideal patient outcomes. Additionally, family physicians that contract with health plans to participate in a financial risk-sharing agreement should be exempt from prior authorizations.

The AAFP believes that generic medications should not require prior authorization. The AAFP further believes step therapy protocols used in prior authorization programs delay access to treatments and hinder adherence. Therefore, the AAFP maintains that step therapy should not be mandatory for patients already on a course of treatment. Ongoing care should continue while prior authorization approvals or step therapy overrides are obtained. Patients should not be required to repeat or retry step therapy protocols failed under previous benefit plans. (2017 COD) (2018 October BOD)
Privilege Support Protocol

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.)

Privileges and Training for New Procedures

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, Documentation of Training and Experience
- Privileges, Electrocardiogram Interpretation
- Privileges, Emergency Care Services
- Privileges in Family Medicine Departments
- Privileges and Training for New Procedures
- 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) (2017 COD)
Privileges in Family Medicine Departments

See also

- AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Privileges at Competing Hospitals
- Privileges, Documentation of Training and Experience
- Privileges, Electrocardiogram Interpretation
- Privileges, Emergency Care Services
- Privileges and Training for New Procedures
- Privilege Support Protocol
- 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 or board of trustees.

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 special/critical care units through appropriate privileging. 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.

Privileges for family physicians must be recommended by the department of family medicine in departmentalized hospitals.

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.

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, current competence, and whenever possible, be evidence based. (1997) (2018 COD)
Privileges, Documentation of Training and Experience

See also

- Family Medicine Faculty Training
- Hospital Medical Staff, Board Certification for Membership
- 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) (2017 COD)
Privileges, Electrocardiogram Interpretation

See also

- Electrocardiograms, Family Physician Interpretation of
- AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Privileges at Competing Hospitals
- Privileges, Documentation of Training and Experience
- Privileges, Emergency Care Services
- Privileges in Family Medicine Departments
- Privileges and Training for New Procedures
- 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)
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) (2017 COD)
Privileges, Special/Critical Care Unit

See also

- AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Privileges at Competing Hospitals
- Privileges, Documentation of Training and Experience
- Privileges, Electrocardiogram Interpretation
- Privileges, Emergency Care Services
- Privileges in Family Medicine Departments
- Privileges and Training for New Procedures
- 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) (2017 COD)
Privileges, Surgical Assistant

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, non-physician surgical assisting should be acceptable only in individual cases where appropriate family physician or other physician assistance is unavailable. (1988) (2018 COD)
Privileging Policy Statements

See also

- AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges
- Privileges at Competing Hospitals
- Privileges, Documentation of Training and Experience
- Privileges, Electrocardiogram Interpretation
- Privileges, Emergency Care Services
- Privileges in Family Medicine Departments
- Privileges and Training for New Procedures
- 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. 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. Family physicians should have access to their patients in all areas of a health care facility, including special/critical units through appropriate privileging.

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) (2018 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) (2017 COD)
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. Medical licensure should continue to be the province of the state boards of medical examiners and not contingent on speciality certification or recertification status. (1974) (2018 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.

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) (2017 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)
Professional Medical Liability, Lawsuits

See also

- Professional Medical Liability
- Professional Medical Liability, Insurance Stipulations
- Physician Expert Witness in Medical Liability Suits

The American Academy of Family Physicians denounces the use of medical liability lawsuits as a means to pursue social and ethical policy.

The AAFP is committed to continuing professional development that leads to better care for patients, families, communities, and populations. Professional self-regulation is an important privilege and responsibility that can contribute to the provision of high quality, cost-effective care by ensuring that the physician workforce maintains the competence necessary to provide such care.

Decisions about state licensure and/or credentialing and privileging by hospitals, insurers, and employers should be based on a physician’s documented training and/or experience, demonstrated abilities, and current competence. Physician and practice quality performance measurement and improvement are measures of competence, as are professionalism and engagement in continuing professional development.

Quality performance measurement and improvement activities undertaken at physician workplaces should be considered satisfactory to meet the Improvement in Medical Practice requirement of Continuing Board Certification.

Specialty board certification can offer an important way to differentiate family physicians from other medical providers. The AAFP believes that maintaining board certification should be understood as voluntary. A wide variety of attributes contribute to a physician’s competence and quality of care, thus participation in programs for physician accountability such as Continuing Board Certification should not be used as an absolute requirement for decisions involving licensure, employment, payment, credentialing or privileging. Failure to maintain specialty board certification should not be used in isolation as cause to deny privileging, credentialing, payment, employment, and/or licensure.

(April 2018 BOD)
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
- 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.

(2000) (March 2019 BOD)
Provider, Use of Term (Position Paper)

See Also

- 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."2,3 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

Public Reporting of Physician Performance, Guiding Principles

Preamble

The AAFP defines public reporting of physician performance as a way to compare physician practice patterns across various dimensions of cost and quality. While useful for comparative purposes, physician profiles are not a comprehensive assessment of physician quality and cannot be used to determine the quality of care provided to individual patients or as a measure of overall quality provided by individual physicians. Further, it is important to recognize that public reporting of physician performance 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.

The purpose of publicly reporting physician performance is to improve clinical outcomes and to enhance the ability of consumers to participate in and make decisions about healthcare. AAFP believes transparency in health care cost and quality information to physicians, patients, and employers is important and supports such efforts provided the data aggregation and analysis is consistent with the AAFP Performance Measures Criteria policy. These criteria encompass the framework in which physician performance data is collected, analyzed, and utilized.

While physician performance programs are developed to provide cost and quality data to physicians and patients, their value should be weighed against the subsequent administrative burden. 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, public reporting of physician performance should:

1. Support the physician/patient relationship.
2. Have as its purpose to assess the quality and efficiency of patient care and improve clinical outcomes.
3. Clearly define what is being measured, how performance scores are calculated, and how those scores are compared to peers.
4. Utilize criteria for comparison purposes that are based on valid peer groups, evidence-based statistical norms and/or evidence-based clinical policies.
5. Select measures that are actionable so physicians can easily act as needed to achieve improved quality of care.

See also

- Performance Measures Criteria
- Pay-for-Performance
- Transparency
- Data Stewardship
- Payment, Physician
- Tiered and Narrowed Physician Networks
- Value-Based Insurance Design
- Vision and Principles of a Quality Measurement Strategy for Primary Care (Position Paper)
7. Explicitly describe the data sources on which measurement is based, e.g., administrative/claims, medical records, surveys, registry, etc.
8. Clearly report on the validity, accuracy, reliability and limitations of data utilized when reporting results and when providing physician feedback. Feedback provided may include:

   a) detailing the steps taken to ensure data accuracy and fair physician attribution of costs of care,
   b) clearly defining the peer group against which individual physician performance is being measured/compared,
   c) disclosing data limitations, e.g., measures in which the primary care physician may have little or no control over cost, patient choice, actions of other clinicians, or the completeness and representativeness of data,
   d) describing the attribution methodology and level of attribution of patient populations to either individual or physician groupings,
   e) assuring measurement is evidenced-based, reliable, and valid,
   f) appropriate risk adjustment in measurement, and
   g) establishing and reporting data using meaningful time periods for data collection.

9. Allow physicians to identify their individual patients who are not receiving indicated clinical interventions to support improvement relative to stated measurement.
10. Provide physicians performance profiles and allow review and reconciliation period prior to publication. This process includes providing:

   a) a minimum of 90 days for physicians to review, validate, and appeal their payer’s performance report before public reporting, and
   b) an immediate adjustment of physicians’ performance rating/designation(s) based upon a successful reconsideration or discovery of errors in the payer’s data

11. Provide consumers adequate guidance about how to interpret the physician performance information and explicitly describe any limitations in the data in lay terms.

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 healthcare 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.4 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).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 2006.6 The volume of medical imaging also declined during this time period.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.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.4-6

**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.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.”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.”9

The American Medical Association’s (AMA’s) approved policy *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.”

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 Medicare Claims Processing Manual states that Medicare administrative contractors (MACs) that process Medicare Part A and Medicare Part B claims for a defined geographic area or jurisdiction (A/B MACs) “must pay for the [professional component] of radiology services furnished by a physician to an individual patient in all settings under the fee schedule for physician services regardless of the specialty of the physician who performs the service.” CMS also notes that the interpretation of a diagnostic procedure includes a written report. Regarding payment for the technical component of diagnostic radiography, Chapter 13, Section 20.2.2 of the Medicare Claims Processing Manual states that A/B MACs “must pay under the fee schedule for the [technical component] of radiology services furnished to beneficiaries who are not patients of any hospital, and who receive services in a physician’s office, a freestanding imaging or radiation oncology center, or other setting that is not part of a hospital.”

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.

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.” 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]). 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. 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.”

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.”³⁰ Similarly, a 1989 study reported clinically significant discordance in only four of 508 radiographs and zero substantial changes in care.³⁶

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.³⁸⁻⁴² Studies reporting a decrease in inappropriate radiographs have shown only modest improvements.⁴⁰,⁴¹

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.

Section VII – References


25. Fain R. American Board of Family Medicine, Senior Editor. Personal communication, April 2016.


(B1999) (2017 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 opposes any regulation or legislation requiring health care providers to collect and report data regarding a patient's legal residency status. (2006) (2017 COD)
Reproductive and Maternity Health Services

See Also

- Reproductive Decisions
- Reproductive Decisions, Coverage for
- Preconception Care (Position Paper)

The American Academy of Family Physicians (AAFP) supports a woman's access to reproductive and maternity health services and opposes nonevidence-based restrictions on medical care and the provision of such services. The AAFP believes maternity and reproductive health services are essential to general health care and should be covered under all insurance plans. (2014 COD) (2018 COD)
The American Academy of Family Physicians (AAFP) encourages all family physicians to 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.

(1989) (2017 COD)
Reproductive Decisions, Coverage for

See also

- Reproductive Decisions, Training in
- Reproductive and Maternity Health Services
- Coverage Equity for Drugs, Testing, Procedure, Preventive Services, and Reproductive Technologies

The American Academy of Family Physicians endorses the principle that women receiving health care paid for through health plans funded by state or federal governments who have coverage for continuing a pregnancy also should have coverage for ending a pregnancy. (2017 December BOD)
Reproductive Decisions, Training in

See also

- Reproductive Decisions
- Reproductive Decisions, Coverage for
- Health Education
- Gender Equity on Prescription Drug Coverage
- Adolescent Health Care, Sexuality and Contraception
- Over-the-Counter Oral Contraceptives
- Contraception Methods for Medicare Patients
- Coverage, Patient Education, and Counseling for Family Planning, Contraceptive Methods, and Sterilization Procedures

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)
Research, Collaborative

See also

- Research, Ethical Participation by Family Physicians
- Research, Family Medicine Journals

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) (2018 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 compensated 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) (March 2019 BOD)
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)
Resident and Student Education, Discrimination In

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 (AAFP) supports residential pool safety measures including the following:

- Permanent perimeter protection of pool by an approved safeguard to limit or delay access of children to the pool. This should include inflatable and portable pools, as well as hot tubs. Fencing or barriers that completely enclose pools (a four-sided fence) without direct access to the house are preferred. Fencing should be at least four feet high and climb resistant with a self-latching and self-closing gate, and less than four inches from the bottom of the fence and the ground.
- Training of household adults, older children and other adult supervisors in cardiopulmonary resuscitation (CPR).
- Phone access for emergency medical services and 911 should be available poolside, including the use of cell phones.
- Safety equipment available poolside should include life buoys, personal flotation devices (PFD) or life jacets, and a reach tool, such as a shepherd's hook.
- Constant adult supervision of young children at all times. Supervise children at arm's length for those less than four years of age at all times. Adults should avoid distractions while supervising young children in or around the pool.
- Teaching children to swim when ready, usually by age four. Parental decision to enroll children 1-4 years into swimming classes should be individualized on the basis of physical and cognitive maturity. Swimming instruction does not guarantee protection against drowning in young children.
- United States Coast Guard approved personal flotation devices should be required for small children and infants near deep water. 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.
- All pools and hot tubs should have drains that prevent entrapment and/or release suction if entrapment occurs.

(1989) (March 2019 BOD)
Residents and Students, AAFP

See also

- Residency Training Leading to Dual Board Certification
- Preceptorships
- Commission, Orientation Manual (4 MB PDF)

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 medical home is foundational to a health care system that improves the quality and efficiency of care. The AAFP monitors 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. While the AAFP recognizes patient choice may prompt use of a retail clinic, that care should not be at the expense of the comprehensive, coordinated, and longitudinal care available through a medical home.

The following are a set of characteristics for Retail Clinics and their sponsoring companies to guide potential collaboration between primary care and these companies:

- Retail clinics must use local community physician medical directors who are actively engaged with clinic staff on the development and use of evidence-based care management protocols and quality improvement. Retail clinics should make efforts to ensure that their medical directors include family physicians or other primary care physicians.
- Retail clinics should support physician-led care. If the patient sees a non-physician provider (NPP), that NPP should be supervised by a primary care physician who is readily available onsite or virtually.
- Retail clinics will support the patient-physician relationship by always referring patients back to their primary care physician for continuing care.
- Core retail clinic services will be focused on a defined set of guideline-based episodic services and should be delivered in coordination with the patients' primary care physician to ensure that care is not further fragmented.
- Chronic care management and comprehensive longitudinal care should be provided by a primary care physician and medical home team and not by a retail clinic.
- For patients with a chronic medical condition(s), the patient and their primary care physician may consider that certain care services may be provided in the retail clinic, when there is a collaborative agreement with the patient’s primary care physician which specifies the guidelines, procedures, and protocols to be used to provide such care.
- Retail clinics must establish operational protocols that facilitate the timely transfer of medical records to the patient’s primary care physician.
- Retail clinics must use electronic health records capable of transmitting medical record data and information to the patient’s primary care physician (and other physicians as appropriate).
- When a patient lacks an established relationship with a primary care physician, retail clinics will encourage and assist patients in identifying a primary care physician in the community.
- Retail clinics will maintain a listing of family physicians.
within a reasonable distance of their location who are accepting new patients.

- Retail clinics will establish a specific email address where family physicians can email and request to be added to the list of primary care physicians who are accepting new patients- i.e. family physician@ (insert).com.

(2006 COD) (2018 December BOD)

See Also

- Electronic Health Records
Role Definition of Family Medicine

See also

- Family Medicine, Quality Health Care in
- Family Medicine, Specialist in
- Family Medicine Faculty Training
- Family Medicine's Role in Undergraduate Medical Education
- 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 supplyiv,
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 supportv, 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.vi

Studies linking rural physician supply and demand, geographic mapping of physician workforce and educational institution outcomes are now availablevii. These findings can be associated with workforce needs projections published in the literature incorporating anticipated healthcare policy reform such as the Affordable Care Actviii, better delineating future needs. Studies investigating factors influencing medical student and resident choiceix are accompanied by an understanding of the unequal geographic distribution of physiciansx.

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 overallxi.

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 settingsxii.

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 Practicexiii. 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 terms 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 locationsxiv. 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 2010xv. 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 Montanaxvi. 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 communitiesxvii, 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 necessaryxix. 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 prescribed 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 durationxx.
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 predictedxxi.

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)xxii

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) codesxxiii 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 inititally prepared and written in 2007 by Randall Longenecker, MD with editorial assistance from Tom Rosenthal MD, Jeff Stearns MD, and Michael 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.


xv For information: web site “US Department of Health and Human Services, Health Resources and Services Administration”. (http://bhpr.hrsa.gov/grants/teachinghealthcenters(bhpr.hrsa.gov)).

xvi For information: website “Targeting Rural and Underserved Track (TRUST) Program”. (http://healthinfo.montana.edu/(healthinfo.montana.edu)).


xviii Hancock C; Steinbach A; Nesbitt TS; Adler SR; Auerswald CL. “Why doctors choose small towns: A developmental model of rural physician recruitment and retention,” Social Science & Medicine, 2009 Nov; 69(9):1368-76.

xxi Chen C; Xierali I; Piwnica-Worms K; Phillips R. The Redistribution Of Graduate Medical Education Positions In 2005 Failed To Boost Primary Care Or Rural Training, Health Affairs, 32, no.1 (2013):102-110.

xxii For information: website “Rural Assistance Center: Rural Training Track Technical Assistance Program”. (http://www.raonline.org/rtt/about_rttts.php(www.raonline.org)).

xxiii For information: website “Rural Urban Commuting Area (RUCA) codes”. (http://depts.washington.edu/uwruca/(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 workforce, 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 ratio 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. Certainly, state and federal loan pay-back and scholarship programs provide much-needed physician manpower for many rural, isolated communities. 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...
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.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,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,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 physicians31 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.33 Physicians attributed this feeling of “security, freedom and identity” to a number of factors, which are listed in Table 3. Cutchin’s papers33,34 help flesh out the concepts validated by Pathman in his more quantitative studies.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 development35 and even Community-Oriented Primary Care (COPC)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.36

Programs that help rural family physicians become successful and stay satisfied with their choice have been developed.38 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.39 Community physician preceptors can serve as role models for residents and as links to rural communities.40

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:**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rank</th>
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<tbody>
<tr>
<td>Factor: Significant other’s wishes</td>
<td>Rank: 1</td>
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<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>
</tr>
<tr>
<td>Factor: Schools for children</td>
<td>Rank: 6</td>
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**Table 2:**
**Factors that Influence Retention**\(^{17,31,41}\)

<table>
<thead>
<tr>
<th>Factor</th>
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<tbody>
<tr>
<td>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.</td>
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<tr>
<td>Physicians who receive part of their residency training in rural areas stay longer in rural practice.</td>
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<tr>
<td>Physicians in rural communities are no more likely to leave their practices than are their urban counterparts.</td>
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<tr>
<td>Urban-raised physicians who enter rural practice stay in rural practice longer than physicians who were raised in rural areas.</td>
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<tr>
<td>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.</td>
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<tr>
<td>Physicians whose spouses are from urban areas stay in practice as long as those whose spouses are from rural areas.</td>
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<tr>
<td>Physicians involved in teaching remain in rural practice longer than those who are not involved.</td>
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<tr>
<td>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.</td>
<td></td>
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<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Lack of quality of rural school systems, perceived or real, is related to length of stay for physicians in a rural practice.</td>
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**Table 3:**
**Security, Freedom and Identity: How Rural Family Physicians Define These Concepts**

<table>
<thead>
<tr>
<th>Security</th>
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</table>

Security: Confidence in medical abilities.
Security: Commitment to goals.
Security: Ability to meet needs of family.
Security: Comfort with local medical community and hospital.
Security: Not too much call.
Security: Respect by community at large and by the medical community.

Freedom

Freedom: Challenge and diversity in medical work.
Freedom: Ability to spend time with patients.
Freedom: Cooperation from medical community and larger community.
Freedom: Power in medical system.
Freedom: Ability to develop health care delivery system.
Freedom: Involvement in the community.
Freedom: Personal and family activities.
Freedom: Developed sense of self and place

Identity

Identity: Loss of anonymity.
Identity: Like-minded practice group.
Identity: Responsible role in hospital and community.
Identity: Respect.
Identity: Fulfilling aspirations for job.
Identity: Seeing self as belonging in the community.
Identity: Awareness of self in time and place.
Identity: Creation of future goals without needing to relocate.


Table 4:
Key Legislative and Governmental Issues

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<tr>
<th>Key Legislative and Governmental Issues</th>
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<tr>
<td>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.</td>
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<tr>
<td>Renew and expand Title 7 funding, which provides funds for family practice training, and link Title 7 funding to rural medical education.</td>
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<tr>
<td>Reform Medicare regulation of graduate medical education to support rural-based medical education.</td>
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<tr>
<td>Revise Medicare regulations, including the Medicare Incentive bonus program and the Area Wage Index of the Medicare Inpatient Hospital Prospective Payment System.</td>
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<tr>
<td>Write legislation to support rural hospitals, which may include strengthening the Critical Access Hospital system and other special arrangements for rural health care funding.</td>
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<tr>
<td>Changes the Personal Responsibility and Work Opportunity Reconciliation Act, which may improve rural economies and improve government support for rural populations.</td>
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Table 5:
Resources for Information About Rural Health
### Web sites

<table>
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<tr>
<th>Web sites</th>
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<tbody>
<tr>
<td>Web site: National Rural Health Association</td>
<td><a href="http://www.ruralhealthweb.org">http://www.ruralhealthweb.org</a></td>
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### 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


School-Based Health Clinics, Guidelines

See also

- Health Education
- Health Education in Schools
- Children's Health
- Hygiene, Personal Hygiene in School Settings

The American Academy of Family Physicians (AAFP) strongly believes that all children and adolescents should have access to a medical home that provides high-quality, continuous, and comprehensive health care services. The AAFP 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 have a positive impact on academic achievement, high school graduation rates, and student engagement at school. They can improve adolescent access to health care and health education when integrated with the medical home. 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. These services can include contraceptive care, sexually transmitted infection, and risk screenings, as well as serving as an access point for subsequent interventions.

Written policies for school health services should be developed 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. School-based health centers must comply with applicable law and other regulatory guidelines to meet the complex needs of adolescents, while respecting their right to confidentiality. (1989) (March 2019 BOD)
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) (2018 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

Decisions about screening for asymptomatic disease can be complex, and require judgment and knowledge of an individual’s risks and medical status. The AAFP encourages patients to consult with their physician regarding selection, use, and interpretation of screening tests.

The AAFP supports evidence-based age, gender, and risk appropriate screening. The AAFP recommends against mass screening or direct-to-consumer screening that is not evidence-based.

(April 2018 BOD) (2018 COD)
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) (2018 February BOD)
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.

No individual member or other 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) (2018 February BOD)
Separation of Families

The American Academy of Family Physicians opposes the forced separation of children from family members or caregivers crossing the United States border unless the child’s immediate physical or emotional health or safety is at risk, as such separation poses great physical and mental health risks in terms of emotional trauma, safety, and diminished overall well-being. Detention has been associated with anxiety, depression, post-traumatic stress disorder, self-harming behavior, sleep disturbances, and social withdrawal in adults and these negative effects are amplified in minor children who are separated from their family members or primary caregivers. The trauma sustained during separation can lead to lifelong adverse consequences. (2018 July BOD) (2018 COD)
Sexual Assault Survivors Rights to Protection

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

- Virtual 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) (2018 COD)
Social Determinants of Health Policy

SEE ALSO

- Population Health
- Poverty and Health - The Family Medicine Perspective (position paper)
- Health Literacy

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)
Solitary Confinement of Youth

The American Academy of Family Physicians (AAFP) opposes all solitary confinement for youth in all adult and juvenile facilities. Solitary confinement causes significant negative health effects, including depression, anxiety, and self-harm behaviors. (2018 July 2018) (2018 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) (2018 COD)
Sports Medicine, Counseling About Risk of Contact/Collision Sports

See also

- 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 (AAFP) recommends that family physicians understand and communicate with patients the risks associated with contact/collision sports, including gender-based differences. Contact and collision sports include any form of activity in which athletes collide with other athletes, inanimate objects, or the ground increasing the risk of bodily injury. Family physicians should inform patients about potential risks, including concussions, and communicate strategies to manage and minimize risk. Physicians should talk with their patients about appropriate return to play protocol to ensure a healthy recovery and avoid further injury. (1990) (March 2019 BOD)
Sports Medicine, Health and Fitness

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

- 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) (2018 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) (March 2019 BOD)
Student Choice of Family Medicine, Incentives for Increasing

See Also

- Family Medicine Interest Groups (FMIGs)
- Family Medicine Clerkship
- Family Physician Workforce Reform
- Undergraduate Training in Family Medicine
- Diversity in the Workforce
- Medical Student Debt Relief
- Preceptorships

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 health as a basic human right 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 wellbeing 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) (2018 COD)
Substance Abuse and Addiction

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 supported 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
http://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=1

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)
Sunscreen Usage in Schools

The American Academy of Family Physicians (AAFP) supports school-based measures to prevent harmful sun exposure to students. Educating students about sun safety, providing shaded areas to play outside, and minimizing outdoor recess during periods of the highest ultraviolet ray exposure are essential to prevent harmful sun exposure. The AAFP encourages the use of sun protective clothing, including hats. The AAFP encourages schools to allow students to self-apply sunscreen brought from home, as well as provide assistance in applying sunscreen with parental permission and with a second adult present for students who cannot apply sunscreen on their own. Students should not be required to have a letter from a health care provider to apply sunscreen at school. (March 2019 BOD)
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) (2017 COD)
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 Underage Alcohol Usage
- 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

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) (2017 COD)
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 outweighs the short-term financial benefits of frequent switching of primary care physicians due to tiering, narrowing, or terminating family physicians from networks. A substantial body of evidence demonstrates that continuity of care improves outcomes and decreases unnecessary utilization. Patients who have a higher level of continuity of care have a greater sense of trust in their physician, greater sense of security, and better communication with their physician. In addition, the ongoing relationship with a patient, when there is continuity of care, contributes to greater physician satisfaction. Therefore, substantial caution should be exercised when using systems that disrupt the ongoing 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.

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 "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 or health systems should not be exclusively based on the cost-of-care delivered or by utilization measures attributed to 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)
- Decriminalization of Possession of Marijuana for Personal Use

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)

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.1 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.8 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.9 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.9 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.1

**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.10 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.11

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.12 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.12 If physicians would advise 90% of smokers to quit and offer them medication or other assistance, 42,000 lives could be saved each year.13

Of the 42.1 million people in the United States who smoke cigarettes, only 5% are able to quit without assistance from healthcare providers.10, 14 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.2 The use of evidence-based programs can more than double success rates.2 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.10 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.10 Tobacco dependence is a chronic disease characterized by remission and relapse, and family physicians should approach treatment for tobacco use with this in mind.10

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 attempts15

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 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](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. If current rates continue, 5.6 million children alive today will ultimately die prematurely from smoking-caused disease. 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.

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. 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. 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. This pattern of predatory marketing brings results as high school students and young adults now smoke cigars at far higher rates than all adults.

**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.

**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. Several studies have recently described “rapid expansion” in their use among adolescents, high school and college students, as well as among adults. 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.

Manufacturers and marketers tout e-cigarettes as cheaper and safer alternatives to traditional cigarettes. 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 level, multiple physical symptoms, and negative effects on indoor air. 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.

The AAFP recognizes the alarmingly increased use of e-cigarettes, especially among youth and those attempting to quit smoking tobacco. 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. 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. 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](http://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.67 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.68 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.1 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.¹ 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.⁶⁹ Since 1964, 2.5 million nonsmokers have died from exposure to secondhand smoke.¹ 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.⁶⁹ 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.¹⁵ 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,⁷⁰ 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.⁷¹ It should also regulate nicotine delivery devices, including e-cigarettes. The FDA is currently considering expanding its jurisdiction to include e-cigarettes.⁷² The AAFP supports this proposed rule change as outlined in a letter to the FDA.⁷³

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.⁷⁴ 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.⁷⁵ 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 (WHO), and in 2003 was unanimously adopted by the World Health Assembly and opened for signature.⁷⁶ Among many other medical and health care organizations, the FCTC is supported by the American Medical Association, the American Cancer Society, the American Thoracic Society, and the American Society of Clinical Oncologists. The World Organization of Family Doctors added its support to the FCTC in 2004.⁷⁷

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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(2009 COD) (2014 COD)
Transparency

See also

- Data Stewardship
- Pay-For-Performance
- Performance Measures Criteria
- Public Reporting of Physician Performance, Guiding Principles
- Payment, Physician
- Tiered and Narrowed Physician Networks

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:

- payers' payment policies
- payers’ claims adjudication software logic edits
- payers’ fee schedules
- payers’ clinical policies
- payers’ data analysis methodology and performance measures used in rating
- physician performance
- reporting of physician health care cost and quality information

Transparency and Equity in Physician Compensation

The American Academy of Family Physicians supports transparency and equity in physician compensation, without regard to gender, gender identity, sexual orientation, and race/ethnicity, though removal of non-disclosure clauses from physician employment contracts or other suitable methods of assuring non-discrimination in compensation. (2018 COD)
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) (March 2019 BOD)
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)
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

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 programs, 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

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.

**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)
Violence, Harassment and School Bullying

See also

- 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

- 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 and other illegal acts against physicians and other health professionals and urges prompt enforcement of laws prohibiting such activities. The AAFP supports classifying violent crimes against physicians and other health professionals as felonies.

The AAFP encourages health care facilities to have a security protocol in place to include security issues when orienting and training new staff, and to consider performing routine security drills or simulations. 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. Physicians and other health professionals are encouraged to build working relationships with local law enforcement agencies. (1993) (2017 COD)
The American Academy of Family Physicians (AAFP) recognizes violence as a major public health concern. Violence occurs in the context of a broad range of human relationships and complex interaction that encompasses social, cultural, and economic risk factors, including but not limited to the influence of the media, substance abuse, interpersonal violence (including sexual and intimate partner violence), fragmentation of family life, availability of weapons, and the rise of gangs and youth violence. Exposure to violence and abuse has been associated with death and severe physical and mental health outcomes.

Violence disproportionately affects vulnerable populations such as women, children, lesbian, gay, bisexual, transgender, questioning, and intersex individuals, and those living in poverty, among others.

In order to support their patients who are victims of violence or are at risk, family physicians need to be aware of the various manifestations of violence, risk factors related to violence, availability of resources and services for survivors of violence and their families. The AAFP also encourages members to become involved in efforts to reduce violence through advocacy, educational means, as well as partnerships with law enforcement and community-based organizations.

Violence (Position Paper)

See also

- Hate Crimes
- Violence in the Media and Entertainment (Position Paper)
- Child Abuse
- Violence as a Public Health Concern
- Intimate Partner Violence
- Violence, Illegal Acts Against Physicians and Other Health Professionals
- Violence, Harassment and School Bullying
- Elder Mistreatment
- Prevention of Gun Violence (policy statement)
- Gun Violence, Prevention of (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.5

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 hormone, and dihydroepiandrosterone), 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.16 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\textsuperscript{29} showed 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.\textsuperscript{24} Additional longitudinal studies have tested a 10-minute intervention that was proved highly effective in increasing the safety of pregnant abused women.\textsuperscript{25} 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.\textsuperscript{26} 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/(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. 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.

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(1994) (2014 COD)
Violence in the Media and Entertainment (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
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


Virtual 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 electronic visits or “virtual e-visits” which occur over safe, secure, online communication systems. AAFP defines a virtual e-visit as an evaluation and management service provided by a physician or other qualified health professional to a patient using a web-based or similar electronic-based communication network for a single patient encounter.

Guidelines

Guidelines for virtual e-visits:

1. Available technology capabilities as well as an existing physician-patient relationship impact whether the standard of care can be achieved for a virtual visit, and clinical guidelines or protocols should be in place that identify whether a virtual visit for the chief complaint/presenting complaints and active diagnoses meet the standard of care;
2. The patient agrees to virtual visit service terms, privacy policy, and charge for receiving a virtual visit from a physician or other qualified health professional;
3. Electronic communication occurs over a HIPAA-compliant online connection;
4. A virtual e-visit includes the total interchange of online inquiries and other communications associated with this single patient encounter;
5. The physician or provider appropriately documents the virtual visit, 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 a virtual visit request are completed;
7. The treating physician or provider within a virtual visit should forward a summary of the visit to the patient’s primary care physician or medical home, and communicate with the primary care physician as necessary; and
8. Virtual e-visits should be a payable physician service.

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 recognizes the important role physicians utilizing J-1 visa waivers have in improving health care disparities by serving rural and underserved communities. (2003) (2018 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)
Vision and Principles of a Quality Measurement Strategy for Primary Care
(Position Paper)

Overview

The American Academy of Family Physicians’ (AAFP’s) Vision and Principles of a Quality Measurement Strategy for Primary Care builds upon existing AAFP policy to provide guidance for future development and use of quality measures in improvement and payment initiatives.

Background

Improving health and health care is a continuous process and a shared goal of patients and all involved in the health care industry. The need for improvement in the United States is demonstrated by both high overall spending and poor rankings on many health indicators compared with other developed nations and some developing nations. Measures are fundamental components of improvement. Measurement allows us to determine if practice changes, interventions, or new models of payment lead to actual improvements or if such changes merely placate those demanding change.

To date, quality measures have focused on the minutiae of hundreds of clinical processes for managing specific diseases and performing procedures but have failed to adequately address factors that have the greatest impact on overall individual and population health. The eagerness to measure has burdened physicians—especially primary care physicians—with the onerous task of capturing structured electronic data to feed an excessive number of measures, taken time away from patients, and led to loss of joy in practice. Quality measurement has become a high-burden, high-cost administrative exercise, focused on financial concerns with little benefit to patient care, population health, and cost reduction. Thirty-three percent of family physicians cited the lack of evidence that using performance measures results in better patient care as a major weakness of value-based payment systems, and an additional 29% cited this as a minor weakness. The burden of measurement contributes to burnout among primary care teams, which in turn is associated with lower quality of care.

Recent national initiatives have taken a closer look at quality measures. In late 2017, the Centers for Medicare & Medicaid Services (CMS) announced Meaningful Measures (www.cms.gov), which calls for a focus on core issues that are most vital to providing high-quality care and improving patient outcomes while reducing burden. The Core Quality Measures Collaborative, convened by America’s Health Insurance Plans (AHIP), established core measures sets for several specialties, including primary care, as an important first step in harmonizing measures across payers. The National Academy of Medicine (NAM) Vital Signs developed a framework of core measures of health, care quality, costs, and engagement. In 2017, the Starfield III: Meaningful Measures for Primary Care summit assembled 70 national and international stakeholders with the goal of moving primary care measures beyond disease-specific measures to measures that address the unique features of primary care most responsible for better outcomes and lower costs. These efforts emphasize the need to re-examine our current approach to quality measurement; focus on issues

See Also

- Performance Measures Criteria
- Pay-for-Performance
- Principles for Administrative Simplification
- Data Stewardship
- Medical Home
- Advancing Health Equity: Principles to Address the Social Determinants of Health in Alternative Payment Models
- Public Reporting of Physician Performance, Guiding Principles
- Payment, Physician
- Family Medicine, Quality Health Care in
that have a great impact on the nation’s health; address what matters most to patients; and make better use of information technology (IT) to ease burden and drive rapid, breakthrough improvements in health care.

Existing AAFP policies address the following issues:

- Primary purpose of measurement and criteria of performance measures: Performance Measures Criteria and Pay-for-Performance
- Burden of quality measures: Principles for Administrative Simplification
- Data sharing: Data Stewardship
- Functions of comprehensive primary care: Medical Home
- Need to address social determinants of health (SDoH) to promote whole-person, comprehensive care: Advancing Health Equity: Principles to Address the Social Determinants of Health in Alternative Payment Models

These policies provide a solid foundation for development of quality measurement within the confines of our current understanding of measurement and improvement science, using technology that is widely available now.

**Vision of a Quality Measurement Strategy**

This paper takes an additional step toward achieving a vision of a quality measurement strategy for primary care that has the potential to accelerate large-scale improvement in health, health care, and cost reduction. We distinguish between quality measures that are used for internal quality improvement (QI) efforts and those used for value-based payment and public reporting because the intended use determines the focus of measures and the rigor with which criteria of importance, measurability, and achievability are applied. We address the leadership role of physicians; the critical role patients and caregivers have in quality measurement and improvement; and the equalization of the partnership between patients/caregivers and clinicians, enabled by more actionable information and sophisticated primary care teams. We consider the importance of systems-level attribution and measurement, shared responsibility for outcomes, and community involvement in improvement efforts. We discuss the most important features of primary care that are responsible for improved outcomes and lower costs. Future efforts to develop measures for primary care should be directed toward these areas. The vision of a quality measurement strategy for primary care is driven by the creation of large data stores and advancements in technology that change the fundamental process of measurement and improvement.

**Principles of a Quality Measurement Strategy for Primary Care**

The AAFP principles outlined below support achievement of the vision of a quality measurement strategy for primary care and establish the basis for such a strategy. These principles can be used to guide health care policy and advocacy, direct development of quality measures, impact value-based payment measurement efforts, and expand on work being done to inform improvement of health care quality.

**Principle 1: Measures serve different purposes, and the AAFP makes a distinction between quality measures and performance measures.** The main purpose of a quality measure is to accelerate internal clinical improvement. Performance measures serve several purposes: providing comparative data for use in value-based payment programs; supporting patients’ ability to participate in and make decisions about health care based on cost and quality; and allocating resources toward identified community and population health needs. Some measures may serve the purposes of both quality and performance measures.

The intended purpose of a measure is important to its design and rigor. Quality measures address the details of patient care, administrative processes, and medical decision-making, and involve striving for attainment of benchmarks or goals. Performance measures address high-level patterns and outcomes of care, comparing various dimensions of quality and cost across organizations and geographic areas. Making this distinction allows the organization to use quality measures to track and explore innovative ways to improve the care of patients, even though such measures may include domains over which the health care organization or physician does not have ultimate control. Performance measures, on the other hand, require that the organization being measured have control over the dimensions involved.
The AAFP makes the following distinctions based on the purpose for which a measure is used:

**Quality Measure:** Quality measures are used within health care organizations to accelerate clinical improvement and are an integral component of QI methodology. They may be designed for application at various levels: individual, group, specialty, system, patient, or population. Quality measures need flexibility to accommodate changes in evidence and guidelines and can be less rigorous than performance measures because of their internal use. Disease-specific measures, process measures, measures that apply to only a small segment of the population, and measures that have face validity are useful for internal quality improvement.

Quality measures allow organizations to gain an understanding of care gaps and the impact interventions have on closing those gaps. Interventions drive purposeful change in organizational systems to improve the capability of health care professionals to properly care for their patients. Quality measures should be selected based on services offered, importance to patients and health care professionals, internal strategic plans, needs of the community being served, and perceived or identified gaps in care. Most existing quality measures are appropriate for use in QI.

**Performance Measure:** A performance measure compares the relative performance of various entities or health care professionals and is used for value-based payment, resource allocation, and patient decision-making. Performance measures should be evidence-based, consistent, universal, well-defined, and transparent. To avoid unintended consequences, they must meet the highest standards for validity, reliability, feasibility, importance, and risk adjustment. Performance measures may prompt internal improvement work.

Performance measures used in value-based payment programs must be risk-adjusted, when appropriate, and allow for exceptions for individual patient circumstances, values, and needs. Performance measures should be limited to factors that have the greatest impact on health, health care, and costs, and are within reasonable control of the entities or professionals to which payment adjustments apply.

Many performance measures currently used in value-based payment fail to meet these standards. Measures may lack sufficient evidence linking them to improved health outcomes, the individuals or organizations held accountable may lack control over outcomes, or measures may apply to a small population, limiting their impact.

Performance measures also provide information that helps patients participate in and make informed decisions about their health care based on quality and cost. Measures that are publicly reported must be understandable, readily available when the public wants them, relevant to the service being sought, and inclusive of providers with whom the patient interacts, and they must address issues of importance to patients and reveal costs. Publicly reported measures should meet high standards for validity and reliability because measures that lack these characteristics may disengage clinicians from improvement, unjustly harm the finances and reputation of health care professionals, and misinform patients about the risks and benefits of various treatments.

Performance measures can identify gaps in services and outcomes at the entity, community, and population levels, and they can be used to direct allocation of public and private resources to address unmet needs. Such measures should not lead to financial penalties for low performance. Rather, they should lead to investment of resources to improve equity, access, and socioeconomic factors that impact health and health care.

**Principle 2:** To achieve the main purpose of accelerating improvement, quality measures must be integrated into a methodological approach. Internal quality improvement efforts require transparency and a safe space to allow honest assessment of care without fear of punishment and without pressure to increase revenue or produce bonus payments. Physicians must have a leadership role in QI efforts, with patients, clinical teams, and community partners as key players.

Implementing an organizational QI process can drive improvements in health and health care. Fundamentals of QI include continuous efforts, specific aims, buy-in from leadership, testing of changes, measurement, feedback, analysis of variation, and spread. QI examines processes and systems of care that may be underlying causes of poor outcomes. Physicians are involved in almost all important processes and outcomes of health care, and they must play a central role...
in improvement efforts.

Candid discussions among care teams without fear of financial penalty or punishment, and data transparency are necessary for effective QI to occur. Physicians demonstrate a willingness to adopt best practices and share clinical insights when they are provided data and resources that indicate a need for improvement. Patients are key players in improvement, particularly when patient activation is necessary for success, and can identify barriers that negatively affect their health or health care. Communities are also key players and can help offer potential solutions to non-medical barriers.

**Principle 3: There should be a single set of performance measures that are universal, meet the highest standards of validity and reliability, and are derived from data extracted from multiple data sources. The measures should focus on outcomes that matter most to patients and that have the greatest overall impact on better health of the population, better health care, and lower costs. At the same time, the burden of measurement on practices should be minimized.**

Performance measures used in value-based payment should include a limited set of measures of quality, cost, and population health. Giving in to the temptation to measure everything that can be measured drives up cost, adds to administrative burden, contributes to professional dissatisfaction and burnout, encourages siloed care, and undermines professional autonomy. In addition, it diverts resources away from the most important factors influencing health and health care, such as SDoH. Extensive experience with performance measures in various systems (e.g., the VA system, the United Kingdom: Quality and Outcomes Framework) has shown excessive measurement can cause unexpected harms while failing to have an enduring positive impact on health outcomes of interest.

To improve representativeness of the data and avoid “cherry-picking” of patients, the same measures should be standardized across payers, programs, and systems of care and universally applied to all eligible patients or populations. Measures currently used in various payment programs lack alignment and are applied inconsistently, which reduces their value and usefulness, limits the ability to aggregate data and determine progress toward a goal, and adds to the burden of data collection and reporting.

Performance measures must be evidence-based and meet the highest standards of validity and reliability. Measures must allow exceptions for individual patient circumstances, values, and needs. Measures with insufficient exceptions may subordinate patients’ values to those of the measure proponents, which would distract from or devalue health care professionals’ efforts to help patients meet their goals. Poor measures of performance may lead to gaming, overtesting, underutilization, or overtreatment.

Measures of performance should be derived from data that are extracted from multiple data sources rather than self-reported by physicians and their teams. Self-reported data are seldom validated for accuracy, reliability, missing data, coding variation, and application of measure specifications. Elimination of self-reporting will end current financial penalties for non-reporting that disproportionately impact small practices. Data extraction will reduce administrative burden and resolve comparability problems in performance data submitted through various mechanisms, but it will require advancements in IT. However, physicians cannot be expected to continue bearing the burden of data collection and reporting while awaiting technological solutions.

Performance measures should focus on the highest strategic priorities, namely those conditions, services, and factors that are known to have the greatest impact on health status, outcomes, and cost. High-priority areas have been identified in several ongoing initiatives, including the Core Quality Measures Collaborative, Vital Signs from the NAM, and Meaningful Measures from CMS. Common themes that surfaced across these initiatives to inform the future focus of performance measures include the following:

- Management of high-risk, high-need, high-cost patients
- Reduction in hospital and emergency department (ED) touches
- Prevention of chronic disease and promotion of healthy lifestyle
- Enhancement of communication and coordination between professionals, patients, and the community
Principle 4: Performance measures should be applied at a system level to promote shared accountability and team-based care. To level the playing field, performance measures should be risk-adjusted, when appropriate, for demographics, diseases, severity of illness, and social determinants of health. All populations and geographic areas must be attributed to at least one system to promote health equity.

Performance measures should be applied at a system level of care, which may entail a group practice, integrated health care system, health plan, accountable care organization, or geographic region (e.g., community, state). Patient and population health are highly dependent on multiple stakeholders in multiple settings and on multiple teams working collaboratively to deliver coordinated, integrated services. They are also dependent on social, economic, and political factors that impact health. On their own, individual health care professionals have limited ability to drive outcomes in health and health care and are constrained by the environment and systems in which they practice. However, performance measurement frequently defaults to measuring care delivered by individuals, and shortcomings are misconstrued as professional inadequacies rather than as a reflection of the system. Feedback to systems should allow detailed dissection of data to help identify gaps in care and to stimulate future improvement efforts.

Performance measures used in value-based payment must be properly risk-adjusted, when appropriate, to account for factors such as demographics, comorbidities, patient behavior and preference, competing patient priorities, and SDoH to level the playing field and avoid financially penalizing entities or health care professionals for factors outside their control. Measures can be risk-stratified and/or populations can be segmented so that complex patients can be included in measures but the data can be analyzed by subpopulations. Exceptions and exclusions can be added to measure specifications to account for patient behavior, values, and choices and to avoid penalizing clinicians for delivering care according to patient-centered goals.

Accountability and attribution of patients and costs are difficult and complex issues, but simplicity emerges when these are done at a system level rather than at the individual clinician level.

The most effective unit or system for performance measures will vary, and any single provider, facility, or patient might rightfully belong to multiple systems. For greatest impact, all populations and geographic areas must be attributed to one or more systems and all providers must be included in one or more systems, regardless of whether formal arrangements are in place. This is necessary to address issues of inequity, access, and cherry-picking, and would ensure that someone is responsible for the health, health care, and costs of all defined populations. Entities and health care professionals could find themselves in overlapping systems with a competitor, which would encourage cooperation and mutual resource allocation to improve factors that influence health outcomes. Holding systems responsible for serving the needs of a geographic population may prevent the closure of clinics, EDs, maternity services, and other essential services in rural areas.

Principle 5: Measures of primary care should focus on the unique features that are most responsible for better outcomes and lower costs, and are under reasonable control of the primary care physician.

Fifty-one percent of all physician office visits are made to primary care physicians. Research has shown that having strong primary care in a health care system reduces costs and improves quality and population health. There are unique features of primary care likely responsible for this effect that are largely under the control of the primary care physician. These features should be the focus of measures of primary care and include the following:

- **Access/first contact**: Primary care that is accessible to the patient as the first point of contact enhances a whole-person focus, reduces disparities, decreases ED and hospital visits, and lowers cost.
- **Comprehensiveness**: Comprehensive primary care that addresses acute problems, chronic disease,
prevention, behavioral/mental health, population health, and SDoH leads to better health and fewer referrals/handoffs, which are known to cause safety concerns.

- **Coordination**: Care that is coordinated reduces duplication, oversights, and medication and other errors, and improves patient satisfaction.
- **Patient and caregiver engagement**: When patients and caregivers are presented with appropriate information, and their values and choices are considered, care is more patient-centered, patients are more satisfied and better able to manage their health, outcomes are improved, and costs are likely to be reduced.
- **Continuity**: Continuity builds relationships, understanding, and trust between physicians and patients; encourages patient activation and commitment to a care plan; reduces the risk of handoff errors; and is more considerate of the social and contextual needs of patients.
- **Care management**: Timely, effective care management of high-risk patients can reduce costs and improve quality for the small number of patients that account for a large percentage of health care expenditures.21

Current measures of primary care are scattered across all diseases, conditions, and preventive needs of patients; are generally indistinguishable from measures of other specialties; and do not adequately assess the quality of primary care. Primary care is much more complex than many people understand. Three out of four complaints that present are self-limited, and 40% of new symptoms do not lend themselves to any current coding system (e.g., ICPC, ICD-10).22,23 In addition, the linear "assembly line" model that has resulted in some advances (e.g., ventilator care) is not appropriate in primary care. Primary care requires a whole-person approach, prioritization of needs, a sophisticated primary care team, and consideration of the goals of the patient within the context of his or her social system.24 Additional research is needed on how primary care is delivered and how to improve and measure care in the primary care setting.

**Principle 6: There should be a principled redesign of health information technology that enables affordable, expansive, accessible aggregation of data, powerful analytics, and meaningful interpretation. Health IT should automate data collection and quality measurement, eliminating the need to self-report. Information should be pushed to clinicians and patients at a point in time when it is most useful for decision-making and action.**25

Electronic health records (EHRs) were not designed to support quality measurement and improvement. A digital redesign of health IT is needed to enable extraction and aggregation of data from multiple sources, and analysis and interpretation of large data stores to reveal patterns of care; this is not possible with small, siloed data stores. Issues of data ownership, interoperability, and data exchange must be resolved to allow the flow of information across disparate health information networks (www.healthit.gov).25 In the future, automated quality measurement will generate evidence from every patient encounter to reveal patterns, predict outcomes of various treatment options, inform new standards of care, and drive large-scale, rapid improvement. Data will prompt clinical decision support at the initial action point, informing quality as it happens. This will effectively move improvement away from reviewing measures and allow immediate action to close treatment gaps. Just-in-time information will equalize the partnership between clinicians and patients, empowering patients to knowledgeably participate in care decisions. Technology will connect patients and caregivers to social networks and community services that are equipped to address socioeconomic factors that impact health, strengthening the role that patients have in managing their own health. This continual learning, self-improving environment will change the face of quality measurement and improvement. (Refer to the family medicine Vision for a Principled Redesign of Health Information Technology (doi.org) for a more detailed discussion of how IT will need to evolve to support health and health care.26)

Technological capacity can already achieve much of this future state, but the high cost limits widescale adoption, especially by independent physicians. Benefits of investing in technology must outweigh the costs for a business environment, such as a physician office, in which financial viability can be threatened by drastic shifts in payment policies and practice costs. The disappointing experience with health IT to date and a lack of trust in "black box" algorithms have made it difficult for physicians to risk investment based on promises of improved efficiency, better care, and lower costs. Physicians have been expected to fill current technology gaps by expending their own time, effort, and resources for quality measurement and reporting, with little, if any, return on investment.
Affordable, advanced technology will alleviate administrative burden, siloed data, incomplete and non-representative data, and lack of timely, actionable feedback. Data extracted from claims, EHRs, surveys, labs, pharmacies, public health data, health assessments, administrative data, and other sources will allow computation of measures for virtually any aspect and segment of care. Data will increasingly be obtained directly from patients through various types of user-friendly technology that provide a rich source of outcomes data. The redesign of health IT will enable insights into care that are not yet possible with today’s information systems.

References:


(December 2018 BOD Executive Committee)
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 subspecialists 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 specialities 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 conditions.
illnesses. Services may be fragmented and duplicated by visits to multiple specialists, and preventive services may not be provided adequately.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{22} Significant delays in care have resulted with some patients waiting more than a year for a simple physical examination.\textsuperscript{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.\textsuperscript{24} In 2008, a study in JAMA revealed that only 2 percent of medical students planned to pursue general internal medicine careers.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{29} Subsequent analysis and the more-rapid-than-expected decline in the production of general internists 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.\textsuperscript{30}

28. A determined number of training positions in U.S. health professions education outside of residency pathways to certification should be available annually for exchange visitors whose costs are paid by their home countries and who return to practice in their home countries upon graduation.

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.\textsuperscript{18,32}

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.\textsuperscript{33}

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.9 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.34

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.35 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.26

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).18 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 261,000.36 Since family physicians currently make up about 38% of the primary care workforce37, 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 2025.38

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.39
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.40-42

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.43

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.43

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.2

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 medicine44

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.45

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.46 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.47 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.30 CHCs should be increasingly utilized as teaching and training sites for physicians and funded to do so.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).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.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.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.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.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.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.52

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

References


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