2023 STFM Annual Spring Conference - Call for Presentations: "Best Submissions" Examples

The following examples represent "the best" submissions as reviewed by the STFM Program Committee. STFM has received permission from the authors/presenters of these submissions to share their good work with you. Please feel free to use these examples as reference for developing your "best" conference submission.

Submission examples are included for the following categories:

- Pre-conference Workshop
- Workshop
- Seminar
- Panel Discussion
- Lecture-Discussion
- Completed Project
- Complete Project Poster
- Developing Project Poster
- Scholarly Topic Roundtable Discussion

PRE-CONFERENCE WORKSHOP

Submission Title:
Health Systems Finances: How the Money Flows and How to Make Business-Based Appeals That Resonate with Health System Leaders

Submission Abstract:
Seventy percent of physicians are now employed by hospitals or corporations. Health care systems based on primary care have better quality of care, better population health, greater equity, and lower cost. There is a national trend toward maximizing clinical productivity of faculty, which reduces the amount of time available teach and to meet administrative responsibilities and accreditation requirements. This may reduce the ability to train needed new family physicians. It is critical that family medicine educators understand the drivers of health system decisions in order to effectively partner with health system leaders to advance excellence in family medicine education and practice. This interactive workshop will provide participants an inside look at how health systems financing, structure, and culture impacts decisions made at the health system level that impact primary care models, family medicine scope of practice, and investment in family medicine education. A variety of didactic and hands-on teaching strategies will deepen participants' knowledge of business and cultural factors that drive health system decisions and prepare them to lead strategic conversations to advance family medicine at their own institutions.

Submission Proposal Questions

This session length is (select one): 4 hours (half day) OR 8 hours (full day)
Full day (8 hours)

Please specify maximum number of attendees
30

Impact - How might your session impact other programs or institutions?
Based on STFM's strategic plan, the Board has approved an initiative to position academic family medicine in health systems so that FM faculty have sufficient time and resources to meet academic requirements, preserve comprehensive practice for family physicians and faculty, improve faculty and learner well-being, and transform teaching sites into clinical and teaching models of excellence. The initiative and this workshop affect a wide spectrum of faculty at residency programs and medical schools across the country. Workshop leaders will train FM faculty and residents to understand the business of medicine in order to work effectively within their health systems. The session will provide an intensive opportunity to enhance knowledge and skills about health systems finance in order to empower faculty to advocate and negotiate for sustainable clinical and teaching models of excellence. Didactic sessions will alter with active, case-based learning with participants developing business-based case for needs at their individual institutions.

Have you presented similar content at an STFM Annual Conference within the past 3 years?
No

If yes, please summarize what have you added or changed since your last presentation.
N/A

Learning Objectives:
First Objective: Demonstrate an understanding of key elements of health system finances and structures that impact decisions about primary care and family medicine.
Second Objective: Discuss the impact of financial and quality data on health system finances.
Third Objective: Advocate within their health systems – using business-based arguments -- for family medicine transformation and/or support.

Session teaching plan - provide detailed description of your teaching strategy for this session including time allocation and plan for audience engagement.
Health System Structure and Finance 101 (4 hours)
Overview of health systems structure and finance focusing on the realities of current financing impact leadership perception and decisions about primary care and family medicine: Decision-making structure; The basics of health systems finance: revenue sources and funding allocation; How health systems thinking impacts academic family medicine; How to create a business case for what you need. Didactics will inform unfolding interactive case studies. Small groups will engage real-life cases that illustrate why leaders may make choices that seem counter-productive from a FM lens. Participants will apply learning to develop strategies to create a business case for family medicine investment.
Developing a Business Case for Change at Home (4 hours)
Small groups will work to define an opportunity for a "win-win" situation at their home institutions (30 minutes). They will develop a business case that meets their need and offers health system ROI, with coaching from Workshop Faculty (2 ½ hours). Teams will deliver a 5 minute "pitch". Feedback by peers and faculty (from the lens of health system leaders) will provide insights to refine their business cases for FM investment.

Assessment Information:
Following are the SMART objectives for the STFM initiative and how success is being measured. Evaluation of these metrics will not be presented at the session, as this is a how-to session, as opposed to presentation of results of a project.
• Increase in the percentage of family medicine faculty who say their health system doesn't restrict their scope of practice.
• By December 2023, 300 STFM members will have participated in in-person or online training on the business of medicine.
• 85% of participants who participate in in-person or online training on the business of medicine will be satisfied
• By December 2023, there will be at least 8 published papers/blogposts/editorials/articles that align with the tactics and action items in the plan.

The lead presenters for this abstract vetted the session concept and description with the CFO and Dean listed as co-presenters, as well as with STFM staff. Drafts of the abstract were sent to Association of Departments of Family Medicine staff and to the Association of Family Medicine Administration listserv as part of the speaker recruitment process.

References: Cite key references that support the session content.

1. Physicians Advocacy Institute. COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2020. June 2021.
2. Lin K. Family Physicians are Natural Health System Leaders. American Family Physician Community Blog. May 19, 2014. http://afpjournal.blogspot.com/2014/05/family-physicians-are-natural-health.html
3. Griesbach S, Theobald M, Kolman K, et al. Joint Guidelines for Protected Nonclinical Time for Faculty in Family Medicine Residency Programs. Fam Med. 2021;53(6):443-452. https://doi.org/10.22454/FamMed.2021.506206.
4. Malhotra D and Malhotra M. Negotiation strategies for doctors – and hospital. Harvard Business Review, https://hbr.org/2013/10/negotiation-strategies-for-doctors-and-hospitals, accessed September 3, 2021.

Is this proposal an official submission on behalf of one of the following groups: STFM Board, STFM Collaboratives, STFM Special Project Teams, STFM Committees, and STFM Fellowships?
STFM Board of Directors

If your workshop will be sponsored by an outside (non-STFM) group, organization, or other funder, please enter the sponsor information here (including name and contact information).
N/A

Keyword One:
Healthcare Services, Delivery, and Financing

Keyword Two:
Economic or Policy Analysis

WORKSHOP

Submission Title:
Dealing With Patients Whose Behavior Is Racist: Creating a Training Module for a Family Medicine Residency

Submission Abstract:
We developed a standardized approach for dealing with racist patient interactions based on a 2016 NEJM article. The protocol ensures that the team (1) processes the incident in order to support team members, (2) emphasizes their unified position of intolerance of racist behavior, and (3) plans an intervention. We will discuss patients' racist behaviors that prompted this protocol and encourage participants to share their approaches. We will present our standardized approach; the resources and tools we used; and the vignettes we developed to train faculty, residents, and staff to use the protocol in inpatient and outpatient settings. Evaluation data and efforts to promote institutional policies and accountability will be shared.

Submission Proposal Questions:

Impact - How might your session impact other programs or institutions?
A 2011 study by Crutcher showed that of 377 FM residents surveyed, 35% reported experiencing intimidation, harassment or discrimination by patients based on race, gender or culture during their residency. Racist behavior by patients, patient requests for reassignment or refusal of care based on the physician or care team member's race or ethnicity are common occurrences. As the NEJM article states, "For many minority health care workers, expressions of patients' racial preferences are painful and degrading indignities, which cumulatively contribute to moral distress and burnout." It is critically important for medical centers and residency programs to create safe, supportive and respectful work environments for all members of the care team. Responding to racist patient behavior appropriately is challenging and requires adequate training and preparation for faculty, residents and staff. This workshop, where participants can practice through role play, will help FM programs begin the process of developing a standardized approach to address racist patient interactions in order to support care team members, especially residents, nurses and staff, and prepare teams to challenge patient behaviors and disrupt the tolerance of racism.

Have you presented similar content at an STFM Annual Conference within the past 3 years?
Yes

If yes, please summarize what have you added or changed since your last presentation.
The seminar on this topic in 2019 went extremely well but the room was packed, and many people could not get in. We needed more time for discussion and did not get to fully present our content because there was so much important dialogue on the topic. Most importantly, we only got to present an inpatient scenario. An outpatient scenario is crucial to present because these situations are very common and often not addressed at all. With the workshop format, we will have time to present the outpatient scenario in addition to the inpatient one. We also have more experience to share using our standardized approach and more evaluation data to present. This topic is very relevant for all faculty and residents and we want to reach all those who are interested. We will also report on our efforts to influence policies and accountability at our institution.

Learning Objectives:
First Objective: Discuss the experience of recognizing racist patient behaviors and addressing or not addressing racist behavior with a team approach.
Second Objective: Apply a protocol for dealing with patients' racist behavior.
Third Objective: Analyze the potential effect of a standardized approach and educational tool in helping care teams respond to racist patient interactions.

Session teaching plan - provide detailed description of your teaching strategy for this session including time allocation and plan for audience engagement.
5 min Introduce presenters, objectives, plan, ground rules-5 min Story of the incident that prompted this work-5 min Pair-and-share: Participant experiences-5 min Team process/Define terminology/Present evidence Review team process necessary to address racism, relevant terminology to create shared language around anti-racism and evidence on the topic-10 min Describe the process of protocol development and training, share protocol Discuss the process of developing the protocol. Present resources and experiential tools, including vignettes that we developed for training. Encourage participants to share their approaches to racist patient behavior-15 min Small groups role-play inpatient scenario. Practice using the standardized protocol, debrief in the small group-10 min Large group – report back-15 min Small groups role-play outpatient scenario, debrief in the small group-10 min Large group – report back-10 min Questions, reflections, conclusions Share how a protocol could be developed in the participants' departments and serve as a prototype for an institutional policy. Discuss how it could also be a catalyst for a process of documenting incidents at the institutional level and then assessing responses and outcomes of the process.

Assessment Information:
1) We have assessed the effectiveness of this presentation with quantitative and qualitative participant feedback provided at the end of each workshop we have led locally, regionally, and nationally. The evaluations have rated the session as almost universally outstanding. Many have expressed the wish for more time or additional workshops to continue the discussion and work on strategies for these situations. We are working to develop a reporting system within our department to assess use of the protocol by teams and the effectiveness of the workshop for training teams to utilize the protocol. We plan to use an email survey 4-6 months after our workshop at the STFM conference to assess the impact and effectiveness of the workshop beyond our program and whether participants have adapted or adopted use of our protocol in their programs.
2) We will present assessment data and participant feedback from workshops held locally at our program and workshops held at two national and one regional meeting.

References: Cite key references that support the session content.
Paul-Emile K., Smith A., Lo B., Fernandez A. Dealing with Racist Patients. N Engl J Med. 2016; 374:708-711.
Paul-Emile K, Critchfield JM, Wheeler M, de Bourmont S, Fernandez A. Addressing Patient Bias Toward Health Care Workers: Recommendations for Medical Centers. Ann Intern Med. 2020;173:468-473.
Olayiwola JN. Racism in Medicine: Shifting the Power. Ann Fam Med. 2016;14: 267–269.
Jain SH. The racist patient. Ann Intern Med 2013;158:632-632.
Whitgob EE, Blankenburg RL, Bogetz AL. The Discriminatory Patient and Family: Strategies to Address Discrimination Towards Trainees. Acad Med. 2016;91:S64-S69.
Crutcher R., Szafran O., Woloschuk W., Chatur F., Hansen, C. Family medicine graduates' perceptions of intimidation, harassment, and discrimination during residency training. BMC Medical Education. 2011;11:88.
Youmans QR. The N-Word. Ann Intern Med. 2019;171:380-1.
Pulsevoices.org
Deborah Pierce. Incidental Finding. April 21, 2017.
Jean Howell. Wounded Messenger. February 13, 2009.
Sara H. Rahman. An American Story. February 17, 2017.
Cynthia X. He. The Masked Asian Psychiatrist. July 14, 2020

Is this proposal an official submission on behalf of one of the following groups: STFM Board, STFM Collaboratives, STFM Special Project Teams, STFM Committees, and STFM Fellowships?
NO

Keyword One:
Anti-Racism

Keyword Two:
Health Policy and Advocacy

SEMINAR

Submission Title:
Trans Care is Primary Care: Training Residents in Transgender Health

Submission Abstract:
Transgender individuals report extreme discrimination by health care providers, the majority of whom they perceive as having insufficient knowledge. This interactive presentation will be led by faculty who train residents in transgender health in two different settings, and it will emphasize the assessment of local educational and community needs. Resources to advance residency training in providing basic and comprehensive transgender medical care will be explored. Several models of training residents will be presented with an emphasis on utilizing national resources to develop curricula with academic and community partnerships that engage residents, improve access to care, and reduce health disparities for this vulnerable population.

Submission Proposal Questions:

Impact - How might your session impact other programs or institutions?
The 2015 Transgender Survey describes transgender health disparities and discrimination by healthcare providers, whom transgender respondents perceive as having insufficient transgender specific knowledge (1). Unfortunately, training in transgender health care is limited (2,3). Due to stigmatization, insufficient transgender medical education(3,4), limited access to gender affirming care (3-5), and lack of evidence-based transgender care recommendations, substantial opportunity exists for improving care for this vulnerable and marginalized population. Primary care physicians demonstrate willingness(6) and great potential to provide holistic care to transgender individuals but lack experience and training.
Using an interactive style that allows session participants to analyze the needs, strengths, and opportunities of their current transgender health curricula, attendees will identify a variety of approaches to improving transgender health education. Emphasis will be on networking, resident engagement, building academic and community partnerships, improving access to care, and reducing health disparities. Session attendees will leave with individual goals for advancing transgender health education at their own institutions.

Have you presented similar content at an STFM Annual Conference within the past 3 years?
No

If yes, please summarize what have you added or changed since your last presentation.
n/a

Learning Objectives:
First Objective: Compare innovative models for training family residents in transgender health care.
Second Objective: Identify resources for curricular development to improve transgender access to care.
Third Objective: Create a preliminary plan to create or improve transgender health training for residents.

Session teaching plan - provide detailed description of your teaching strategy for this session including time allocation and plan for audience engagement.
Introduction (0-10 min)
-Brief intro of participants
-Background on national transgender health disparities
-Role of Family Physicians and opportunities (Resident Led)
Breakout (10-15 min)
-Groups of 2-3 analyze their current transgender health education needs and look at strengths and opportunities using an assessment tool
Comparison of Trans Training Models (15-40 min)
-Presenters compare and contrast various models of residency transgender health training
-1 resident from each program gives a resident perspective
-Discuss the practical usability of local and national resources for development of transgender health curricula

-Describe ways in which partnerships with local communities can enhance both access and education (Resident led)
Breakout (40-45 min) - 5 min
-Participants set transgender health educational improvement goals and identify resources that allow them to reach goals
Wrap-Up and Discussion/Q&A (45-55 min) - 10 min
Additional materials: Audio/video comments from patients on their experience seeing residents in our practices that will run during set up and after the session; this video would also be available to attendees after the session.

Assessment Information:

1) UK Residents are assessed annually for transgender knowledge and attitudes beginning in 2020
   UK Transtrack residents since 2017: 8 (6 graduates, 2 active)
   Assessment of graduates (Transtrack and non-track) providing transgender care and feedback on the program in progress
   23 residents in the past 5 years at Penn State Hershey Residency, which is an 8-8-8 program, have elected to participate in the LGBTQ elective.
   1 resident at Penn State Hershey has elected to participate in the Marginalized Populations Area of Concentration, which was started in 2021, with a focus on LGBTQ health.
   7 graduates of Penn State Hershey Residency in the past 5 years are known to be providing transgender health care services.
2) Both Dr. Sell and Dr. Fallin-Bennett have presented in similar formats (e.g. participatory analysis and planning through hearing examples and Q&A) at regional and national conferences in the past with positive evaluations and helpful networking.

References: Cite key references that support the session content.

1. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi M. The Report of the 2015 U.S. Transgender Survey. Washington, DC; 2016. doi:10.1038/064604a0.
2. Obedin-Maliver J, Goldsmith ES, Stewart L, et al. Lesbian, gay, bisexual, and transgender–related content in undergraduate medical education. JAMA J Am Med Assoc. 2011;306(9):971–977.
3. Korpaisarn S, Shafer JD. Gaps in transgender medical education among healthcare providers: A major barrier to care for transgender persons. Review Med Endo Disorders. 2018.19: 271–275
4. Johnston CD, Shearer LS. Internal Medicine Resident Attitudes, Prior Education, Comfort, and Knowledge Regarding Delivering Comprehensive Primary Care to Transgender Patients. Transgender Heal. 2017;2(1):91-95. doi:10.1089/trgh.2017.0007.
5. Dickey LM. Toward developing clinical competence: Improving health care of gender diverse people. Am J Public Health. 2017;107(2):222-223. doi:10.2105/AJPH.2016.303581.
6. Shires DA, Stroumsa D, Jaffee KD, Woodford MR. Primary Care Clinicians' Willingness to Care for Transgender Patients. Ann Fam Med. 2018;16(6):555-558.

Is this proposal an official submission on behalf of one of the following groups: STFM Board, STFM Collaboratives, STFM Special Project Teams, STFM Committees, and STFM Fellowships?
NO

Keyword One:
LGBTQ+ Health

Keyword Two:
Graduate Medical Education and Training

PANEL DISCUSSION

Submission Title:
Leaders in Advocacy: Women Faculty at the Forefront

Submission Abstract:
In this session, four women faculty will answer questions about their experiences being seasoned advocates and helping others start advocating. The session will be informative for both those new to and versed in advocacy. You will hear from women working in local, regional, and national types of advocacy. Speakers will discuss how they advocate for a wide variety of sociopolitical issues, such as reproductive justice, maternal employee rights, and leadership opportunities for underrepresented groups. In addition, they will discuss how they started advocating and how they mentor and train medical students and residents in advocacy skills. Join us to explore how you can start being an advocate or teaching others to follow in your path.

Submission Proposal Questions:

Impact - How might your session impact other programs or institutions?
Family physicians have a unique perspective on patients' health given our holistic and community-oriented approach. Health outcomes are affected by clinical care only 16% of the time whereas socioeconomic factors, health behaviors and physical environment have a stronger impact. Family physicians are crucial in advocating for change in these other areas in order to most effectively improve our patients' health. As family medicine educators, it is imperative that we role model and explicitly teach our residents and students how to be effective advocates. In fact, the new Milestones 2.0 include more specific verbiage about advocacy being part of a residents' professional responsibility. Currently (and historically), few residency programs and medical schools include formal advocacy training thus many practicing family physicians do not have the knowledge or skills themselves to be able to teach advocacy. By hearing from a variety of presenters from different institutions, participants will learn new approaches that they can bring to their own workplace.

Summary of expertise of panelists including supporting evidence
Jocelyn Young, DO, MSc: Residency faculty in NY; directed Political Advocacy Residency Track; local, state and national advocacy with Medical Society of New York, New York AFP, and AMA; mentors colleagues and trainees in organized medicine
Jennifer Hartmark-Hill, MD: Medical school faculty; President-Elect of Arizona Medical Association; Core curriculum on advocacy; founding co-director for an "Advocacy & Health Policy Leadership" elective; faculty advisor for AMSA Chapter and for grassroots student legislative interest group
Aisha Wagner, MD: faculty at FQHC in LA; Planned Parenthood; advocacy focuses on Reproductive Justice presentations and conversations, creating supportive spaces for people and providers of color, working to combat racism in medical institutions and organizations, and writing and media; medical director of TEACH (a Bay Area organization focused on training residents in early abortion through a Reproductive Justice lense)
Andrea Anderson, MD, FAAFP: Associate Chief of FM at George Washington School of Med; co-directs Health Policy Scholarly Concentration; Chair of the D.C. Board of Medicine; Serves on ABFM BOD and FSMB BOD; 2019 STFM Advocate Award winner; featured by CMS, DHHS, NPR, C-Span, NBCNews, CBN

Learning Objectives:
First Objective: Describe at least three forms of advocacy in family medicine.
Second Objective: Describe methods for teaching advocacy to residents.
Third Objective: Identify one specific advocacy activity that they will pursue.

Have you presented similar content at an STFM Annual Conference within the past 3 years?
No

Session teaching plan - provide detailed description of your teaching strategy for this session including time allocation and plan for audience engagement.
0-5 minutes: Moderator will introduce each panelist and explain the goals of the panel discussion
5-10 minutes: Audience will complete online poll to give panelists a sense of who is in the audience (FM education role; current level of involvement in advocacy; propose 1 question to the panel)
10 - 40 minutes: Moderator will ask the following questions and will allow each panelist to respond (2 mins each panelist)
- How did you get started in advocacy?
- Where have you found mentors to guide your own path in being an advocate?
- Describe your current advocacy activities
- How do you teach advocacy skills to others?
40 - 55 minutes: Moderator will ask 1-2 questions from the audience poll responses
55 - 60 minutes: Evaluation of session

References: Cite key references that support the session content.
Andrews J, Jones C, Tetrault J, Coontz K. Advocacy Training for Residents: Insights From Tulane's Internal Medicine Residency Program. Acad Med. 2019;94(2):204-207.
Basu G, Pels RJ, Stark RL, Jain P, Bor DH, McCormick D. Training Internal Medicine Residents in Social Medicine and Research-Based Health Advocacy: A Novel, In-Depth Curriculum. Acad Med. 2017;92(4):515-520.
Boroumand S, Stein MJ, Jay M, Shen JW, Hirsh M, Dharamsi S. Addressing the health advocate role in medical education. BMC Med Educ. 2020;20(1):28. Published 2020 Jan 30.
Fried JE, Shipman SA, Sessums LL. Advocacy: Achieving Physician Competency. J Gen Intern Med. 2019;34(11):2297-2298.
Hood CM, Gennuso KP, Swain GR, Catlin BB. County Health Rankings: Relationships Between Determinant Factors and Health Outcomes. Am J Prev Med. 2016;50(2):129-135.
Howell BA, Kristal RB, Whitmire LR, Gentry M, Rabin TL, Rosenbaum J. A Systematic Review of Advocacy Curricula in Graduate Medical Education. J Gen Intern Med. 2019;34(11):2592-2601.
McDonald M, Lavelle C, Wen M, Sherbino J, Hulme J. The state of health advocacy training in postgraduate medical education: a scoping review. Med Educ. 2019;53(12):1209-1220.

Is this proposal an official submission on behalf of one of the following groups: STFM Board, STFM Collaboratives, STFM Special Project Teams, STFM Committees, and STFM Fellowships?
STFM Collaborative: Women in Family Medicine

Keyword One:
Women in Family Medicine

Keyword Two:
Health Policy and Advocacy

LECTURE-DISCUSSION

Submission Title:
Standardized Interviews to Increase Underrepresented in Medicine Matched Applicants in anUrban Family Medicine Residency

Submission Abstract:
Racial and cultural concordance between patients and providers leads to better health outcomes and patient satisfaction. The Penn Family Medicine Residency Program in Philadelphia, Pennsylvania serves a population comprised of 78% of patients who identify as non-white, non-Hispanic and 66% who identify as underrepresented minorities. In 2018, the University of Pennsylvania Family Medicine Residency Program identified a need to increase the proportion of underrepresented in medicine family medicine residents recruited and admitted to the program. Recognizing the benefits of increased diversity, the Underrepresented in Medicine Recruitment Committee conducted a quality improvement project with the aim of increasing racial and cultural concordance between our patients and their providers. The first intervention consisted of the addition of a health equity question to add quantitative data to each applicant interview. In 2020, the recruitment committee created a holistic review rubric, with standardized application review criteria and scoring by which all residency applicants were assessed. These interventions resulted in a statistically significant increase in the percentage of UIM candidates interviewed and ranked. In the 2021-2022 application cycle, the committee implemented an interview rubric, with standardized questions and a quantitative assessment by which all interviewees were assessed to minimize bias.

Submission Proposal Questions:

How might your session impact other programs or institutions?
The AAMC definies Underrepresented in Medicine (UIM) to include “those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population.” These include individuals who identify as African American/Black, Hispanic, American Indian and Pacific Islander. The representation of UIM in the physician workforce does not reflect population trends with only 8% of U.S. physicians identifying as UIM in 2013. Recognizing that there are many factors influencing the percentage of UIM, including but not limited to, the relative representation of UIM in medical school matriculation compared to the general population, and their subsequent graduation and specialty choice, many medical schools and residencies have examined their admission and interview criteria to minimize bias in selecting candidates. At the Penn Family Medicine Residency, we used a Quality Improvement framework to guide changes to the residency recruitment program to increase the percentage of matched UIM candidates, which other programs can use as a foundation to adapt these approaches to their own programs.

Have you presented similar content at an STFM Annual Conference within the past 3 years?
Yes

If yes, please summarize what have you added or changed since your last presentation.
Prior content that was presented focused on the Health Equity Interview Question and the Holistic Review. This current presentation focuses on the next phase of the root cause analysis intervention of Standardized Interview Questions and Rubric applied to the 2021-2022 application. The new Standardized Interview Process focuses on minimizing the significant bias that occurs during interviews, including virtual interviews.

Learning Objectives:
First Objective: Apply the A3 Quality Improvement framework to a graduate medical education recruitment challenge.

Second Objective: Evaluate the standardized interview process created by the UIM Recruitment Committee.

Third Objective: Create and implement new strategies within participants’ programs for UIM recruitment.

Session teaching plan - provide detailed description of your teaching strategy for this session including time allocation and plan for audience engagement.
2 min: Introductions
1 min (cumulative time 3): Outline and Objectives
2 min (cumulative time 5): Background
10 min (cumulative time 15): New Intervention: Standardized Interview Process
5 min (cumulative time 20): Results and Conclusions
10 min (cumulative time 30): Discussion and Questions
Total: 30 min

Assessment Information:
There was a statistically significant increase in the percentage of UIM interviewed, percentage of UIM ranked, and percentage of UIM matched in the program from 2016-2021, $p<0.05$. During the 2020-2021 application cycle, 67% of the intern class who matched to the program were UIM residents. Aside from the results of the Match, there were additional benefits that were observed through the changes made to the recruitment and evaluation process. It allowed for an increase in transparency on how applicants were selected, which ultimately improves the selection process for all applicants. This project also created a forum to have discussions around race and health equity within the residency. Based on these efforts, in 2021, our Department of Family Medicine and Community Health was awarded the Champion in Inclusion, Diversity, and Equity Award of Excellence at University of Pennsylvania. Ultimately, we aspire to maintain a diverse group of trainees and faculty to meet the needs of our patients, and hope to share this with other programs to improve their application process.

References: Cite key references that support the session content.
Walker, K. O., Moreno, G., & Grumbach, K. (2012). The Association Among Specialty, Race, Ethnicity, and Practice Location Among California Physicians in Diverse Specialties. Journal of the National Medical Association, 104(0), 46–52.
Cooper-Patrick L, Gallo JJ, Gonzales JJ, Vu HT, Powe NR, Nelson C, Ford DE (1999). Race, gender, and partnership in the patient-physician relationship. JAMA, 282(6):583-9.
Edmond, M., Deschenes, J., Eckler, M., & Wenzel, R. (2001). “Racial Bias in using USMLE Step 1 Scores to Grant Internal Medicine Residency Interviews.” Academic Medicine, 76(12), 1253-1256.
Swedish Family Medicine Residency Cherry Hill and Boston Medical Center (2018, May). Residency Diversity 2.0. Lecture presented at the annual meeting of Society of Teachers of Family Medicine, Washington, DC.
Wusu M, Tepperberg S, Weinberg J, Saper R. Matching Our Mission: A Strategic Plan to Create a Diverse Family Medicine Residency. Fam Med. 2019; 51 (1): 31-36.2019.
AAMC: Roadmap to Diversity and Educational Excellence: Key Legal and Educational Policy Foundations for Medical Schools, Second Edition. 2014.
Lett LA, Murdock HM, Orji WuAysola J, Sebro R. Trends in Racial/Ethnic Representation Among US Medical Students. JAMA Netw Open. 201

Is this proposal an official submission on behalf of one of the following groups: STFM Board, STFM Collaboratives, STFM Special Project Teams, STFM Committees, and STFM Fellowships?
NO

Keyword One:
Anti-Racism

Keyword Two:
Graduate Medical Education and Training

COMPLETED PROJECT

Submission Title:
"Precepting Takes Too Long"—A QI Project on Efficiency & Quality of Residency Precepting

Submission Abstract:
Residents identified the top three problems with outpatient precepting as (1) "precepting takes too long," (2) "lack of good learning environment," and (3) "preceptor not available when needed."
Based upon suspected key drivers, office precepting was subjected to four month-long, experimental innovations: (1) batched-case precepting, (2) extra preceptor, (3) 1-Minute Preceptor faculty development for the preceptors, and (4) a focusing tool for the residents. Custom kiosk-based software measured the primary outcomes of precepting wait time, talk time, and total time. Surveys assessed the secondary outcomes of quality and satisfaction.
We evaluated 5393 precepted patient care events over 5 months. Batched-case precepting reduced talk time and total time from 5:02 (min:sec) and 6:20 to 4:14 and 5:18 respectively (P = .004). The resident focusing tool also improved talk time and total time to 4:19 and 5:37 (P = .01). Extra preceptor and 1-Minute Preceptor interventions were ineffective. Time spent waiting for an available preceptor, an average of 33 seconds, never improved. Qualitative feedback was favorable for batched-case precepting, 1-Minute Preceptor, and the resident focusing tool. Post-project survey reflected improvement in resident satisfaction with precepting.
Resident satisfaction with speed and quality of office-care precepting can be measured and improved. We found innovations that work in our setting, and this project can serve as a model for others addressing similar concerns.

Submission Proposal Questions:

Impact - How might your session impact other programs or institutions?
Education and supervision of resident outpatient care occurs in every residency. Residents and their faculty want each patient care episode to be educational. Yet they also want each precepting encounter to be brief enough not to slow down busy residents from their busy schedules of waiting patients. Many struggle with how to make precepting encounters efficient yet effective.
This session will show other residency educators that the duration and quality of precepting can be measured, evaluated, and innovated with conventional QI techniques. It will also share our particular experiments and findings, which may be applicable elsewhere.

Learning Objectives:
First Objective: Analyze the components of the overall time it takes for residents to precept their cases.
Second Objective: Recognize the technical challenges to measuring the duration of precepting and consider the feasibility of our solution in their setting.
Third Objective: Know which of our experimental interventions were effective and consider which might work in their setting.

Describe the outcome of your implementation or innovation (metrics, goals, evaluation methods).
Note: N/A" is not an acceptable response.
Two innovations (batched case precepting, resident focusing tool) shortened precepting talk time and total time in statistically significant fashion. No intervention reduced precepting waiting time. Batched case precepting and the resident focus tool were most positively received in qualitative and quantitative feedback, 1-Minute Preceptor faculty development was more mildly positive, while use of an extra preceptor happened rarely and produced no quantitative or qualitative overall impact. The project as a whole improved the three largest issues of resident frustration, and produced a great deal of satisfaction that resident complaints were heard and prompted action. Based upon favorable results and feedback, our residency program adopted the innovations of batched case precepting and the resident focusing tool permanently.

References: Include references that support the session content.
Neher J, et. al., Five-Step "Microskills" Model Of Clinical Teaching, J Am Board Fam Pract 1992; 5:419-24.

Ferenchick G, et. al., Strategies for Efficient and Effective Teaching in the Ambulator Care Setting, Acad Med 1997; 72:277-280.

Is this proposal an official submission on behalf of one of the following groups: STFM Board, STFM Collaboratives, STFM Special Project Teams, STFM Committees, and STFM Fellowships?
NO

Keyword One:
Graduate Medical Education and Training

Keyword Two:
Teaching Skills

COMPLETED PROJECT POSTER

Submission Title:
Harmonizing Male and Female Human Papillomavirus Vaccination Rates in a Family Medicine Residency Practice QI Project

Submission Abstract:
In the 2020 centenary year for women's right to vote, our family health center pursued optimal and equal human papillomavirus (HPV) vaccinations. We aimed to harmonize HPV vaccinations between 11- to 26-year-old males and females.
We compared intervention-2020 to baseline-2019 HPV vaccination data. Our interventions were (1) patient-focused (leap-year HPV coloring contests, seasonal HPV posters, immediate sensory incentives [hitting a 22-inch gong], monthly $50 gift card lotteries) and (2) provider-led (presumptive recommendation, pharmacist outreach for any dose, physician vaccination review following emergency room visits).
For 2020, 663 patients 11- to 26-years-old (69.1% female, 67.9% African American) had at least one face-to-face visit. Comparing 2020-intervention to 2019-baseline data showed a stable female (F) initiation rate at 78.8% compared to 78.9% and an improved male (M) initiation rate at 81.0% compared to 70.8% (P = 0.01). Completion rates improved for both genders (F 68.6% vs 65.2%, M 64.9% vs 58.0%). Our 2020 age 13- to 17-year-old-male data compared favorably to 2020 NIS-Teen national data (initiation 91.8% vs 73.1%; completion 85.2% vs 56.0%).
For ages 11 through 26, female and male initiation (2.2 percentage points [PP] difference) and completed HPV vaccinations (3.7% PP difference) showed near parity. Harmonized ACIP recommendations and multiple strategies, including a patient vaccination coloring contest, improved overall completions and decreased the HPV vaccination gap.

Submission Proposal Questions:

Impact - How might your session impact other programs or institutions?
It is now recognized that the HPV cancer-reducing vaccination is important for protection against male predominant oropharyngeal cancer as well as cervical cancer. HPV vaccination rates have been suboptimal in the United States ever since the introduction of HPV vaccinations for females in 2006 and for males in 2011. Male HPV vaccination rates have always lagged behind. Updated Advisory Committee on Immunization Practices recommendations in 2019, with equal approval for HPV vaccinations for males and females ages 9-26 years, provided an opportunity to close the gap for male patients. Additionally, NIS-Teen HPV vaccination rates for early catch-up ages 13-17 year-olds are reported annually but published reporting is low for the full age range. We are presenting a multi-strategy quality improvement project that reports HPV vaccination initiation and completion (2- or 3-dose) for ages 11-26, males and females. Our patient-focused strategies, in particular, may be of interest to programs or public health departments that want to improve HPV vaccinations for all eligible males and females and to report on the full age spectrum.

Learning Objectives:
First Objective: Apply HPV vaccination strategies to both eligible males and females ages 11 through 26 years old.
Second Objective: Apply HPV vaccination strategies to close the male-female HPV vaccination gap.
Third Objective: Recruit patient interest in HPV vaccinations with patient-focused activities with immediate and intermediate rewards.

Describe the outcome of your implementation or innovation (metrics, goals, evaluation methods).
Note: N/A" is not an acceptable response.
Our goal was to take advantage of newly harmonized recommendations from the ACIP and to give HPV vaccinations to both males and females ages 9-26 years. We measured cumulative HPV vaccination initiation and completion for all patients ages 11-26 years (and age subsets 11-12, 13-17, and 18-26 years) with at least one health center in-person visit during calendar year 2020 and compared these rates to the baseline 2019 year. We offered a coloring contest with rewards to these same age subsets, both male and female. We do not have comparable and recently published national data for comparison to our results for this fuller HPV vaccination-eligible age range. However, 2015-2016 NHANES estimates for >1 dose of HPV

vaccine of 53.9% for females and 21.3% for males 19-26 years-old suggest that HPV vaccination rates in the late catch-up ages are low. Our 2020 18-26 year-old HPV vaccination initiation rates were overall 76.2% (female 76.8%, male 74.4%) and for 11-26 year-olds overall 79.5% (female 78.8%, male 81.0%).
Of note, though 2020 was a majority pandemic year, we continued outreach to eligible patients for HPV vaccination initiation and completion.

References: Cite key references that support the session content.
Elam-Evans LD, Yankey D, Singleton JA, et al. National, regional, state, and selected local area vaccination coverage among adolescents aged 13-17 years – United States, 2019. MMWR. 2020 August 21;69(33):1111-1116.
Ellington TD, Henley SJ, Senkomago V, et al. Trends in incidence of cancers of the oral cavity and pharynx – United States 2007-2016. MMWR. 2020 April 17;69(15):433-438.
Lewis RM, Markowitz LE, et al. Human papillomavirus vaccination coverage among females and males, National Health and Nutrition Examination Survey, United States, 2007 – 2016. Vaccine. 2018 May 03;36(19):2567-2573.
McGaffey A, Lombardo NP, Lamberton N, Klatt P, Siegel J, Middleton DB, Hughes K, Susick M, Lin CJ, Nowalk MP. A "Sense"-ational HPV Vaccination Quality Improvement Project in a Family Medicine Residency Practice. J Natl Med Assoc. 2019 Dec;111(6):588-599. doi: 10.1016/j.jnma.2019.06.004.
Pingali C, Yankey, D, Elam-Evans LD, et al. National, regional, state, and selected local area vaccination coverage among adolescents aged 13-17 years – United States 2020. MMWR. 2021 September 03;70(35):1183-1190.

Is this proposal an official submission on behalf of one of the following groups: STFM Board, STFM Collaboratives, STFM Special Project Teams, STFM Committees, and STFM Fellowships?
NO

Keyword One:
Preventive Medicine

Keyword Two:
Patient Engagement

DEVELOPING PROJECT POSTER

Submission Title:
Faculty Perceptions of a Streamlined, Clinical-Competency Committee Process

Submission Abstract:
Clinical competency committee (CCC) meetings are the cornerstone of resident assessment. We found our meetings were overly time consuming, subjective, and limited by lack of assessment data. Some faculty members perceived their role to be that of the objective assessor, while others felt they should serve as advocates.
We restructured our CCC process to better delineate mentoring and advising roles, streamline meetings, and create a shared mental model about faculty responsibilities and the decision-making process. We conducted structured interviews with all faculty members after 1 year of experience with these changes and used field notes to identify themes.
Faculty appreciated the efficiency of the new process, with meeting times decreased by half. Delineation of the mentor and advisor roles was viewed positively by faculty, and resident assessment was perceived as more objective. However, some areas remained challenging to assess. Some faculty members remained unclear regarding their expectations in the mentor role.
CCC changes were generally well received by faculty. Future directions in our institution include improving data capture on performance for certain milestones, assessing resident perceptions of both their performance assessment and mentoring relationships, and ensuring clear communication of expectations and roles. We would also be interested in replicating similar process adaptations at other institutions to see if benefits persist.

Submission Proposal Questions:

Impact - How might your session impact other programs or institutions?
Other institutions may also struggle with efficiency in their CCC process, and there is sparse evidence to guide improvement in this area.(1) Faculty in other institutions may face similar barriers to those noted within our program for CCC assessments: a lack of quality data to inform competency decisions(2) bias in decision making(3) or lack of shared mental models regarding the goals of the CCC(4,5).
Particularly in smaller community programs such as ours, mentoring and advising roles are often intertwined with performance assessments occurring within the CCC. Advising and mentoring functions are related but distinct, and other programs may also find value in more specifically delineating these roles to clarify both resident and faculty expectations in these relationships(6). Separating these roles may also allow focused faculty development in each.
Finally, while this is not yet studied in this developing project, our hope is that clear expectations surrounding faculty-resident advising versus mentoring relationships will improve the quality of both. We also hope that transparent CCC data collection and resident assessment can help identify and decrease bias in learner assessment(3-5,7).

Learning Objectives:
First Objective: Discuss barriers to efficient and equitable CCC assessments.
Second Objective: Distinguish faculty members' roles in advising versus mentoring, and how each role may relate to CCC assessments.
Third Objective: Describe a process to support efficient and structured resident assessment within the CCC.

Provide expected results if available:
Pre-implementation, CCC meetings took 40 hours to review 36 residents. On average, 12 faculty worked to make milestone determinations and complete necessary documentation for each resident’s biannual comprehensive assessment. With the new process, meetings take 20 hours or less, with 6 faculty responsible for the determinations. Post-implementation, the majority of faculty spent the same amount of time outside CCC meetings for mentoring tasks, but less for advising tasks, suggesting more time for mentorship. Assistant program directors took on more advising tasks, given their higher share of protected administrative time in that role.

Faculty perceived process changes, to be discussed in detail within the session, positively. Specific benefits they saw included more objective resident assessment, better quality of mentoring relationships, and improved transparency in decision-making, particularly concerning remediation decisions. Concerns about the new process centered on confusion about roles and expectations within the new system during the initial rollout. We plan to assess resident perceptions of the fairness and quality of their CCC evaluations and the quality of their mentoring relationships as the project progresses.

References: Cite key references that support the session content.

1.Nabors et al. Milestones: A Rapid Assessment Method for the Clinical Competency Committee. AMS. 2017 Feb13(1):201–9.
2. Ekpenyong A, Becker K. What resources do clinical competency committees (CCCs) require to do their work? A pilot study comparing CCCs across specialties. Med Teach. 2021 Jan;43(1):86-92
3.Dickey C, Thomas C, Feroze U, Nakshabandi F, Cannon B. Cognitive Demands and Bias: Challenges Facing Clinical Competency Committees. J Grad Med Educ. 2017 Apr;9(2):162–64.
4. Hauer, K, et al. “Ensuring Resident Competence: A Narrative Review of the Literature on Group Decision Making to Inform the Work of Clinical Competency Committees.” J Grad Med Educ 2016 May;8(2): 156–64.
5. Ekpenyong, A, Padmore J, Hauer, K. The Purpose, Structure, and Process of Clinical Competency Committees: Guidance for Members and Program Directors. J Grad Med Educ 2021 Apr;13(2): 45–50.
6. Woods SK, et al. Defining the roles of advisors and mentors in postgraduate medical education: faculty perceptions, roles, responsibilities, and resource needs. J Grad Med Educ. 2010 Jun;2(2):195-200.
7. Hauer, K, Edgar L, Hogan S, Kinnear B, Warm E. The Science of Effective Group Process: Lessons for Clinical Competency Committees. J Grad Med Educ 2021 Apr;13

Is this proposal an official submission on behalf of one of the following groups: STFM Board, STFM Collaboratives, STFM Special Project Teams, STFM Committees, and STFM Fellowships?
NO

Keyword One:
Mentoring

Keyword Two:
Graduate Medical Education and Training

SCHOLARLY TOPIC ROUNDTABLE DISCUSSION

Submission Title:
Teaching "How to Teach": Establishing and Enhancing a Longitudinal Resident as Teacher Program for Residents and Faculty

Submission Abstract:
Although the Accreditation Council for Graduate Medical Education (ACGME) requires training that enhances resident and faculty teaching skills, many programs struggle to effectively teach teaching skills (outside of faculty development opportunities available at professional conferences). This session will discuss the implementation of an optional, yet successful longitudinal resident as teacher program, which meets once monthly. The session will discuss topics included in the curriculum (22 topics), tips that have led to rapid expansion of the program (even during the COVID-19 pandemic), and how we have gotten a large variety of faculty from the College of Medicine, who are passionate about teaching, to enthusiastically volunteer to teach in the program. In this session, 5 years of experience will be shared so that you can implement a similar program or further expand a current program at your institution. Survey data has demonstrated high levels of satisfaction with these teaching sessions—the average score is 4.5/5—and the program has expanded by a magnitude of 10 over the past 5 years. Since the program was successful in teaching residents and fellows "how to teach," it was requested that it be offered to faculty as well.

Submission Proposal Questions:

Impact - How might your session impact other programs or institutions?
During the STFM Annual Conference in 2021, I presented about how to effectively implement a required Resident as Teacher Workshop (half-day workshop). In follow-up correspondence with participants, I discussed our optional monthly Longitudinal Resident as Teacher Program and it was expressed that this was a needed topic of interest. Thus, this session is designed to help other programs implement a Longitudinal Resident as Teacher Program at their own institutions. It will include pros/cons and potential pitfalls of various approaches and share resources to allow attendees to implement these approaches at their own programs/institutions, whether in entirety or pertinent portions. I heavily debated about whether to submit this in a Roundtable Discussion format vs. as a Lecture-Discussion and feel it can be equally well done in either format (I am open to both formats).

Learning Objectives:
First Objective: Implement (or enhance) a longitudinal resident as teacher program at their institution.
Second Objective: Discuss five attributes of a longitudinal resident as teacher program that increase optional participation by residents/fellows after hours.
Third Objective: Discuss two attributes of a longitudinal resident as teacher program that increase faculty's enthusiasm to teach in the program.

Please describe project results completed or in process at the time of submission (if none are available, indicate N/A):
1) Survey data demonstrates the effectiveness of the Longitudinal Resident as Teacher Program sessions – overall rated at 4.5/5 on a Likert scale of 5.
2) In addition, this optional, after-hours program has expanded by a magnitude of ten (within five years).

References: Cite key references that support the session content.
1) https://www.acgme.org/Specialties/Program-Requirements-and-FAQs-and-Applications/pfcatid/8/Family%20Medicine
Accessed September 12, 2021
2) Chokshi, BD, Schumacher HK, Reese K, Bhansali P, Kern JR, Simmens SJ, Blatt B, Greenberg LW. A "Resident-as-Teacher" Curriculum Using a Flipped Classroom Approach: Can a Model Designed for Efficiency Also Be Effective? Academic Medicine. April 2017;92(4):511–514.
3) Achkar, MA, Davies MK, Busha ME, Oh RC . Resident-As-Teacher in Family Medicine: A CERA Survey. Family Medicine. 2015;47(6):452-8.

4) Hill AG, Yu TC, Barrow M, Hattie J. A Systematic Review of Resident-as-teacher programmes. Medical Education. 2009;43:1129–1140.

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NO

Keyword One:
Graduate Medical Education and Training

Keyword Two:
Teaching Skills