

Council on Medical Practice

November 7, 2024

2:30 – 4:30 p.m.

Location: Waterway 8

Zoom connection information:

Meeting ID: 864 8416 8970

Passcode: 893037

<https://us02web.zoom.us/j/86484168970?pwd=Cyb2BfXBlvcgwbNXJdrpgaxjIGlI9G.1>

AGENDA

1. Call to order by Tina Philip, DO, chair (Puja Sehgal, MD, vice chair)
2. Introductions
3. Approval of report – April 12, 2024
4. Current business
 - a. Discuss upcoming legislative session.
 - b. Updates on recent council action
 - i. Update on resolution to the AAFP Congress of Delegates asking for further advocacy and member resources to address problems related to patient attribution.
 - ii. Update on council action to request that the TAFP CME Planning Committee develop CME focused on best practices to reduce administrative burden when using electronic health records.
 - iii. Update on council action asking the TAFP Board of Directors to engage AAFP regarding action related to the current CPT coding system.
 - c. Review TAFP Strategic Objective No. 1 and discuss ideas for future action. (See back-up material for the full description of strategic objective No. 1)
 - d. Discuss questions and potential guidelines for using artificial intelligence in practice. (implications for use in residency programs, and the potential HIPPA danger posed by AI smartphones when dictating notes for electronic medical records, and others as identified by council).
5. Other business
6. Recognition of outgoing chair and vice chair, and introduction of new chair and vice chair.
7. Adjourn

Jonathan Nelson and Heather Osborne are the staff liaisons for this council.

COUNCIL ON MEDICAL PRACTICE REPORT

Author: Jonathan Nelson

Meeting date: April 12, 2024

Meeting Location: Renaissance Austin Hotel, San Antonio Room

The following members attended the meeting in person: Tina Philip, Triwanna Fisher-Wikoff, David Vaughan, Oscar Garza, Puja Sehgal, Marian Allen, Richard Young, Nimat Alam, Jennifer Greenblatt, Serene Selli, Gabriela Zambrano Hill

The following members attended the meeting virtually: Vicki Bakhos Webb, Lara Gaines, Nicole Lopez, Elena Zamora, Jacob Coranado, Katia Jean Baptiste, Jennifer Liedtke

The following members attended as guests: Terrance Hines

This council is staffed by Heather Osborne and Jonathan Nelson

ACTION ITEMS

1. That the council form a task force to draft a resolution to the AAFP Congress of Delegates asking for further advocacy and member resources to address problems related to patient attribution.
2. That the council submit a request to the TAFP CME Planning Committee for the development of a CME presentation focused on best practices to reduce administrative burden when using electronic health records.
3. That the council draft a letter to the TAFP Board of Directors asking them to engage AAFP regarding progress and expected action the Academy will take now that AAFP has changed its policy on coding and payment, acknowledging that the current CPT coding system does not adequately reflect the breadth and depth of family medicine.

MINUTES

1. The meeting was called to order by Tina Philip, DO, chair at 2:35 p.m.
2. The council report from November 9, 2023, was approved.
3. The council received an update on AAFP and TAFP advocacy on payment for the new G2211 add-on code for complexity.
 - a. Members discussed a new pelvic exam code, 99459, that has been significant but is thought to be broadly unknown. Members suggested information on the code should be distributed to the membership.

- b. Members raised concerns that residents are often not paid for some add-on codes, like G2211.
- 4. The council discussed the problem of patient attribution, specifically that value-based care plans attribute patients to physicians, the physicians try but fail to ever contact the patients and thus never see them, then the physicians receive low quality scores for those patients.
 - a. The council decided to form a task force to draft a resolution to AAFP Congress of Delegates. Drs. Vaughan, Zamora, Young, and Greenblatt volunteered to serve on the task force.
 - b. The council plans to request assistance from the Academy's current delegates and alternate delegates to the COD, senior TAFP staff, and whoever those people suggest.
- 5. The council reviewed the practice management resources offered online by the Harris County Medical Society and the Ohio Academy of Family Physicians. Members directed staff to investigate these resources further and to make a plan to expand practice management resources offered on tafp.org.
- 6. The council revisited the idea of hosting a "hassle factor log" on tafp.org – an idea the council had previously considered. Due to the risk identified by staff and members, and the increased information and resources offered by AAFP to address administrative burden, the council decided to abandon this idea.
- 7. Members reviewed draft learning objectives for a potential TAFP CME presentation on reducing administrative burden associated with health information technology and electronic health records. Members approved the draft objectives and voted to submit them with a request for such CME from the TAFP CME Planning Committee.
- 8. The council discussed recent developments in the use of artificial intelligence in the delivery of care. The council noted that the Academy plans to offer CME on AI in family medicine at this year's Annual Session and Primary Care Summit, and the council intends to invite the speaker to present at the associated Member Assembly during the conference.
- 9. Dr. Richard Young stated that since AAFP changed its policy on coding and payment to acknowledge that the existing CPT coding system does not reflect the depth and breadth of family medicine, the Academy has not taken any action on the matter. He said the Academy should continue to advocate such action from AAFP. The council considered drafting a resolution to COD but decided to send a letter to the TAFP Board of Directors instead, asking the board to consider the matter.
 - a. Richard Young and Jonathan Nelson agreed to serve on the task force to draft the letter. They will present the draft to the full council for approval with the intention that the council will present the letter to the TAFP board before its next meeting, which we think will be in August.
- 10. The meeting was adjourned at 4:15 p.m.

RESOLUTION NO. 306 (Texas C)

Patient Attribution Improvement in Health Plans

Introduced by the Texas Chapter (Co-Sponsoring Chapter(s): Colorado)

WHEREAS, Patient attribution is the process whereby health plans assign a patient to a single physician or clinic responsible for managing the quality and cost of their care, and

WHEREAS, patient attribution is a fundamental aspect of achieving a fairer, value-driven primary care payment system, predicated on rewarding physicians for the quality rather than the volume of patient care they provide, and

WHEREAS, inaccurate patient attribution can lead to fragmented care, poor health outcomes, and increased health care costs due to delayed, unnecessary, and duplicative services including preventable hospital admissions, and

WHEREAS, current patient attribution methods employed by health plans often lack transparency, consistency, and reliability, resulting in frequent misattributions and confusion among patients and physicians, and

WHEREAS, improving patient attribution methodologies can enhance care coordination, promote preventive care, and facilitate the delivery of value-based care models, ultimately benefiting patients, physicians, and payers alike, and

WHEREAS, it is imperative to establish standardized guidelines and requirements for health plans to enhance patient attribution accuracy, transparency, and fairness, now, therefore, be it

RESOLVED, That the American Academy of Family Physicians advocate for standardized guidelines and requirements for health plans to improve the accuracy, transparency, timeliness, and fairness of patient attribution processes and methodologies that emphasize voluntary agreements between patients and physicians, and be it further

RESOLVED, That the American Academy of Family Physicians advocate for formal mechanisms to allow physicians to verify and correct attribution data as necessary, and be it further

RESOLVED, That the American Academy of Family Physicians provide resources for members to help them address patient attribution problems in their practices.

(Received 7/30/24)

Fiscal Note: \$24,000

Political Risk Assessment: Low

Background

The first resolved clause asks the AAFP to advocate for standardized guidelines and requirements for health plans to improve the accuracy, transparency, timeliness, and fairness of patient attribution processes and methodologies that emphasize voluntary agreements between

patients and physicians. The AAFP has two related policies. The first is the [Guiding Principles for Value-Based Payment](#), which states at a high level “Methodologies used to determine the patients for which physicians and care teams are held accountable must prioritize existing patient-physician relationships over less reliable claims or geographic methods while ensuring physicians and primary care teams have reliable, timely information about the patients for whom they are held accountable.” This policy, for which the AAFP already advocates with public and private health plans, is central to the first resolved clause’s call for reliable information, including for which patients a family physician is accountable in value-based arrangements.

The AAFP expanded this policy to optimize payment for primary care by developing a set of call-to-action briefs intended to translate the guiding principles into actionable steps key stakeholders can take to implement value-based payment models to sustainably support primary care teams. One of the six call-to-action briefs focuses on [Establishing Accountability in Value-based Payment Models for Primary Care \(Position Paper\)](#). Key recommendations from this brief relevant to this resolved clause include:

- Prioritize patient selection whenever identifying an individual’s ongoing source of primary care consistent with the HCP-LAN recommendation
- Include a patient-verification step when historical claims data are used for attribution to ensure the methodology has produced the correct result from the patient’s perspective
- Prioritize prospective and timely attribution where physicians are informed in advance of the performance year of the patients they are to be held accountable for and notified of changes regularly and in real-time

The second resolved clause asks the AAFP to advocate for formal mechanisms to allow physicians to verify and correct attribution data as necessary, and the third resolved clause asks the AAFP to provide resources for members to help them address patient attribution problems in their practices. The AAFP does not have current policy or resources on actions for family physicians to take to verify and/or reconcile attribution data as necessary.

Current Policy

[Establishing Accountability in Value-based Payment Models for Primary Care \(Position Paper\)](#)

[Guiding Principles for Value-Based Payment](#)

Strategic Initiatives Related to Key Strategies

Support the Family Physicians of Texas and Their Practices

1. Reduce administrative burdens imposed on physicians by public and private payers so physicians can spend more time caring for patients.

- ADVOCATE – Support federal and state legislation to reduce administrative burdens throughout the documentation, compliance, claims and billing processes.
- CONNECT – Create opportunities for family physicians to connect, network, share experiences, and learn best practices in addressing administrative burdens.
- EDUCATE – Conduct workshops and training sessions to educate physicians and staff on identifying and addressing practice efficiencies that reduce administrative burdens.

2. Promote innovative compensation models for family physicians and their care teams that recognize and reward the services they provide, while minimizing uncompensated administrative tasks.

- ADVOCATE – Increase the availability of and participation in value-based care and other alternative payment models, including subscription-based primary care.
- CONNECT – Strengthen and promote TAFP’s Partners in Health program that fosters partnerships with organizations helping family physicians succeed in value-based care.
- EDUCATE – Increase member communication and education on value-based care and other alternative payment models, including subscription-based primary care.

3. Champion a physician-led, team-based approach to patient care, enhancing efficiency and delivering comprehensive care.

- ADVOCATE – Support policy and payment models that recognize and incentivize team-based care to ensure that the contributions of all team members are recognized and valued, reinforcing the importance of every role within the care team.
- CONNECT – Partner with other health care professional organizations to create opportunities for family physicians and non-physician care team members to connect, share experiences, and learn about best practices in team-based care from each other.
- EDUCATE – Promote the effectiveness and cost-efficiency of physician-led, team-based care with policy makers and other stakeholders.

4. Position family physicians to succeed in the ever-changing health care marketplace.

- ADVOCATE – Ensure family physicians are appropriately compensated for all services provided within the current fee-for-service system and advocate for greater investment in primary care by public and private payers.
- CONNECT – Utilize TAFP’s various communication channels to profile innovative member practices that are delivering high-quality, cost-effective care.
- EDUCATE – Develop and disseminate case studies to policy makers and business leaders, illustrating the comprehensive and cost-effective care provided by family physicians.

TAFP Strategic Plan 2024: Year One Staff Report

October 31, 2024

To maintain accountability in meeting the objectives of the strategic plan we developed one year ago, staff tracked activities and projects by their related key initiatives. The exercise has proven highly valuable, revealing how much of our day-to-day work relates directly to the goals Academy leadership established. We also can see those areas we need to focus on in the next few years.

Completed

In progress

Ongoing

No activity

1. Support the Family Physicians of Texas and Their Practices

1.1 Reduce administrative burdens imposed on physicians by public and private payers so physicians can spend more time caring for patients.

ADVOCATE – Support federal and state legislation to reduce administrative burdens throughout the documentation, compliance, claims and billing processes.	STATUS
• TAFP submitted a resolution to the AAFP Congress of Delegates asking for further advocacy and member resources to address problems related to patient attribution. The resolution was adopted.	7/25/2024
• The Academy is working with multiple family physicians who’ve been appointed to TMA’s Council of Socioeconomics, Alternative Payment Committee, and Independent Practice Committee to develop state legislative policy aimed at administrative simplification.	Fall 2024
• Signed onto the Seniors’ Timely Access to Care Act to streamline prior authorization under Medicare Advantage.	Fall 2024
CONNECT – Create opportunities for family physicians to connect, network, share experiences, and learn best practices in addressing administrative burdens.	
• Published “Patients over Paperwork: Tackling Administrative Burden” toolkit on tafp.org.	10/15/2024
• Member Assembly at ASPCS will feature a discussion on using technology to address administrative burden.	11/8/2024
EDUCATE – Conduct workshops and training sessions to educate physicians and staff on identifying and addressing practice efficiencies that reduce administrative burdens.	
• CMP created draft learning objectives and example educational offerings for future CME on best practices to reduce administrative burden when using EHRs.	4/12/2024
• Hosting CME “Reducing Administrative Burden for Family Physicians” at ASPCS.	11/8/2024
• Hosting CME “Documentation and Coding” at ASPCS.	11/10/2024

1.2 Promote innovative compensation models for family physicians and their care teams that recognize and reward the services they provide, while minimizing uncompensated administrative tasks.

ADVOCATE — Increase the availability of and participation in value-based care and other alternative payment models, including subscription-based primary care.

- ASPCS Member Assembly will feature a townhall discussion on alternative payment models. 11/8/2024
- Drafted legislation to file next session to allow for value-based contracting in the PPO/EPO market. Fall 2024
- Continuing to meet with health plan leaders on bringing more direct primary care and value-based health insurance products to market. Ongoing
- Participated in the Duke-Margolis Institute for Health Policy multistakeholder conference to advance accountable care models in the Texas safety net. 11/1/2024

CONNECT — Strengthen and promote TAFP's Partners in Health program that fosters partnerships with organizations helping family physicians succeed in value-based care.

- CFW Member Assembly featured panel discussion with three partners: Aledade, Austin Regional Clinic, and Main Street Health. 4/12/2024
- Added seventh Partner in September 2024. 9/1/2024
- Hosting free non-CME Practice Management Workshop: Aledade's Value-Based Care Technology Solutions for Primary Care at 2024 ASPCS. 11/9/2024
- Posted multiple promotions of PIH participating companies across social media platforms. Yearlong

EDUCATE — Increase member communication and education on value-based care and other alternative payment models, including subscription-based primary care.

- Hosted CME "Thriving in Practice Through Value-Based Care" at ASPCS. 11/10/2023
- Hosted "Value-Based Care Workshop" at ASPCS. 11/11/2023
- Hosted CME "Value-Based Care: Family Medicine's Time Has Come!" at CFW. 4/12/2024
- Included value-based care education in TAFP's Student and Resident Summit. 8/24/2024
- Participated in AAFP's Primary Care for America event in Austin, featuring representatives of numerous practices and efforts to help physicians excel in advanced payment model practice. 6/25/2024
- Hosting Free non-CME Practice Management Workshop: Aledade's Value-Based Care Technology Solutions for Primary Care at 2024 ASPCS. 11/9/2024
- Published AAFP story on member Dr. Glick and her path to direct primary care across social media. 9/18/2024

1.3 Champion a physician-led, team-based approach to patient care, enhancing efficiency and delivering comprehensive care.

ADVOCATE — Support policy and payment models that recognize and incentivize team-based care to ensure that the contributions of all team members are recognized and valued, reinforcing the importance of every role within the care team.

- TAFP provided testimony to Senate Health and Human Services Committee opposing independent practice for APRNs and calling for support for team-based care.
- Provided comments to the state Value-Based Care and Quality Committee.
- Developing policy and will be pursuing legislation next session on payment models that support team-based care.

9/18/2024

Fall 2024

Fall 2024

CONNECT — Partner with other health care professional organizations to create opportunities for family physicians and non-physician care team members to connect, share experiences, and learn about best practices in team-based care from each other.

- Worked with CPAN and Peri-PAN on mental health access CME presentation at 2024 C. Frank Webber.
- Participated in the inaugural Texas Association of ACOs meeting.
- Continue to serve as a founding member and executive committee of the Texas Primary Care Consortium.

4/13/2024

Fall 2024

Ongoing

EDUCATE — Promote the effectiveness and cost-efficiency of physician-led, team-based care with policy makers and other stakeholders.

- TAFP provided testimony to Senate Health and Human Services Committee opposing independent practice for APRNs and calling for support for team-based care.
- Reported on that hearing and published our testimony on both expansion of APRN scope and of test-and-treat expansion for pharmacists.

9/18/2024

9/18/2024

1.4 Position family physicians to succeed in the ever-changing health care marketplace.

ADVOCATE — Ensure family physicians are appropriately compensated for all services provided within the current fee-for-service system and advocate for greater investment in primary care by public and private payers.

- Sent letters to health plan CMOs advocating payment for G2211 across all lines of business. Worked with AAFP to call for payment of the complexity code and educated members on when and how to bill the code.
- Submitted comments on proposed Medicare Physician Fee Schedule in support of AAFP's efforts to improve payment and administrative efficiency for family physicians.

2/22/2024

9/6/2024

CONNECT — Utilize TAFP's various communication channels to profile innovative member practices that are delivering high-quality, cost-effective care.

- Profile of Jon Rich, DO, on career in ACO providing value-based care.
- Highlighted member Christopher Crow, MD, winning AAFP's Graham Physician Executive Award for his innovative work with Catalyst Health Group and LightPath Health.

4/10/2024

10/3/2024

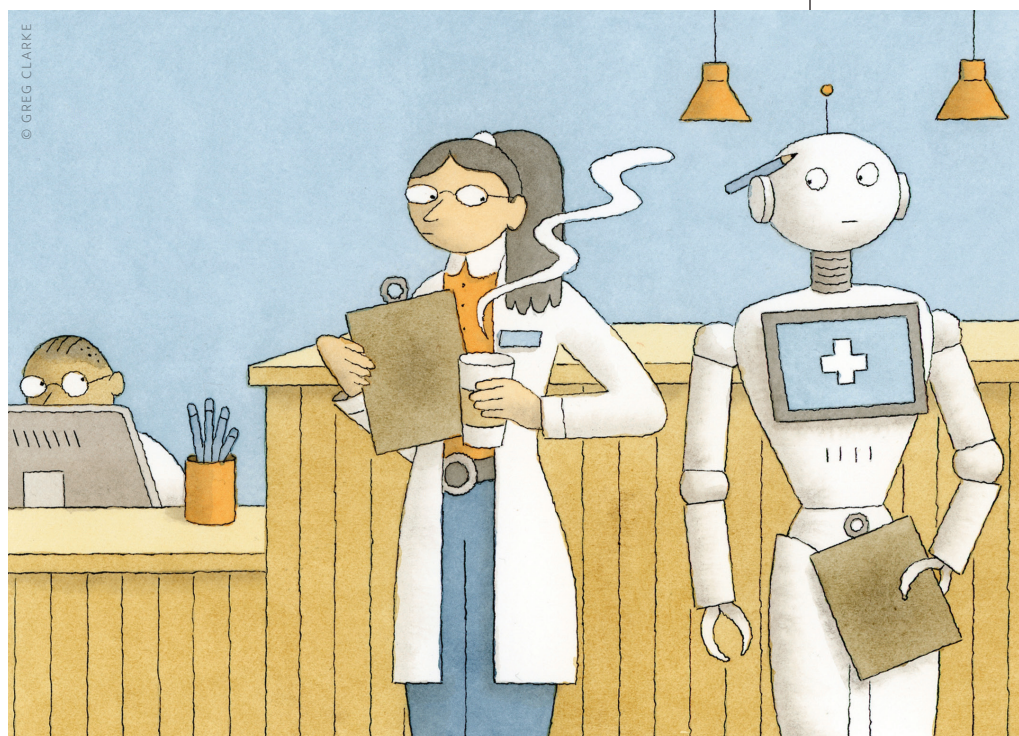
EDUCATE — Develop and disseminate case studies to policy makers and business leaders, illustrating the comprehensive and cost-effective care provided by family physicians.

STEVEN E. WALDREN, MD, MS

The Promise and Pitfalls of AI in Primary Care

Programs like ChatGPT have the potential to greatly diminish your administrative burden. But how do you get started — and can you trust them?

Near the end of 2022, a group called OpenAI launched ChatGPT, a large language model (LLM) artificial intelligence (AI) chatbot. It may have seemed like a novelty at first (e.g., “Write a poem about Medicare in the style of *Hamilton*”), but it soon became apparent that ChatGPT and AI models like it could have huge implications for education, business, and even medicine.



By January 2023, ChatGPT had become the fastest-growing consumer software application in history, reaching 100 million users in just two months (TikTok held the previous record at nine months).¹ Before the end of the year, other companies launched similar products, such as Google's Bard and Microsoft's Bing Chat (now Copilot).

AI is here to stay and will likely become more embedded in our daily lives in the coming years. If used properly, it could be a

ABOUT THE AUTHOR

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tremendous boon to primary care physicians, potentially ridding us of administrative tasks that are a leading source of burnout.² But, as with any new technology, there are downsides. This article seeks to illuminate some of the ways AI can help primary care practices now and in the near

AI models are always learning, but it's not advisable to use the current models to guide clinical decision-making.

future — and some of the ways AI could be downright dangerous.

WHAT IS AI?

At its most basic, AI is when computers try to mimic how the human brain works, learning from the information (data) they take in and becoming progressively more capable.

AI has existed in various forms for decades, but what's different about ChatGPT and other LLMs is the sheer amount of data they are able to process and their ability to be "generative." Generative AI can take a prompt from a user (an input as text, image, etc.) and can output almost instantly a novel response based on what it has learned from a massive corpus of existing data. Using Google or another traditional search engine is like looking through books in a library yourself and copying down what one author wrote. But using a generative AI program is like having an assistant who can look through all the books in the library and synthesize all of

that information into a brand new answer.

LLMs are generative AI models trained on enormous volumes of text. The training process allows the model to learn statistical relationships between words and phrases. It then uses these relationships to predict the most likely next word given the user's prompt (and the prior words it just generated). In its most simplistic sense, it is a fancy autocomplete model like you see in smartphone texting applications, where the phone predicts what you may want to type next based on phrases you've used in the past.

One of the reasons AI researchers are so interested in LLMs is the potential for "emergence," which is when an AI model can accomplish tasks that it was not explicitly trained to perform. There is some debate among academics about whether the current models have achieved true emergence, but there is no denying that LLMs can generate responses far beyond what people assumed they could accomplish.

What does that mean for health care? It's not entirely clear yet, but the technology is moving fast. Early LLMs could barely pass the U.S. Medical Licensing Examination, but more recent models, such as Google's medically focused Med-PaLM 2, have achieved relatively high scores.^{3,4} Some of the leading EHR companies are also testing ways to integrate generative AI within their programs.⁵

USER BEWARE

Before we get to how the new generative AI models can help, we should understand how they could harm. First, it is important to remember that these models were trained to generate the best next word (probabilistically speaking) — not to understand logic, the scientific method, or medical questions. Second, their learning is only as good as the data used to train the model (a common maxim in computer science is "garbage in, garbage out," which means that any shortcomings in the data used to create a program will manifest themselves in the program's execution). This leads to two of the biggest problems with current generative AI products: bias and hallucinations.

Any significant biases in the data can be learned by the model. Then the model's

KEY POINTS

- New artificial intelligence (AI) systems such as ChatGPT can reduce administrative burden, but their current shortcomings make it inadvisable to use them to aid clinical decision making.
- Tasks AI can help with now include drafting prior authorization requests, rewriting medicolegal forms in more patient-friendly language, and explaining normal test results.
- Proprietary or HIPAA-protected information should only be submitted to closed, private AI systems, not open systems such as ChatGPT.

responses will be informed by these same biases, which is why you may have read reports of chatbots producing conversations that are racist, sexist, homophobic, or otherwise awful.⁶ Bias in medicine is well-documented, even in clinical guidelines.⁷ Therefore it would not be surprising for generative AI models trained on existing scientific literature to perpetuate these biases. AI developers are designing and implementing tactics to confront this challenge, but AI users should be conscious of the potential for bias in the responses.

The second shortcoming is when LLMs make up something that is not true. AI literature calls this a “hallucination,” which conveys the concept that the AI does not seem to “know” it is being untruthful (i.e., lying). If confronted by the user (with a subsequent prompt), the model is likely to continue to respond as if the hallucination were true, or respond like a toddler and deny it did anything wrong. This type of behavior makes sense. The model was trained to predict the next best word and learned from the vast amount of human text, not all of which adds up. But hallucinations are a very serious obstacle for being able to use LLMs in medicine. For example, in one high-profile instance, ChatGPT created an entire fake data set to support a hypothesis about ophthalmologic care.⁸

Generative AI models are always learning, and each iteration is generally more capable than the last, but it’s not advisable to use the current models to guide clinical decision making. You must be able to carefully double-check the AI’s answers, and after doing that you’ve likely wasted more time than you saved. Plus, surveys show most patients are uncomfortable with the idea of doctors using AI to inform treatment decisions.⁹ Fortunately, surveys also show most doctors are similarly wary of it.¹⁰

COMMON USES IN PRIMARY CARE

Now that we’ve provided the necessary caveats about AI in medicine, it’s time to get to the fun part: how generative AI can help family physicians with some of the tasks they most despise. (If you want to experiment with generative AI as you read this article, you can create a free account

at <https://chat.openai.com> or <https://bard.google.com>, but make sure to follow the safeguards described in the box below.)

With a quick browse through the web, we can find news stories, journal articles, blog posts, and forums that discuss the possible uses of LLMs in health care.¹¹⁻¹⁵ These range from performing administrative tasks to generating communications for patients to translating medical jargon. Here are some of the use cases.

- **Rewriting medical or legal forms** in patient-friendly language. For example, you might ask the AI program to “Rewrite this informed consent form for those who read at an eighth-grade level: [insert text]” or “Create a new informed consent form for those with low health literacy.”

- **Summarizing information** such as a

THREE SAFEGUARDS FOR USING AI IN MEDICAL PRACTICE

1. **Use artificial intelligence (AI) large language models (LLMs) when the physician or other user is able to easily verify the accuracy of the AI output.** For example, it is easy for a physician to look at an AI-generated office visit note and quickly verify whether it is accurate and complete. But when using LLMs to generate initial drafts of messages to patients about lab results or post-diagnosis/post-procedure instructions, first ask, “Can I independently verify the accuracy of the AI response?” and “Does verifying it take less effort and time than generating the output myself?”

2. **Do not enter any protected health information or private organizational information into open online LLMs**, such as ChatGPT and Google’s Bard. For those cases, instead use an LLM embedded in a company focused on health care solutions, such as an EHR vendor, that will operate under a HIPAA business associate agreement. Do your due diligence on the company by asking them questions about the safety of their solution, including their processes to ensure accuracy. You should also plan to verify the output because you are still liable for the safety of your patients. It is essential to protect patient privacy and organizational security. The information entered into an AI model is not safeguarded from public view unless specifically noted, as in a proprietary model.

3. **Use the LLM only in low-risk situations.** Clinical uses are not recommended in primary care at this point. But independent physicians or physicians in leadership positions could consider leveraging LLMs for administrative functions, for example, creating employee policy documents or generating newsletters for teams. Verification of the information is still needed in these cases. Consider the LLM response a first draft that you must edit, which is still usually much faster than creating a document from scratch.

patient's medical record, a report, insurer policies and regulations, and journal articles. An example would be asking an AI embedded in your EHR to "Give me all the information on [patient X] pertaining to diabetes" or asking ChatGPT to "Summarize this journal article: [insert text]."

- **Generating initial drafts of patient communications** such as responding to portal questions, explaining test results, providing general education on chronic disease care, or explaining new diagnoses. Researchers have found that ChatGPT often responds to patient questions with more empathy than physicians (the machines don't have the same time constraints as us).¹⁶ Still, when it comes to test results, you might want to explain abnormal results yourself and reserve AI for explaining normal results ("Explain normal results for an electrocardiogram").

- **Searching for information within a trusted source** such as the medical record ("Has the patient had a colonoscopy in the last 10 years?") or an evidence-based guideline ("Using the following guideline, what is best course of treatment for a patient with [condition]? The guideline is [text of the guideline]"). While this might seem like using AI to aid clinical decision making, it's

insurance appeals, etc. For example, "Write a letter to [insurance company] requesting authorization for a patient to get an MRI of the left knee." To strengthen your prior authorization request, ask the AI program to reference scientific literature that supports it (but remember to double-check for AI hallucinations), or paste in the insurance company's template or copies of similar requests that were successful in the past and tell the program to use them as models.

- **Generating documentation from an audio recording of an office visit.** There are already AI products on the market that act as virtual scribes, recording the appointment, transcribing it in its entirety, creating a summary, and placing it in the patient's record.¹⁷

Even the uses described above require safeguards (see page 29), such as considering the AI-generated text to be a draft that you must review for accuracy. I would not recommend just firing up ChatGPT, for instance, and using it immediately in practice. Although its makers have added options to keep your chat history private, conversations with ChatGPT are still recorded temporarily and the program has suffered privacy breaches in the past.¹⁸ So, while it might be fine for rewriting generic informed consent forms, any information that is proprietary to your organization or HIPAA-protected should go through an AI platform covered under a HIPAA business associate agreement. And, as noted, current AI models can produce "hallucinations." The consequences may not be as dire for administrative tasks versus clinical ones, but it's still something to be alert to.

AI models can produce "hallucinations."
The consequences may not be as dire
for administrative tasks versus clinical
ones, but it's something to be alert to.

actually using AI to search and curate the trusted guideline that is aiding your decision making.

- **Populating clinical registries.** AI programs within EHRs can increasingly take on this data entry task, using medical records to find and place the appropriate patients on the registry ("Find all patients who have billed for services involving [insert ICD-10 codes] in the past two years and put them in a spreadsheet").

- **Generating initial drafts of referral letters, prior authorization requests,**

LOOKING FORWARD

In my mind, there is no question LLMs will have a prominent position in medicine over the next several years. We are already at a place where there is too much information for humans to manage in health care. Having AI that can summarize and review every piece of information and never forget a single data point can significantly improve health outcomes and decrease the cognitive burden on physicians. Having AI that can handle administrative tasks will free physicians from the EHR and paperwork and allow them to focus on the patient and care delivery. At least one

university is already offering a combined doctor of medicine/master of science in artificial intelligence degree to help prepare physicians for this future.¹⁹

Yet, I also think AI presents significant peril. As long as the financial incentives of medicine are misaligned, there are market pressures to leverage innovations such as LLMs to do things that are not in the best interest of patients and primary care (such as insurers allegedly denying claims based on AI algorithms).²⁰ Because of AI's promise and peril, I believe primary care physicians must become educated about it and its application in medicine. Family physicians should weigh in on the design, development, and deployment of AI in medicine to ensure it is more helpful than harmful to patients, primary care physicians, and practices. **FPM**

1. Hu K. ChatGPT sets record for fastest-growing user base — analyst note. Reuters. Feb. 2, 2023. Accessed Dec. 18, 2023. <https://www.reuters.com/technology/chatgpt-sets-record-fastest-growing-user-base-analyst-note-2023-02-01/>

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