STARFIELD SUMMIT IV
REENVISIONING
FAMILY MEDICINE
RESIDENCY EDUCATION

Family Medicine Leadership Summit

Focus Group Summary
By Focus Group Leaders

Introduction:

The six focus groups convened and individually developed a summary document which provided perspectives on the 6 Core Questions asked by the Starfield Summit Leadership Committee.

Copies of each group's documents were distributed to one another and reviewed to see if there were themes that crossed across all groups. These themes were then matched and paired up. Themes that came across in all 6 different questions groups were prioritized.

All summary forms were combined into this lead document which will be published at Starfield Summit under the ACOFP and AOBFP brand. Below are the opinion statements that were shared from each focus group

Institutional Focus Group (Leader – Natalie Nevins, DO)

Core Questions:

5) What is the right balance between Innovation and Standardization?
6) How can we improve the social accountability of graduate medical education?

Opinion Statement:

In terms of standardization, the focus was directed to the importance of social accountability of graduate medical education for public safety The public needs to be protected – this is an unstated, but essential element of the ACGME's charter to oversee medical education training systems in this country. One persistent question that should be answered be answered is whether all graduating residents are prepared to be competent physicians. This leads to a follow-up question on how the educational system evaluates competence for not only residents, but faculty as well. The framework of Competency-Based Medical Education is an effective beginning to outcome-based systems in residency training. Yet questions remain regarding what level of competency needs to be consistent across all training programs. Should there be a competency track within residency training? Should competency-based frameworks also be used to train and assess faculty? Faculty needs to be skilled in education and evaluation. There needs to be better safeguards in place for the faculty to be able to do that job. Some considerations include:

- Standardization of the quality of faculty by developing national guidelines and/or training
- Specific standardized courses offered by the ACGME or other organizations for a longitudinal curriculum in Family Medicine
- Standardize the process of both learning and teaching across multiple domains and venues.
- Develop additional training on adult learners
- Create new evaluation tools that are 'fit for purpose' (*i.e.,* have both validity and utility)
- Develop more specific programs designed to increase interprofessional communication as an element of both patient safety and quality improvement

An area of innovation that has occurred by necessity is the swift increase in the adoption and utilization of telehealth and telemedicine. These have become an important component for providing medical car for society during this recent pandemic. It is recognized that in the COVID and post-COVID world telemedicine must be integrated and used effectively from medical school to residency training environments. While not a 'new' skill set, institutions have recognized the essential need to teach this skill in new ways to current and future learners in both the graduate and undergraduate worlds. While there is a need for telemedicine as an avenue to deliver care and manage patients, it was reaffirmed that it cannot completely take the place of in-person patient visits. The challenge for Osteopathic physicians is the need to be able to competently determine when a telemedicine or in-person visit is most appropriate for the clinical situation.

Another area of interest in terms of innovation was the perceived growing need for the expansion of Family Medicine fellowships. While a limited number of fellowships exist within the current framework of graduate medical education, it is recognized that the increasing breadth and scope of care both desired and (in many cases) required of Family Physicians will necessitate opportunities for additional specialized training. Family physicians are now functioning as hospitalists, intensivists, laborists, emergency room physicians and numerous other roles that have been the result of a shortage of specialists in many geographic regions of our country. Currently there are no options within family medicine for fellowships in these areas. Increasing fellowship types and standardizing an approach to fellowship training across the nation will help to greatly reduce health care disparities that occur both due to geographic and socioeconomic status. To do this, we must develop interprofessional training and identify national experts across these domains to develop standards and work with all family medicine residency programs that wish to include such innovative options within their health care GME system. Fellowship training can provide opportunities for emphasis training areas which may not be easy for all programs to accomplish (*e.g.,* Obstetrics and Women's Health). We should consider the option of offering increased or emphasis training for family medicine residents training and planning to practice in rural locations. Programs should define their emphasis on training between urban and rural health needs. Specific areas of focus discussed included:

- Critical care
- General surgery
- Obstetrics/Women's health
- Emergency & Trauma care
- Endocrinologic management

Other areas of innovation identified included diversity and social accountability training (with the consideration of Fellowship training in caring for patients with reduced access to healthcare) and an increased focus on leveraging distance-learning to enhance training at schools and residency sites. Utilization of such technologies would allow residents to have broader exposure to both topics and quality teaching experiences for a much broader range of health care issues. The idea of quality remote learning is one whose time is clearly here.

Last, the public needs to be educated as to who Family Physicians are and what they do. A better job needs to be done to create an innovative message on Family Physician's role not only in medicine, but in society and the world. This understanding of the larger role of the physician as societal leader needs to be included within residency training. Quality care is more than just technical proficiency. Residents should understand the role of the family physician outside the clinic and hospital. The physician has an important role in community.

Certification Body Focus Group (Leader - Gregory James, DO, MPH, FACOFP *dist.*)

Core Questions:

1) What does society need from family physicians in the future?
2) What should we teach?

Opinion Statement:

Training in diversity is a topic that should be a priority for both core questions. The modern family physician is likely to encounter a much more diverse patient population in terms of ethnicity, gender identification, educational and financial backgrounds as well as the other traditional defining characteristics we have seen over the last two centuries. Furthermore, as family physicians adopt technologies that allow them to have a broader reach and impact in terms of who they care for, it becomes imperative that they are prepared to understand and respect those same populations both as a matter of humanism and professionalism. Training that focuses on these elements should play a critical part in meeting this task going forward.

As the healthcare system's benchmarks of quality have changed over time, we have seen shifting paradigms for how we assess the overall value of the profession to society. It is imperative that graduate education aligns with the standards of value-based care which focuses on overall health outcomes as opposed to frequency of visits. Value-based care aligns well both with efficiency of utilization and health promotion/disease prevention concepts that have long been championed by the specialty of Family Medicine. Furthermore, this shift in the way we practice allows the profession to meet the patient where they are, both in terms of need, financial viability and access. Adjusting the famous words of NHL great, Wayne Gretzky, by 'skating to where the patient is going to be', we position ourselves better to meet the needs of that patient. We wish, in essence, to further the empowerment and engagement of the patient and we believe our training should reflect this idea.

We believe that family physicians must continue to remain at the core of both caring and coordinating for patients they see. Family physicians form the strongest and most longitudinal relationships with patients and these integral bonds should demonstrate the need for family physicians to be at the center of patient care paradigms now and in the future.

Understanding the current and future business models of medical practice is another aligned goal and answer to these questions. It is felt that providing additional training in such areas not only increases the long-term viability of the learner within a health-care system where physician leadership is essential in all domains (including financial), but it also ensures that trainees are best prepared to negotiate through the inevitable challenges they will encounter during their years of practice.

Last, in consideration of what we should be teaching, we believe that more attention should be given to validated data which identifies the highest priority medical problems in terms of prevalence and severity. Our core training should focus on the 'top 20' problems identified and diagnosed by such groups as the National Institutes of Health (NIH). We also believe it is important to have the 'right' people training our residents – those individuals who are not only educationally qualified but have a fair and optimistic view of the role of Family Medicine in the larger health care system.

Practicing Clinician Focus Group (Leader - Ronna New, DO, FACOFP)

Core Questions:

1) What does society need from family physicians in the future?

4) How can residency education support graduates' ability to shift practices and populations over time?

Opinion Statement:

Society has a clear need for family physicians in the future. Family Medicine should be at the center of care both in terms of providing continuity for the patient as well as serving as both a physical and metaphorical 'home' for the individual patient's access to the healthcare system. Family physicians should be the key point of interaction for the patient's care and it is imperative that residents should be trained for the future as the patient care coordinator and leader in their practice. This needs to be incorporated more heavily within the residents training meet the patient's needs in terms of

financial status and geographical accessibility. Alongside this role, the training related to the business aspects of medical practice need to be increased during the residency training period, something most physicians learn during their first years of practice, often with adverse financial and career ramifications due to a lack of knowledge.

Residency programs must be able to provide better preparation for a lifelong career in medicine. This means having exposure diverse clinical practice settings (*e.g.,* rural versus urban) as well as opportunities to develop skillsets needed for careers in diverse areas such as academic medicine or healthcare administration. Some elements that should be considered include:

1. Teaching the skill of self-care and resiliency
2. How to educate residents to treat diverse populations
3. Provide support opportunities for rural and small programs to train out trainees to expose them to diverse population to better prepare them
4. Encourage ACGME to look at Fellowship development opportunities for programs that wish to serve underrepresented services in areas with low access to critical specialty care, such as obstetrics. In the same vein, programs should be stratified in new and creative ways to better capture the wide variety of practice environments seen in Family Medicine (*e.g.* programs that prioritize ambulatory versus in-patient care or in-patient medicine)
5. Teaching Innovation: Telehealth, teaching resident change is ok and teaching resident how to embrace change and embrace innovation, look for clever ways to reward the residents more when they are innovative (*e.g.,* If someone dropped out of continuity of requirement, how to count telehealth visits).

In addition, the focus group felt strongly that there must be accommodation made to re-evaluate what is 'essential' to training for all FM programs and residents. Significant discussion was had about the fact that many smaller programs could not meet standards more achievable by larger or unopposed programs (such as having FM faculty to teach OB or conduct inpatient management of pediatric patients). Rather than eliminate these elements, it is felt that these, too, should be considered for 'special designation' to allow programs that can and are interested in achieving those elevated standards, they are able to (and not penalizing the majority of other programs)

Last, in reviewing the The 4 Cs, we believe that the first C – First contact care – needs further clarity or revision to place it within Continuity or Continuum of Care. This might be more descriptive and appropriate moving forward.

Clinical Faculty Focus Group (Leader – Johnathon Torres, DO, FACOFP):

Core Questions:

2) What should we teach?

3) How should we teach?

Opinion Statement:

As identified, there is a distinct need to focus on Continuum of Care as a distinct and identifiable element of residency training. Such experience becomes critical in many, if not most medical cases (*e.g.,* ensuring that every resident has an opportunity to counsel a patient on contraception, inform patients if they are pregnant, manage the initiation of obstetrical care, including initial testing and again throughout the pregnancy from a maintenance and management perspective, ultimately culminating with delivery and post-partum follow-up.. The current system does not fulfill this and neglects to distinctly capture the value of FM physicians contributing to the field of chronic or episodic care of pregnant women in the office. They are not managing or comfortable managing medial problems or chronic illness, pain or OMM which are valuable aspects the residents can benefit from and should be included in continuum of care obstetrics patients. Currently there is not a format for that to take happen. Education should be provided on how to best provide transition continuity of care from a patient to physician perspective manage the patient throughout the transition of care

as it currently extends residents cannot count inpatient episodes of care toward continuity numbers. Care of the same patient in the office and when they are hospitalized. There is a need for educational and clinical value of following from office to the hospital and transitioning back to the community. Strengthening that role and recognizing value of encouraging the development of a robust program for transition of care would benefit residents and patients. The definitions are currently too restrictive.

Another issue highlighted was the challenge of over-standardization leading to unrealistic expectations for both training and practice. One example that was highlighted were obstetric delivery numbers in New Jersey, which were too low to allow residents to feel competent to deliver babies in practice. This sentiment was echoed by others, who have pointed out that over-standardization does not make sense in a country with so many distinct 'geographies' in terms of medical need. There are some programs that have more other deliveries than others because of these requirements but practicing physicians' opinions that these standards are onerous and do not contribute to the overall competency of resident physicians entering practice are mirrored on many documents from analogous groups on the Starfield website. The scope of practice for FPs is diminishing or narrowing nationwide despite of higher requirements through ACGME. It also is (or should be) driven by more than residency training. The means by how to get there is potentially setting a more basic standard so every FM bare minimum needs to have a certain requirement how many pregnant women, pediatrics or clinic patients are seen. But then the resident or the program can choose to focus on a certain area of specialty and meet the basic standards *e.g.* how many pregnant women are seen, how many peds patients are seen, how many clinic patients are seen? Then one can choose to focus in a certain area and then have a call covering OB or Pediatrics etc. The same goes for in patients, sports med, pediatrics, OMM, behavioral health. The community may require a different focus from that residency program, incorporating that program in that process. We suggest formalizing the process and engaging residents in the process so that every program will complete a community needs assessment. Some considerations include: How can one evaluate and what the community requires, what are the opportunities to improve and what are the weaknesses. This can then lead to formulation of a plan on how these elements will be met which could be submitted to the FMRC for review and possible approval.

Resident Focus Group (Leader - Deaundre Dyer, DO):

Core Questions:

1) What should we teach?

3) How should we teach?

Opinion Statement:

The focus group discussed that there is underwhelming education in business and specifically business of medicine. There should be high emphasis on expansion for new procedural teaching (such as point of care ultrasound) as these elements become essential tools aiding in assessment, diagnosis and treatment of patients. Patient safety and health care regulation discussions lead, inevitably, to advocacy, as so much of the domain of medicine is in the political arena there is no way to avoid being a patient advocate with being a political advocate.

There is also a need for more standardization and expansion of elements needed for faculty skills (*e.g.,* such as specific training in implicit bias and social determinants of health as well as accepted learning and assessment frameworks). Significant attention should be given to standardization of numerous elements of residency training. Some of the highest priority ones include:

- Faculty Competency
- Procedural Competency
- Competency-Based Learning and Assessment

• Cultural competency in Medicine

Student Focus Group (Leader – Student Dr. Thomas Duffy):

Core Questions:

3) How should we teach?

5) What is the right balance between Innovation and Standardization?

Opinion Statement:

As others have stated, family medicine training needs to expand its scope of practice from what has been 'traditionally' defined as within the realm of Family Medicine. Major consideration should be given to how scope and breadth of practice has evolved over the last 10-20 years. In addition, the ability to identify specific strengths and challenges of programs, with the express plan of supplementing perceived gaps was considered a high priority in terms of rewarding innovation while maintaining standardization. For example, some programs are great at OB, joint injection or ultrasound, but may not only be able to perform ultrasound but interpret ultrasound results and procedures. It may move into radiology territory, but radiology expands up to and takes surgical operations and do not want to spend time doing ultrasound. Creating 'tracks' within FM training would allow programs to better stratify their particular areas of focus, leading to better alignment between students seeking specific 'extra' skillsets and programs offering them. As has been suggested, the ability of programs to create travel and learning opportunities with other programs that may have different skillsets, environments and practice styles could be invaluable for preparing residents for these elements in their future careers.

In terms of innovation, numerous opportunities were identified:

As has been suggested, the ability of programs to create travel and learning opportunities with other programs that may have different skillsets, environments and practice styles could be invaluable for preparing residents for these elements in their future careers. The idea of 'resident swapping' was discussed as an opportunity for diversification of clinical experiences. Such opportunities would allow residents to see different patients with different problems and accessible resources, as well as potentially allow for greater training in areas such as ethnic competency, LGBTQ+ training and lower income populations.

Maximizing technologic access to both resources, patients and preceptors would allow for better overall training programs with an 'evening out' of relative strengths between programs.

Social Accountability is above and beyond simple care of patients or simple practice of medicine. There is a higher calling related to knowing what the patients need medically and culturally what they need from society element.

Major Recurring Themes

- Physicians must be trained according to accepted competency frameworks and must be trained by faculty who have also been trained/assessed through standardized frameworks
- Residents must have access to a broad scope of training opportunities that allow for exposure and training to different patient populations in terms of geography, socioeconomic status and social determinants and age/gender/orientation/ethnicity
- Programs should have opportunities to develop specialty tracks which fit particular, under-represented areas of FM, to better align both programs and residents in the pursuit of additional training for areas such as obstetric care, emergency care, etc.

- Innovation must come not only in terms of adoption of new technologies, but in expansion of access to patients and broadening of opportunities for FM residents during the training period
- One theme not specifically mentioned above but identified by **all groups** as being critical was the importance of maintaining and strengthening osteopathic distinctiveness in the residency training system. All groups agreed that osteopathic Tenets and Principles still hold significant value for both patients and trainees and that there should be further consideration of teaching the tenets to everyone interested, MD or DO. These tenets represent a strong element of humanism as applied to the modern-day practice of medicine and they must remain both identifiable and measurable.

Summary

The above document represents the summation of the input provided by the ACOFP and AOBFP Focus Groups – we offer it in the hopes of generating robust discussion at the Starfield Summit and for years to come. Family Medicine will continue to have a central role in which the medical profession fulfills its covenant with society to provide the best practitioners to care for them. The ACOFP and AOBFP are proud to offer both guidance and leadership as we move forward.