Family Medicine Leadership Summit

Focus Group Summary
By Question

Introduction:
Copies of other groups documents were distributed to be looked at to see if there were themes that would resonate with other groups, match and pair up. Themes that came across in all 6 different questions groups were prioritized.
All summary forms were combined in one lead document to be published at Starfield Summit under ACOFP and AOBFP brand.

Question 1: What does society need from the personal physician of the future?

- Family Physicians need to be trained to be the leaders in a primary care team.
- Family Physicians must be advocates for promoting wellness and health rather than treating disease.
- Family physicians must be able to address populations with great health disparities.
- Patients are looking for ease of access, transparency, and rapid turnaround of information in a private environment.
- Family physicians need to be able to invest in technology. They need resources.
- Society needs access to family physicians – Family Physicians are challenged with the structure of their practice to survive in challenging economic times.
- Family Physicians need to be trained in business models – not to the level of an MBA but at least the basics ~~of~~ in the business of medicine and running a practice.
- Society needs comprehensive and coordinated care
- Society needs Family Physicians that have a belief in lifelong learning.

Society needs the family medicine physician of the future to be an advocate for the patient/profession, compassionate, skilled in providing care "across the continuum," adept in innovation/new platforms to improve patient access to care, a leader in practice/community and always focused on keeping the patient at the "center" of care, treating the "whole patient" and placing value on "hands-on" care.

- Advocacy for the Patient/Person as a Whole & the Profession
- Desire for more ambulatory focus within FM training to better prepare trainees
- Continuity of Care & Coordination should be one "C"
- Provide experiences to foster community engagement by the physician
- "First contact care" definition needs to be better defined – Perhaps change to "continuity" only as the "first contact" is not always the person that ends up coordinating care/it is the physician that builds the relationship with the patients and has true "continuity" with them
- Treating the "whole person" requires more training in psychiatry (across all age spectrums)
- Incorporate more training across continuum of life (realizing that many programs focus more on middle-aged adult than newborn/pediatric/geriatric)
- Leadership training is needed – teaching trainees how to be leaders in their care team (facilitating better chronic care management/across disciplines) as well as in their community

Question 2: What should we teach?

- Wellness emphasis for Residents & Faculty, optimal aging, preventative care with an emphasis to treat daily chronic conditions is essential.
- There should be an emphasis on public health education.
- Osteopathic Principles & Practice should be an essential element of training
- Family Physicians need region-specific knowledge based on practice location.
- Emphasis on Continuum of Care over continuity patient experiences.
- Allow lower general requirements with opportunities for special interest.
- Increased emphasis on health information technology.
- Increased emphasis on point of care ultrasound (POCUS).
- A gradual transition to a competency-based education.
- Centralized didactic and clinical skills labs to train and assess residents.
- Behavioral Health, Pain Management & Obesity Management.
- Programs need to incorporate training in Telehealth/Innovation and train residents that having better access to care (for the patients through telehealth/same day appointments/other) is an expectation from the FM physician and provides better care to the patient – look at how program requirements should change because of this need in training (such as in changing how these visits "count" for resident requirements)
- Teach importance of "value" in care – better access to care for patient improves health/continuity and decreases cost (decreases urgent care visits/hospitalizations, etc.)
- Trainees need training in how to manage patients when they cannot do a "hands-on exam" and manage patient via telehealth/telephone, better delineations of when this is appropriate vs when patients needs hands-on exam and focus should always remain on importance of hands-on care for trainees/future physicians
- FM trainees must be trained to collaborate amongst specialties to be at "the center" of their patient's care
- OB – mixed feelings but majority feel that there should be some training but an opportunity for trainees to go into a program with "OB Recognition Status" for more immersive OB training if they have interest/plans to practice where more OB care is needed, allow standards for residency programs to be able to "customize the level of OB training" based on location and trainee needs (do not make OB requirements for programs so stringent/large that they cannot be met by some of the strong/small programs) (trainees can seek out programs that have "OB Recognition Status" if that is their desire)
- Provide training in compassion/emotional intelligence/cultural sensitivity through all levels of training – clinical exposures/modules
- Incorporate formal training in behavioral management/lifestyle modification

Question 3: How should we teach?

- The certifying body should assist the residencies in teaching the value of lifelong learning.
- Provide ongoing affordable training modules and options in multiple formats (live, on-demand, recorded, etc.).
- There are fundamental topics and procedures that are essential to the foundation of a family physician. The changing landscape requires a more robust business management curriculum. There has to be a minimum threshold of healthcare systems understanding, a graduating physician must possess in order to thrive.
- In order to address health disparities, we must intention in our focus on the root of these disparities and their negative impact on our patients. We must change our core competencies to reflect the importance environmental factors on the health and well-being of our patients.
- Protected Learning Time
- Comprehensive Chronic Disease
- Permit specialist supervision
- Emphasize continuum of care over raw encounters.
- In-person is still preferred.

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

Allow for Program Focus which allows for community needs assessment and designing curriculum to meet local needs. Residents learn the process and become competent.

Residency education can support graduates' ability to shift practices and populations over time by teaching self-care/resiliency, exposing residents to diversity in populations and practices, teaching care "across the continuum," developing a love for lifelong learning in the resident, encouraging thought development/innovation, and improving on curriculum in the "business of medicine."

- Curriculum in Resilience Skills Training
- Teaching Self-Care to Residents
- Exposure to Diversity – Patient & Practice Cultures
- Skills Training in Continued Cross Coverage (inpatient, outpatient, nursing home/LTC, nursery, NICU, etc)
- Again, exposure to continuum of care (birth to death)
- Formal curriculum that focuses on importance of lifelong learning/CME and instills this in residents/is "role-modeled" by attendings
- Exposure to multiple practice settings (private clinics, rural, urban, direct primary care, PCMH, etc)
- Didactic training/modules in diversity and inclusivity training
- Rotations in underserved populations/special interest groups (perhaps as a "detail" so programs have flexibility)
- Exposures in community service/community outreach
- Encourage/promote skills in thought development/innovation (see detailed attachment for more description and list of topics)
- Increase training in the "business of medicine," skills in resource management, chronic care management, pharmacy services/prior authorization, learning how to lead a team and "delegate" where appropriate

Question 5: What is the right balance between regulation and innovation?

While it is integral to embrace innovation to best serve patients and avoid anachronism within our society, residency programs should innovate in standardized ways to ensure all residents are equipped to meet the challenges of the modern world. Such as:

- Rapidly developing technology.
- Need for flexibility in standards due to diversity of residency programs' access to resources and patient populations
- Innovation in technology can result in changes to the scope of practice in Family Medicine
- Innovation in information systems (research journals, EMR, society guidelines, reference materials) can result in changes to standard of care.
- Standardization must apply to non-medical aspects of physician training.
- ACGME required procedures should be updated.
- Minimum criteria across multiple areas of medicine should be revised to reflect modern practice of Family Medicine.
- Permitting residency programs to define community needs and create program focus to meet identified needs.
- Allows for tailoring to population and community needs.

We can ensure that every graduating resident has the necessary knowledge and skills to function as a fully competent family physician while also encouraging innovation in residency education by:

- Need for skilled and competent faculty to teach and evaluate the resident.
- Need training in use of telemedicine
- Need to validate skill set of residents
- Adoption of family medicine fellowships which would be on par with those in other specialties
- Use National Experts to speak to the residents, virtual didactic time with residents for standardized approach from National Experts
- Need to inform the public on what a full scope Family Medicine physician does

Question 6: How can we improve the social accountability of graduate medical education?

Increasing social accountability of residency programs depends on educating both the public and the residents to better understand the impact each group has upon the other. Such as:

- Cultural Competency
- Public transparency starts with educating the public and addressing their needs.
- Creating more residency training locations in rural and underserved areas.
- Increasing the first-hand exposure residents receive to areas of public need.
- Training residents to be more holistically aware of the society and systems in which they practice.
- Make standards for educating residents on local resources for patients' needs.
- Possibly making advocacy and community involvement required of residents.
- Educating residents on the financial impact of the healthcare they provide. Preparing residents to care for lower socioeconomic and rural areas to care for those in need (public health/population health and humanism training).
- Programs should include education on social health.

We can we increase transparency and better respond to the needs of the public by:

- Better tracking of patient outcomes from continuity clinic.
- Better training in interpersonal skills/professionalism.
- Better training of PD's and faculty on resident selection and identifying unqualified residents.
- Increased mental health training in diagnosis, treatment, and follow-up, including need for counselling.
- Patient surveys that reach the resident level.
- Set up built in OSCE opportunities for a "standardized" patient to be added to the schedule in the resident continuity clinic for filming and review with the resident.

How effective are current mechanisms of continuous quality improvement for residencies?

- Not currently very effective.
- Look at outcomes, "big picture", and readmission rates, in/out patient.
- Apply ACO measurements. Resident QI projects need to be more than "check the box".
- Diversity training/cultural competency. More exposure to the diverse populations for residents.
- Include the needs of the community and add a community member at large (i.e. patient from resident clinic) for direct feedback on GMEC.
- Education and evaluation in emotional intelligence to further understand the needs of the patients and society.