Family Medicine organization convening focus group: Association of Departments of Family Medicine

Participants (type and name): Chairs of Departments of Family Medicine
Date of focus group: October 2, 2020 (120 mins)

We asked two core questions to the chairs and had them discuss components of these questions in breakout groups. The two core questions were:

A) Thinking about the 5 "Cs", how will they look in 10 years in the context of residency training? [5 groups: comprehensiveness, continuity, coordination, 1st contact, and community engagement]
B) What is the right balance between innovation and standardization? [5 groups: maternity care, procedures (incl simulation), chronic illness care, acute illness care, social determinants]

What questions did your focus group address and discuss?	What themes were developed in the discussion?	Any foundational or critical components in the themes?
A) Comprehensiveness	1. We should continue to be complexivists, providing continuity, providing both inpatient and outpatient care as well as OB and peds. We feel that this continuity reduces error, reduces cost, and is of Value, and if done right, improves patient satisfaction. 2. Telehealth, MAT, POC ultrasound, and working with teams to pull off the comprehensiveness will be critical newer skills that all our residents should be trained in. 3. Family Medicine Training, and the complexity of the training is critical for clinical decision making. Even if you are not planning to do OB or ICU care, training in those areas improves the ability of the trainee to learn critical decision making. 4. We feel that all residents should graduate with all skills	Continue to be comprehensive – this is becoming an added value as we move into emphasizing cost and quality. We stand by comprehensive care including OB, even if it is not practiced, it makes our trainees better doctors.

	necessary to provide comprehensive care, remembering that they don't have to be perfect at every skill or in every area when they graduate. 5. WE specifically recommend against tracks for resident training, and feel all residents should graduate with at least basic skills in all areas. Strong consideration should be given to either mandatory or optional 4th year of training to provide extra training tailored to where they will practice	
A) Continuity	1. Need to care for patients with complex chronic conditions 2. Looking for after hours care, how to provide a broader spectrum of care with this? (telehealth is an option) 3. Need to have continuity and comprehensiveness in caring for panel of patients - referral rate should be low, use more e-consults 4. Need RC-FM to recognize that FM is in a wide variety of settings -- hospital, ER, community; FP needs to enhance coordination skills for the future	Continuity is key to providing high quality, cost effective care, especially for those with chronic conditions. There needs to be training to provide continuous, comprehensive care for a panel of patients with an emphasis on keeping them well and minimizing the use of specialty referral (instead use telehealth consultations). RC-FM should also flexibility for programs to meet their local needs for training in continuity (train for the skills you might use after graduation)
A) Coordination	integration should be an alternative name not just the role of the FP but should be taught to all and other professionals have a key role	Importance of team-based care We should be ahead of where we are now with coordination in 10 years - so we really can still be the personal physician

	this is key to value-based medicine and is a core leadership skill	
A) First Contact	In a system moving to urgent care and virtual visits, how do we ensure this role? FPs are appealing providers in these settings because of their comprehensiveness; if we can get more FPs into urgent care roles, more patients will have first contact. If we can set it up so that these FPs in urgent care then refer to other FPs instead of specialists, we can control the cycle (and save the system money for value-based care)	Our obligation is to try to move the system; with a system moving toward urgent care and virtual visits, we need to fill more urgent care positions to increase access to the specialty and then set it up where we then refer to ourselves (urgent care FP refers to continuity care FP)
A) Community Engagement	1. Feel that it is vital for the physician of the future to be "of the community" 2. Feel that training needs to add rigor tp community engagement	
B) Maternity care	Obstetrics is too important to leave to obstetricians, need to be innovative though depending on hospital resources; should standardize training in ALSO and L&D Important part of continuity, building relationships Within the larger education of FPs - different procedures we may or may not do as we go through our lives; recognize that this is true for OB and other services, not so much asking what everyone does but the importance of teaching it so	Many family physicians may decide not to practice OB, but continuing to train in it is important for providing the best care for patients

	can provide high quality care and be the “personal physician”	
B) Procedures (incl simulation)	1. Should be 50% standardization, 50% innovation; 2. Simulation should be required for procedures in which your training institution doesn't have enough volume 3.There should be a list of required procedures that are chosen based on the following criteria: a. Critical procedure for first contact - think emergency procedures like central lines but maybe not Swan Ganz catheter but think prenatal care and resuscitating a baby and ALSO but not necessarily have to have a large number of deliveries b. Procedures you can't learn on YouTube - probably don't need to require - things like removing a fishhook that you can easily learn watching a video. c. Procedures that you will frequently do in practice (e.g. POCUS but not doing an echocardiogram) d. Procedures that are critical for service of a patient - things like women's health, prenatal care, skin procedures, etc.	Suggested way to prioritize training for procedures; with recognition of flexibility for some innovation and use of simulation where not enough volume locally
B) Chronic illness care	Continuity site must have sufficient numbers of chronic care patients to provide chronic care management training - this is the best place for this training (can’t synthesize skills well when out on rotations) Innovation side - technology/telehealth, need to	Moving forward, it is important that residents can provide basic standardized chronic care management for graduation from residency

	be able to manage chronic care during crises! Teleprecepting as innovation - way to bring in specialists and FM preceptors (training extenders) Artificial intelligence - rate limiting factor is getting good data out of EHRs, once we can jump this hoop it will lessen reliance on specialists	
B) Acute illness care	Across continuum including ED, Critical Care, Urgent Care, Acute Office Visits Innovation in process of care and delivery such as telemedicine; use of simulation/ultrasound as innovations Standardization in core skills; RRC set core competencies and each program be able to be innovative in how the competencies are taught and where based on local resources but standardization can help make sure programs get the resources they need. Flexibility needed during times of crises	Standardize for core skill sets across the care continuum but allow for flexibility in teaching
B) Social determinants of health	50/50 standardization and innovation standardization of the core concepts (Community Health, SDOH, Population Health, Advocacy, Public Health, Community Engagement)	Learning about SDOH should be a requirement!

	Innovation is how these are achieved to meet local needs and individual resident interest – for example, block with longitudinal experience (i.e. required COPC project…)	