STARFIELD SUMMIT

...where primary care research inspires policy and practice

DISCUSSION TOPIC:

What Clinical and Social Needs Does the Public Need Family Medicine to Address?

Why this is important (brief description):

Family Medicine was founded in 1969 to respond to the need for community-based physicians to provide access to care across a broad scope of practice. Over the last 50 years, our patients, their health problems and the organization of care have changed dramatically. What problems in health and health care should the personal physicians of the future be trained to address?

What We Think We Know (Bulleted evidence + Seminal references):

American health and healthcare are getting worse, despite much activity, great expense and a major first step toward health care reform:

- According to the National Research Council Americans die earlier and are sicker compared to all other industrialized countries, despite outstanding performance in survival of very small babies, sophisticated transplants or major trauma—and this poor performance comes at cost in health care that is 2-3 greater than other similar countries. [i]
- American life expectancy began to decline as of 2014[ii], with disproportionate declines in rural areas, the result of many factors that include opioids & diseases of despair, but also rising multimorbidity.
- The explosion of chronic disease and increasing multimorbidity drive 75% of mortality, morbidity and cost, and increasing specialization, discoordination, and fragmentation (i.e. "every disease has a clinician") may be worsening, not improving health outcomes[iii] while increasing expense.

Communities face new threats that could benefit from Family Physician upskilling and community engagement[iv], including: 1) the threat of emerging infectious disease made clear by COVID, 2) epidemic opiate and other substance abuse, 3) systemic racism and health disparities, whose presence in our health system are recognized more than ever, 4) climate change and its impacts on health, 5) LGBTQIA disparities, 6) Gun and other violence, 7) an epidemic of loneliness with major clinical implications, and more.

The organization of health care has not kept up with the dramatic changes in disease and in society, and personal physicians must be trained to lead solving these problems:

- Transitions of care are a major cause of poor quality and high cost
- Vast and increasing obstetrical deserts and rising maternal morbidity, which may be related to accelerating closure of rural hospitals and decline in Family Physicians delivering obstetrical care[v]
- Lack of integration of behavioral and physical health, increasing cost and dyscoordination of care.
- Lack of integration of public health and primary care, highlighted by the COVID pandemic leaving community physicians and their communities on their own, without PPE, without data, without testing and often without connection—a match lit to tinder as our society confronts anew civil rights.
- Many stakeholders will be involved in the solution to these problems, but a key part of the solution will be a new generation of personal physicians with broader capacity and flexibility, willingness to serve both patients and communities and commitment to think differently about how best to organize care.

Questions for Group Consideration at the Starfield Summit:

1. To what extent should personal physicians be the spearhead of change and health and health care - and how can the major revision of residency requirements support this?
2. New models of care are required to improve transitions of care and prevent hospitalization and readmissions. How should residency requirements support this?
3. How can we train personal physicians to practice integration of physical and mental health, and how should residency requirements support this?
4. How do we support integration of medicine and public health, and how can residency requirements support this? How can we produce a new generation of personal physicians who attend to both needs of both their patients and the populations they take care of?
5. Does multimorbidity require a fundamentally new approach to residency education? How should residency requirements support the personal physicians of the future addressing better multimorbidity?
6. How can the residency revision help to create the development of personal physicians who lead the development of community resources and better connect the community and health care?
7. How will we train the personal physician of the future to engage with their patients at every level, starting with the doctor patient relationship and shared decision making to formal patient involvement in practice and health system governance to community organizations?

REFERENCES:

[i] Institute of Medicine and National Research Council. 2013. *U.S. Health in International Perspective: Shorter Lives, Poorer Health*. Washington, DC: The National Academies Press. https://doi.org/10.17226/13497

[ii] Woolf SH, Schoomaker H. Life Expectancy and Mortality Rates in the United States, 1959-2017. *JAMA.* 2019;322(20):1996–2016.

[iii] Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. *JAMA Intern Med*. 2019;179(4):506-514.

[iv] Folsom Group. Communities of solution: the Folsom Report revisited [published correction appears in Ann Fam Med. 2012 Jul-Aug;10(4):365]. *Ann Fam Med*. 2012;10(3):250-260

[v] Tong ST, Makaroff LA, Xierali IM, et al. Proportion of family physicians providing maternity care continues to decline. *J Am Board Fam Med*. 2012;25(3):270-271. doi:10.3122/jabfm.2012.03.110256