STARFIELD SUMMIT

...where primary care research inspires policy and practice

A 5th C? – Community Engagement – Family Medicine Residency Training

Why this is important (brief description):

U.S. primary care has long focused on the care of the individual patient, not the needs of the entire community. The patient-physician relationship was the dyad at the center of healthcare. But rising healthcare costs, poor health outcomes, and increased awareness of deep-rooted inequality in the US have underscored the flaws of practicing medicine by treating only the individual. It is now well understood that physicians cannot improve the health of the individual patient without addressing community level or social factors that impact health. Community engagement, long heralded as essential to Community-Oriented Primary Care (COPC) or Primary Health Care (PHC) globally, is an overdue element in the evolution of U.S. primary care. This 5th C is concerned with how to account for the local community's healthcare needs when planning, governing, and implementing health care services. Yet, five decades after the Folsom Report offered "communities of solution" as an approach for improving US healthcare, many physicians still work in silos and focus solely on the needs of the patient in front of them, leaving the health of the community as an afterthought. Training an effective family medicine workforce for the future will require a shift from teaching only care of the individual to teaching team-based care of individual patients in the context and through engagement of their communities. Adequate care for patients must account for social determinants of health and develop novel strategies for addressing negative determinants. The role of the primary care physician in this process is thus expanded to include public and community engagement.

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

- Social and community level risk factors clearly drive the health of individuals and communities, and if unaddressed in high risk patients, result in higher inappropriate utilizations of services, higher healthcare costs and poorer health.[1,2]
- Studies have shown that the physician alone is unable to meet the social needs of the patient and patients do not expect, or in some cases want, their physician to provide resources to address their social risk.[3]
- An effective approach to social determinants of health is to address the needs of the community.[5,6,7]
- Growing consensus exists that we should train future physicians on team-based approaches to meeting community needs where the physician is 1 member of a larger team including social care professions.[4]
- Primary care and family medicine may be a potent antidote to racial and health inequity.
- Curricular changes regarding community engagement improve residents' perceived understanding of population and public health. A multidisciplinary curriculum that encourages leadership, scholarly work, and community engagement can help to grow the community-based primary care workforce.
- "Communities of solution," as proposed by the 1967 Folsom Report, and Community Oriented Primary Care are concepts available to educators seeking to instill principles of community-engagement in training
- Identifying "cold-spots"—areas with diminished community support and access to health care—as opposed to traditional "hot spots" is important to improve health. Family physicians can assist in this process.
- Training in Place works: Residents with training exposures to community health centers, rural health clinics and critical access hospitals are more likely to work in safety net settings downstream.

Questions for Group Consideration at the Starfield Summit:

- How should primary care focus on individual patient social needs AND the needs of the community?
- What efforts are necessary to address individual patient social needs (hotspotting) and what efforts are necessary to address patient social needs at the community level (coldspotting)?
- How might public health and community-based organizations participate in or at least collaborate in family medicine education and residency training?
- Team training for family medicine residents should include…? Who is part of the team and how to actuate this broad team that can address social needs of patients and communities in residency training? Should we include local public health agencies in precepting our residents and practice teams? Should public health be part of that team? (BTW, the answer is yes.)
- What is the role of family medicine in health equity, race equity?
- How should residents and family physicians participate in local advocacy? How does participation in advocacy complicate the value of professionalism.
- What is the role of graduate medical education in health equity, race equity? It certainly should not contribute to worse inequity.
- Should primary care focus its efforts on the social needs of the individual patients or the social needs of the community?
- Should primary care clinicians be paid for managing individual patients' social needs or should payment be based on the social needs of the community in which the primary care clinician practices?
- What payment mechanism might support primary care efforts at addressing the social needs of our patients and communities?
- What type of training curriculum is best for teaching about the social needs of our patients and communities? Lecture, precepting, rotation, longitudinal, scholarly work, etc.
- What efforts may address implicit bias, explicit bias, really just bias, in residency training?
- How should residencies engage their community? As just a source of patients? Should every residency have a community advisory board? Or patient advisory committee?
- How should residents engage the community outside the exam room and practice walls?
- How much time should residents spend thinking about, learning from, and being involved in community events and activities?
- What community events and activities might have an educational value to residents?
- What community events and activities might a resident, faculty, or whole program provide value to?

References:

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4. On behalf of the Society of General Internal Medicine, Byhoff E, Kangovi S, et al. A Society of General Internal Medicine Position Statement on the Internists' Role in Social Determinants of Health. *J GEN INTERN MED*. Published online June 9, 2020. doi:10.1007/s11606-020-05934-8

5. Westfall JM. Cold-Spotting: Linking Primary Care and Public Health to Create Communities of Solution. *The Journal of the American Board of Family Medicine*. 2013;26(3):239-240. doi:10.3122/jabfm.2013.03.130094

6. Gotler RS, Green LA, Etz RS. *What 1966 Can Teach Us About the Future of Primary Care: The Case for Communities of Solution*. Milbank Memorial Fund; 2020. doi:10.1599/mqop.2020.0610

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