Re-Envisioning the Future of Family Medicine Residency Education
Conference Arrangements and Agenda
12.20 FINAL
Draft 5.7.20

Meeting Objectives:

1. Convene a diverse array of stakeholders to review evidence and discuss the future of family medicine residency education.
2. Develop consensus on key themes to be included in the major revision of the ACGME Family Medicine Residency Requirements.
3. Identify areas which require further research and dialogue.

Meeting Dates:

1. Sunday Dec 6th, 2020
2. Monday Dec 7th, 2020

Arrangements:

1) 70-90 people (59 in summit group including planning committee, plus 8 in ACGME writing group (led by Potts) and 5 in Residency Task Force (led by Magill) plus Kirk, Ogrinc, staff and some presenters)
2) Zoom based, with 50 on screen when possible, with WebEx as backup.
3) 3 main sessions of about 90 minutes each day, with breaks in between main sessions and optional social periods built in.
4) Questions will be taken by hands on video or through chat.
5) Planning committee and pre-identified partners will moderate sessions.
6) Technology assistance at the beginning of each day and available on call via text at 785-691-7660.
7) Summit planning group will be on cell phone text group to facilitate communication during sessions.

Principles for Promoting Active Participation and Consensus:

1) Summit members will introduce themselves and begin discussion of issues in MEDSHR Closed Community in October.
2) Participants will read materials in advance: draft papers and commentaries available on private social media site (confidential pre-publication), plus focus/discussion group results (all available at https://residency.starfieldsummit.com/ website). Background briefs and many key references will be available at this site.
3) Observers (ACGME Writing Group, ABFM Residency Task Force, Representatives of ACGME and ABMS) will observe on MEDSHR but will not speak unless formally a part of the program.
4) We will ask all participants to indicate their professional role in their Zoom name, i.e., PD, faculty, resident, Chair, RC-observer.
5) All participants with video on; observers will not have video on.
6) "Flipped classrooms", with no formal talks more than five minutes, 2/3rd time in each session will be discussion, in addition to Chat
7) We will have active moderators, with assistants reading chat. Moderators and assistants will be chosen largely from the Planning Committee members.
8) For overviews, no more than 5 minutes, commentaries no more than 3 minutes and comments/questions no more than 1 minute. We will start each session sharply on time. We will strongly encourage time discipline, both in presentations and questions. Speakers will try to avoid slides completely, or use as few slides as possible, so that for most of the time, screens will include mostly videos of summit participants.
9) Varying formats in each large session—large group, small groups, debate, with zoom polls to trigger discussion and record consensus.
10) Each session will have a conclusion via poll, summary comments by raconteur or small group report out in chat to larger group or in email.
11) Optional informal interactive breaks will be organized, two by generation and one by region of the country with icebreaker questions related to residency education.
12) Many of the participants will be serving as peer reviewers of the core papers and commentaries.

13) The emphasis on the first day will be evidence, with reflection and integration second day.
14) We have tried to include many of participants as presenters
15) Small groups will be sized to promote conversation. Participants will sign up for small groups on particular areas of clinical interest and expertise before the meeting. Other small groups will be assigned by career phase and region. Career phase groups will meet twice to facilitate familiarity among participants. Observers will not be a part of small groups to limit size and facilitate free discussion.

December 6 (all times EST)

10:00am-10:45am EST
Optional Icebreaker: Small Groups, randomly assigned. Introductions and Question: How would I change residency education, followed by Zoom meetings random 6-8 people per group, with introductions. Also, technology assistance available now and on demand during conference.

Participants should sign on to main session between 10:45-10:50.

11:00am-12:45pm EST
Session 1: What Does Society Need from Family Physicians?

Even before the COVID-19 pandemic, there was ample evidence that the overall performance of US health care system is poor. We are sicker, live shorter lives, and health disparities continue to grow, all at much greater expense than peer countries. In the last 40 years, the gap in life expectancy between the US and other countries of similar wealth has grown. More recently, despite health care reform and a major economic expansion, our life expectancy has begun to fall - even before COVID-19. This session will explore what Society needs from family physicians. What are the major clinical and health problems that the family physicians of the future must be able to address?

A related question is the benefit of primary health care. There is substantial evidence that the 4 Cs (first contact care, continuity of care, comprehensiveness, and coordination of care) are core functions of primary care and are critical for the health of the public. However, more than a generation has passed since they were articulated and studied by Barbara Starfield. Should these attributes be the foundation for future family medicine residency education? If so, should they be adapted, given the changes in health care in the US in the last 30 years? Furthermore, with the lack of progress in assuring health equity coupled with widespread acknowledgement of the key role of the social determinants of health, what is the case for including community as a core function of primary care and in the residency education of family physicians?

Moderators: Warren and Karen

11:00-11:10am: Welcome, Introductions, Observers, Ground rules, Arrangements, Greetings from ACGME Dr. Kirk (3 minutes), ABMS Dr. Ogrinc (3 minutes) (Karen)

11:10-11:20 am: Introduction: Overview of Framework, what isn't on the Agenda, Schedule. (Warren)

11:20am-12:10pm EST: What does society need from family physicians?

Improving health and health care will require many partners and myriad changes across delivery systems, education, and society. Foundational to this, however, will be personal physicians who will take care of most patients and most clinical problems in communities. What clinical and healthcare challenges are so important in terms of quality of life, morbidity, and cost that ***all*** *family medicine residents in the next 15-20 years must be able to address them?*

Presentations (11:20-11:45): Kahn (overview-5 minutes), Bazemore (The 4Cs and Community-5 minutes); Short Reactions: Howard-Early Career, Bowen-Mid-Career, Bachelder-Late Career (3 minutes each)

Moderator: Karen

Large Group: Questions for discussion (11:45-12:05):

1. What are the most important clinical and health problems of the next generations we must address? What else should we consider? What shouldn't all family medicine residencies address?
2. Should first contact care, continuity, comprehensiveness, and coordination be the foundation for family medicine residency education? Should we include community as a fifth C?

Zoom Polls (12:05-12:10: What clinical and health care problems should all residencies address? (choose all of the above) Should the 4Cs, adapted for the 2020s, be the foundation of family medicine education? (yes/no) Should Community be a core part of family medicine residency education? (both yes/no)

12:10-12:45pm EST Scope of Care Trained in Residencies

Moderator: Warren

Presentations (12:10-12:25): Austad-Hospital, Barr-Maternity Care, Degruy-Behavioral Health, Wheat-Communities and Public Health, Schmitz-Rural Health and Health Care, Misra-Osteopathy, (3 minutes each). These presentations will make the case for why it is important for family physicians to train for and what training should consist of.

Large Group Question for Discussion (12:25-12:55): What scope of practice should all family medicine residences train for?

Zoom Poll (12:55-1:00): What Scope should all family medicine residencies train for? Pure continuity, ambulatory + inpatient medical, continuity + inpatient medical, continuity + inpatient medical + maternal/infant/childcare, other

1:00-1:30pm Break

1:30-3:15 EST pm

Session 2: How should the new residency requirements support our response to society's needs?

How should the new residency requirements support our response to what society needs? The Family Medicine Residency Requirements sets the accreditation standards for all family medicine residencies in the US—and graduation from an ACGME accredited residency is a requirement for Board certification. Yet residency requirements are not merely a list of desirable curricula—they are standards set for what must be done, and they must set rules for all residencies. In this sense, they are the "basement". At the same time, in recent years, a variety of educational accrediting bodies have begun to lead rather than follow change, notably in interprofessional education and diversity. This session will ask what the standards should include to support residencies as they strive to meet society's needs.

1:30-2:35 pm What should the residency requirements include?

Moderator: Karen

1:30-1:40: Welcome Back. Greetings from the ACGME Writing Committee--Dr. Potts (3 minutes) with comment on ACGME context of initiatives around disparities, diversity) and the ABFM Residency Task Force--Dr. Magill (3 minutes, about the requirements for board eligibility and support of career development and mastery)

1:40-1:55: Presentations: Arenson-Team Based Care, Bartell-Multimorbidity, Gravel-Professionalism, Liao/Lehmann-Patient Engagement, Elliot-Addressing Diversity and Disparities-3 min each

1:55-2:00: The Charge to the Small Groups

2:00-2:25: Small groups 8-10 people, participants will sign up in advance, observers will not participate. Each group will review the relevant commentaries in advance and will focus on developing 1-3 recommendations for the RC. These are challenging problems, often with no consensus: we encourage robust discussion. Each group will have twin leads—someone with content expertise, and a facilitator who will also scribe/report out.

a. *Integrating behavioral health*: How can we train personal physicians to practice integration of physical and mental health, and how should residency requirements support this?
b. *Integrating community and public health*: How do we support engagement in communities and social determinants of health and integration of medicine and public health, and how should residency requirements support this?
c. *New models of hospital care*: New models of care are required to improve transitions of care and prevent hospitalization and readmissions. How should residency requirements support this?
d. *Responding to Obstetrical deserts and increasing maternal morbidity/mortality?* What should be the requirements for maternal care in residencies?
e. *Multimorbidity/Complex patients*: Does multimorbidity require a fundamentally new approach to residency education? How should residency requirements support the personal physicians of the future addressing better multimorbidity?

f. *Professionalism*: Professionalism is foundational to the social contract, and over the last 15 years, medical schools have incorporated substantial curricula on this topic. What should family medicine curricula do?
g. *Team-based Care*: There is general consensus about the importance of team-based care. What are the priorities for residencies in training team-based care, and how should the residency requirements support it?
h. *Improving Rural Health*: Over the last generations, the mortality differential between rural and urban areas has increased. Family physicians are critical for health and healthcare in rural area. How should the residency requirements support rural GME and preparing graduates for service in rural areas?
i. *Addressing Diversity and Disparities*: We are living in an age of a new civil rights movement. ACGME has a major institutional requirement to promote diversity and inclusion. What should family medicine residencies prioritize to promote diversity and address disparities, and how should residency standards support that?

2:25-2:35 Reconvene in large group. Report out of the most important recommendations by group (one minute/one recommendation each). Facilitators will also put recommendations in chat. Each team reports out their 1-3 recommendations in the chat, scribes send documents for compilation.

2:35-3:15pm EST : The Practice is the Curriculum

Moderator: Warren

The family medicine residency practice is a key component of the education of our residents: in many ways, the practice ***is*** *the curriculum. And, given what we know about imprinting, much of what determines the long-term potential benefit of personal physicians in addressing the triple aim is set in residency. So, what should the residency clinical practice look like? For two generations, residency requirements have emphasized the structural components of family medicine residencies, such as size, staffing and faculty control by residency faculty. While important, these characteristics may be less important in the current environment than the process and outcomes of residency continuity practices, such as access, quality, referrals, continuity, and cost effectiveness, all of which can be measured and managed. Moreover, how will we involve patients, from governance and patient advisory councils, to QI to shared decision making?*

2:35-2:45: Presentations: Neutze-The Practice is the Curriculum (5 minutes), Commentary (3 mins): Phillips-Imprinting

2:45-3:15: Large Group Open Discussion: Frame as three different questions and zoom polls post-discussion (10 minutes each)

Should well-defined panels of patients and clinical performance reports (access, quality, referral rates, continuity, and cost effectiveness) for residents be included in program requirements?

Organization of the FMC: Should patient engagement be built into residency requirements? (advisory panels, QI, shared decision making)

Should residency requirements address size, staffing and control by residency faculty? How should residents be involved in practice administration/practice management?

3:15-4:00pm Break

4:00-5:30pm

Session 3: How should we teach?

Beyond what to teach is how to teach. Since our founding 50 years ago, pedagogy has changed dramatically, and our paradigm is changing from a focus on experience to a focus on competency. Moreover, led by ferment in Canada and in undergraduate medical education, there is increasing interest in the duration and sequencing of graduate medical education.

4:00-4:50pm: Implementation of Competency Based Medical Education

Moderator: Warren

4:00: Welcome Back and Introduction to this session

Over the last 15 years, competency-based education has spread across health professions education. The first model in medicine was in orthopedic residencies, but more formal competency assessment is beginning to spread to many different specialties and professions. The COVID pandemic has highlighted the competency basis of decisions made about readiness for autonomous practice, especially in 2021. The challenge in a generalist discipline is how and how much to implement formal and explicit competency-based assessment.

Introduction/pre poll: How aggressively should Family Medicine implement competency-based Medical Education in family medicine residency education? (Scale: not implement to as aggressively as possible)

Presentations: (4:00-4:13) Holmboe/Saultz/Allen: The Case for CBME in a generalist Strategy for Implementation, the Gaps between Theory and Practice, The Perspective from Implementation of the ACGME Milestones

4:15-4:25: Invited Commentaries from Faculty, DIO/Chair McCrory, McCarter (3 minutes each).

4:25-4:50: Town Hall/ Questions from the Floor

- What should be the goal for residencies? What is practical?
- What is the right balance between experience/time—for example, counting weeks of curriculum or numbers of visits (counting numbers) and explicit of specific clinical competencies?

Close: Repeat Zoom poll: How aggressively should Family Medicine implement robust competency-based family medicine residency education? (Rank on scale 1-10)

4:50-5:30 EST: Duration and Sequence of Training

Moderator: Karen

In recent years, there has been increasing interest in the duration and sequencing of residency training. Since 1969, family medicine training in the US has been 3 years, and the vast majority of family physicians do not subspecialize; internationally, there is a range to 2 to 5 or more years. What should the right duration of core residency training be? In addition, other specialties have benefited from an additional period of training—the development of case lists, along with an oral exam or presentation of data.

Introduction, pre-Zoom Poll 3 vs 4 vs 3 + 1 mandatory vs 3 + 1 optional (will need introduction of options)

4:50-5:05: Presentations: Douglass-4-year, Woolever-3-year, Newton-Lessons from other Specialties, Fowler-Canadian perspective

5:05-5:25: Questions from the Floor

Close Zoom Poll: 3 vs 4 vs 3 +1 (mandatory) vs 3 + 1 (optional)

5:25-5:30 pm **Wrap up and instructions for next day**

5:45—OPTIONAL GROUP MEETINGS

5:45-6:30 Optional small group meetings by career phase—early, mid, late career. Participants will have signed up with their groups. Staff will pre-assign to groups of approximately 10: Patient and public members to meet separately.

5:45-6:45 ACGME, ABFM observer groups will meet in parallel. (meetings hosted by Potts/Magill)

7:00 Summit planning group—observations, midcourse corrections

Day 2:

10:00-10:45am EST OPTIONAL BREAKFAST MEETINGS

Optional Breakfasts: 6 groups by region, with participants self-selecting. Staff will post definition of regions. Introductions and discussion topic—what are issues most important for your region? Summit planning group to attend and share notes on chat in the large group meeting following.

Please sign into main session by 10:45.

11:00am-12:20pm Session 4

11:00-11:30 am

Large Group: Where are we after 24 hours?

The purpose of this session will be to give an opportunity for the group to comment/react to the discussions so far. What are the big lessons? What have people learned?

Moderator: Warren

Regional Differences: informal reflections from morning icebreaker? What are important regional considerations?

Town Hall format: Reflections over Night: What have you learned? What are questions which still need to be answered?

11:30-12:20pm EST

Long Term Adaptability: (Large/Small Group Hybrid)

Moderator: Karen

As the COVID pandemic has demonstrated, adaptability is a key feature of family physicians as they meet the needs of their community, either in the short term or over careers. What are the most effective ways of preparing family physicians to be master adaptive learners? It is important to include not just knowledge, but technical skills, communication, and the professionalism needed to respond to community needs and to improve care.

11:30-11:45: Presentations: Edje/Price (5 minutes), Commenters by career phase Okwuwa-Early, Shih-Mid, McVay-Late (3 minutes each)

11:45-12:05: 12 groups by phase of career (4 each, early, mid, late). Participants will self-assign in advance of the meeting.

Question: What or how must residents learn in order to be adaptable over their careers? What should we build into residency training?

Each individual will take 2 minutes to silently reflect on one aspect of residency training which should be mandatory in order to support the development of family physicians as master adaptive learners, then the small group will share and prioritize. Each group will self-organize and come with 2-3 ideas to present to the larger group. Each group will also post recommendations on chat at the large group session.
12:05-12:15: Report out one idea per group

12:15-12:45pm Break

12:45-2:30 pm EST Session 5

Building a National System for Ongoing Improvement in Residency Education.

We are gathered to give recommendations about standards for family medicine residencies. But our task is more than scope of practice, core topics and assessments, it is also about developing a national system of residency education that continues to improve over time. In this context, at this moment in history, we face two fundamental questions. First, what is the right balance between innovation and standardization? And second, how can we optimize residencies' ongoing quality improvement of their educational and clinical programs?

Moderator: Warren

12:45-1:30pm Innovation vs Standardization

The first RC requirements for Family Medicine were elegant and short (only four pages long!) --and underscored the need for innovation. Over the last 15 years, there have been four major trials of innovation in residencies-P4, I3, LOT, RPI and a fifth CLINIC FIRST starting. However, there are anecdotal reports from employers and evidence from the family medicine milestones that significant numbers of residents are graduating without achieving proficiency in many milestones. Should we promote as much innovation as possible or underscore the importance of competence on departure?

Moderator: Warren

12:45-1:05 Presentations: Carney: Why innovation is important for developing standards. (5 minutes), Garvin- Why standards are necessary if innovation is to be meaningful. (5 minutes), Commentaries: Clements-Family Medicine Milestone Data, Peterson-Graduate Survey Data, Araujo-comment from Residency director

1:05-1:25 Discussion: What is the right balance between Innovation/Standardization? How can the RC requirements help this?

1:25-1:30 Post Discussion Zoom Poll—balance 1-10 for innovation/standardization

1:30-2:05pm EST: **Continuous Quality Improvement of Residencies**

Dramatic shifts in both pedagogy and clinical care have created huge pressures for change in family medicine residencies over time. How robust has ongoing self-review and continuous quality improvement been among Family Medicine residencies? How responsive have residencies been responding to community needs? In addition, as a component of its implementation of the Next Accreditation System, the ACGME has instituted a variety of mechanisms for ongoing review or programs, including surveys of residents and faculty and the Spotfire system with ongoing submission of residency data. How effective have these mechanisms been?

Moderator: Karen

Prepoll: Effectiveness of Program CQI, Effectiveness of ACGME Review

1:30-1:50 Presentations: CQI of Residencies (Carek 5 minutes), Social Accountability (Kaufman 5 minutes); Reactions by Program Directors x 1, DIO x 1 (Villalon-Gomez, Lefebvre 3 minutes each)

1:50-2:05 Discussion topics: How effective are residency processes to improve quality of education and clinical care? How can the standards improve ongoing review? How can ACGME oversight be improved? What data or processes would help residency programs and their sponsoring institutions improve their learning environments and community responsiveness in the future?

2:05: Post-zoom poll: Carek themes.

2:05: 2:30: **ACGME Scenario Planning Themes** (5 mins), followed by 20 mins discussion. Dr. Stacy Potts, Chair ACGME Family Medicine Writing Group

2:30-3:30 pm Break

3:30-4:30 EST: Session 6
The Future of Family Medicine Residency Education: What Does Society Need from Family Medicine Residencies?

Moderators: Karen/Warren
We return to where we started. What does society need from family physicians over the next generation? Over the last two days we have discussed the foundation of training in terms of the clinical and health problems family physicians need to be able to address, the foundations of the primary care health benefit, what we should teach, how we teach, how we can help family physicians to become

master adaptive learners to meet the needs of their communities and over their careers, and keeping the system of residency education healthy. In this final session, we return to our initial questions, and ask the questions: what role will we play in meeting the needs of society? How much change is necessary in our residency training programs?

Another important question is the future of the specialty. Please review in advance the papers on the diversity needed for the specialty in the future and developing future teachers, researchers and leaders.

Moderators: Warren and Karen

3:30 Pre-Zoom poll: if there is no change, will family medicine residencies as currently organized meet the needs of society over the next 25 years? (1-10) How much change should there be? (1-10)

3:35-3:40 Public Members Report Reflections

3:40-4:05 Large Group Reflections:
What did you learn?
What surprised you?
What inspired you?
How will this contribute to the future of the specialty?

4:05-4:30 Wrapping up
Summary of Summit Themes from 2 days
Discussion

Zoom poll: if there is no change, will family medicine residencies as currently organized meet the needs of society over the next 25 years? (1-10) How much change should there be? (1-10)

Conclusion: next steps, what to expect?
What will you tell others about this summit?

4:45-5:30 EST Optional Observer meetings

Summit planning group (learnings, next steps)
ABFM, ACGME observer groups optional meetings