Family Medicine Updates

From the North American Primary Care Research Group

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NAPCRG LAUNCHES VIDEO TO PROMOTE PRIMARY CARE RESEARCH

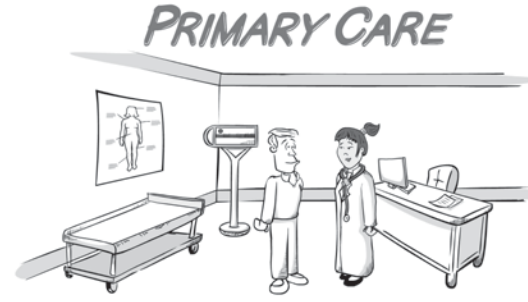
At the 44th Annual Meeting of the North American Primary Care Research Group (NAPCRG), held in Colorado Springs, Colorado on November 12-16, 2016, NAPCRG launched a new state-of-the-art YouTube video to stimulate interest in primary care research among trainees and community clinicians and explain the importance and impact of primary care research on patients and community. The video was produced by the Reframe health lab, with the same hand-drawing style as their popular "23 and ½ Hours" video promoting exercise.

NAPCRG recognizes that it is difficult to engage physicians in primary care research as there are a number of perceived barriers to conducting research in a primary care setting, including writing and submitting grant proposals and writing and publishing papers. The goal of the video is to help break down these barriers and encourage primary care research in community practices and to encourage students to pursue academic endeavors such as primary care medicine and research.

The video introduces students, residents, and practicing physicians to the resources of the American Academy of Family Physician's National Research Network (AAFP-NRN), the North American Primary Care Research Group (NAPCRG) and many regional practice-based research networks (PBRNs). These organizations and networks can provide nascent researchers with the support and skills they need to break through the barriers that prevent them from carrying out primary care research either by themselves or in collaboration with colleagues. The video shows that primary care physicians involved in these organizations are exposed to novel ideas and research, which can lead to practice improvements that put their practices years ahead of their colleagues. Collaborating with academic researchers, thought leaders, editors of primary care research journals, and heads of government agencies provides for a fertile exchange of ideas and makes the practice of medicine much more rewarding.

NAPCRG has also developed a webpage to supplement the video that provides resources to those interested learning more about primary care research and its impacts.

The video is available on the NAPCRG website, as well as NAPCRG social media channels and YouTube.



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FAMILY PHYSICIANS PLAY INTEGRAL ROLE IN EMERGENCY MEDICINE

In 2010, *Annals of Family Medicine* published an article on the challenges facing family physicians providing emergency care.[1] Since that time, the American Academy of Family Physicians (AAFP) has encouraged and supported activities that have increased visibility for those family physicians providing emergency and acute care. The AAFP "special interest group" renamed the Member Interest Group Emergency Medicine/Urgent Care (MIG EM/UC) (http://www.aafp.org/about/member-interest-groups/mig/emergency-medicine.html) offers a unique forum for family physicians practicing emergency medicine and urgent care. Family medicine includes urgent care, but family physicians within emergency medicine (EM) continue to face critical practice challenges. As a specialty, new strategies are needed for promoting the essential role of family medicine in emergency care. The challenges are escalating, and we must not be complacent.

AAFP policy emphasizes that family physicians are trained in the breadth of medical care and, as such, are qualified to provide emergency care in a variety

of settings. This important AAFP policy has yet to be incorporated into health policy. Joint training programs between the American Board of Family Medicine (ABFM) and the American Board of Emergency Medicine (ABEM) provided an important organizational milestone, but did not solve the issue. Workforce data now provide compelling evidence that family physicians will always be an essential part of the EM workforce, but EM specialty societies are "specialty centric" (doing what is best for the specialty of organized emergency medicine) instead of "patient centric" (doing what is best for patients). Restrictive credentialing and hiring biases against family physicians are still widespread and may be accelerating. According to recently reported events on the AAFP MIG EM/UC message boards, even family medicine physicians with 10 to 15 years of experience in EM are being displaced from their jobs. This phenomenon is occurring even as short-staffed emergency departments are hiring advanced practice providers due to workforce shortages.

The United States is recognized internationally as the leader in EM and family medicine (FM) specialty training. But this excellence may have hindered cooperation between the specialties. Forty years ago EM became an American Board of Medical Specialties (ABMS) "primary specialty" with the support of the ABFM. Some of the pioneers of this new specialty were family physicians who recognized the close similarities and envisioned "extensive cooperation between EM and FM."[2] In subsequent decades, however, EM was unwilling to recognize its historical and intrinsic relationship with FM.[3,4] Globally, the situation is different, since EM is "specialty led," but not "driven" (by perceived competition).[5] In other countries, family medicine training is recognized as providing an important foundation for emergency medicine training. In Canada, physicians can either complete a 1-year emergency medicine fellowship after an FM residency, or can train in a 4-5 year program similar to the specialty training of EM residencies in the United States. The Canadian system provides a helpful model for rural emergency departments in the United States. Residency-trained emergency physicians provide academic leadership to the specialty, but family physicians are recognized for their essential role in providing emergency care. This is not limited to Canada, since many other countries have developed emergency medicine training as an adjunct to primary care.

Family medicine is dynamic and remains committed to improving the training of family physicians in EM. Emergency care remains a part of family medicine residency training requirements, and discussions around length of training and content has led to expansion of the required emergency department (ED) clinical experience. The 2016 Program Requirements in Family Medicine demonstrate continued attention to emergency care training. The required curricular time has been clearly defined, requirements for advanced life support have been clarified, procedures for both medical and trauma emergencies are specified, and the minimum experience with pediatric and critical care patients have been delineated. Fellowships for family physicians provide enhanced skills in EM, and there are currently 10 programs listed on the AAFP website, with others throughout the country. The increasing number of EM fellowships show FM's continued emphasis on improving quality of care in the ED. These provide advanced education in EM for FM-trained physicians who plan to practice EM full time, regardless of location.

The reality of the emergency medicine workforce is best seen in the marketplace, not in academic publications. In spite of restrictive positions on ED credentialing by the 2 leading EM professional societies (American College of Emergency Physicians [ACEP] and American Academy of Emergency Medicine [AAEM]), emergency medicine has new CME products aimed at family physicians. The EM Academy offers "a 3-phase crash course in emergency medicine basics for physicians and advance practice providers who are new to the ED," and the Center for Medical Education offers 2 levels of EM boot camps, including an "Advanced Emergency Medicine Boot Camp: The Master Practitioner." These entrepreneurial programs recognize the actuality that family physicians are an essential part of the workforce.

AAFP policy emphasizes the essential role of family physicians in providing rural emergency care: in rural and remote settings, family physicians are particularly qualified to provide emergency care. The rural practice of medicine requires a broad skill set since this is a resource- and subspecialty-limited environment. There are more limited diagnostic and treatment modalities and limited specialty backup available. There are often no trauma teams (except the ED staff), and fewer subspecialists available. Skills in obstetrics are important, as well as admitting privileges from the ED. (Most residency-trained emergency physicians have limited obstetrical skills and a philosophical objection to admitting patients). Family physicians in rural areas care for their patients from the cradle to the grave, during chronic illness and acute, life-threatening events. Emergency care is an integral part of this.

In 2001, Williams and Prescott called for a "shift in thinking and action" to address the issues facing rural EDs.[6] Fifteen years later, these changes have still not occurred. EM's perspective is myopic and has focused solely on trying to get more EM residents to

rural areas. Family medicine has been almost entirely excluded, even though most rural EM care is provided by family physicians. Not only are these physicians essential to the workforce, but in remote and wilderness areas family physicians currently supplement the shortage of ABEM faculty. This arrangement could be expanded to other rural EDs.[7] Compounding this problem, when EM residents go to rural areas, retention is difficult due to lack of family connections, financial incentives, and access to specialists.[8]

But these issues are not limited to rural EDs. A recent study showed a startling fact that should challenge current paradigms: family physicians are essential in all types of EDs. Banks et al[9] showed that even in urban ERs, patients are likely to be cared for by a family physician. This study, from the Robert Graham Center for Policy Studies in Family Medicine and Primary Care, challenged the assumption that family physicians are only providing emergency care in rural EDs. Family physicians' contribution to emergency care was substantial even in urban EDs, and there was no significant difference between the complexity of complaints. Rural and urban EDs are also influenced by patient satisfaction metrics, and generate ED competition and influence revenue. FM training provides an edge in this area with its focus on patient-centered care and communication.

In 2006, the Institute of Medicine (IOM) provided a mandate for EM organizations, emphasizing "collaborative efforts between specialties, and core curricula for all physicians involved in emergency care...Family physicians are an essential component of the ED workforce with a high level of competency in emergency care through a combination of residency and post-residency education, directed skills training and on-the-job experience." But emergency medicine organizations have failed to respond to this mandate.[10]

Opportunities for change exist, but the catalyst for change needs to come from outside the specialty of EM. Family medicine should take initiative with other health policy organizations such as the Joint Commission: Accreditation, Health Care, Certification (JCAHO), the Centers for Medicare & Medicaid Services (CMS), and the American Heart Association to help implement these changes. We need to make it clear that family physicians have an essential role in EM. Health care executives need to be aware of the strengths that family physicians possess in patient-centered care. Today's EDs are far more than just ERs; they function as intersections between inpatient and outpatient care.[11] A recent article in *Annals of Emergency Medicine* identified the centrality of EDs in addressing community health and the social determinants of health.[12] Socially and medically complex patients make up an increasing number of ED patients. Family physicians are well suited to addressing these patient- and public health-centered issues that influence EDs function, throughput, and efficiency.[12] With persistent shortages of residency-trained emergency physicians, plus new external changes facing all EDs, there is an urgency to identify staffing models that are dynamic and collaborative, and recognize the importance of family medicine. Now and in the future, staffing models that include family physician leadership will offer an ideal structural arrangement for rural, community, and even urban hospitals.

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