Family Medicine Updates

ADFM Association of Departments of Family Medicine
VISION, VOICE, LEADERSHIP
From the Association of Departments of Family Medicine

Ann Fam Med 2011;9:274-275. doi:10.1370/afm.1272.

EDUCATION OF STUDENTS AND RESIDENTS IN PATIENT CENTERED MEDICAL HOME (PCMH): PREPARING THE WAY

The American Academy of Family Physicians, in conjunction with the American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association published *Joint Principles for the Medical Education of Physicians as Preparation for Practice in the Patient Centered Medical Home* in late 2010. The principles of the Patient Centered Medical Home were defined in terms of the attributes/competencies needed. The major components of the Patient Centered Medical Home include: an ongoing relationship between a patient and his or her personal physician; a physician-directed, team-based care model; whole person orientation; care coordination / integration; quality and safety as hallmarks; enhanced access to care, and finally, payment that appropriately recognizes the value added. The corresponding educational sub-principles for each major attribute of the Patient Centered Medical Home were written describing the learning objectives for medical students and residents to learn the competencies necessary to actualize these components in the care of patients and families.

In December 2010 the Association of Departments of Family Medicine (ADFM) distributed a survey to chairs of all departments requesting information about how we teach medical students and residents about PCMH. The response rate was over 50%. Ninety-five percent of responding departments reported that they were involved in some aspect of medical student and/or resident education in PCMH. The curricular components most often listed included the utilization of EHRs, defining and implementing appropriate access, e-prescribing, implementation of group visits, care management programs, utilization of chronic disease registries, rapid cycle quality improvement methods, e-mail/other asynchronous communication, and referral tracking. Survey data revealed that 41% of departments had implemented a specific PCMH curriculum for medical students and 65% had developed a PCMH curriculum for residents. The table below illustrates the utilization of different PCMH topics and methods. Curricular teaching methodology revealed that didactic conferences were used much more often in the teaching of medical students when compared to residents. This difference may be because students are in departments and clerkships for a limited block period of time compared to residents' longitudinal experience. On the other hand, curricular elements/methods utilized in resident teaching were quite varied, including didactic conferences, longitudinal projects, work with panels in population health, implementation of rapid cycle quality improvement methods, the use of group visits and specific training in team based care. Each of these content areas were mentioned with nearly equal frequency.

The majority of respondents also indicated a willingness to share their curriculum with others either in a presentation format at meetings or in a shared publishable form.

ADFM plans to develop and share a compendium of well-defined curricula that teach the education principles elucidated in the joint principles document. Other family medicine organizations will be contacted regarding those residency programs that are not administered by departments in order to learn what kinds of PCMH curricula and teaching may occur in these programs. The evolution of the Patient Centered Medical Home must move beyond practice redesign into curricular redesign, so that we can most effectively train the family physicians of the future. This will be a significant component of family medicine teaching, learning and research. Sharing examples of how to manage this curricular transition is an important part of our educational leadership – creating trans-

PCMH Curricular Components

	Medical Students	Residents
Didactic conferences	26	39
Longitudinal projects	11	33
Work with panels/population health	9	33
Specific training in team based care	15	32
HIT innovations to improve care	17	34
Use of disease registries	9	33
Group visits	9	34
Rapid quality improvement	8	36
Other		

formed practices in which students and residents can experience these innovations first hand.

Clearly this is a topic which has great interest within a broad swath of family medicine. We will work closely with other organizations in the family of family medicine and the Council of Academic Family Medicine (CAFM) to coordinate efforts in this area and disseminate materials to the widest possible group.

Alan David, MD; Libby Baxley, MD and the ADFM
This commentary was reviewed by the PCMH Taskforce Co-Chair and members of the ADFM Executive Committee.

Reference

1. *Joint Principles for the Medical Education of Physicians as Preparation for Practice in the Patient Centered Medical Home.* December, 2010. http://www.acponline.org/running_practice/pcmh/understanding/educ-joint-principles.pdf.

From the Association of Family Medicine Residency Directors

Ann Fam Med 2011;9:275-276. doi:10.1370/afm.1273.

INNOVATION IN FAMILY MEDICINE RESIDENCIES: STRUGGLING TO CREATE CLASSICS FOR THE FUTURE

"Innovation distinguishes between a leader and a follower." Steve Jobs

"Innovation! One cannot be forever innovating. I want to create classics." Coco Chanel

Program directors work each day to produce graduates prepared for future practice yet rooted in the ideals and values of the classic family medicine past. Residency programs are currently engaged in a dramatic outburst of activity in new curricular models as well as practice transformation directly involving residents, most commonly using the PCMH model. Students and residents show great enthusiasm for this new model which provides them a possible path out of a "hamster care" future as health care payment models begin to move away from a fee-for-service methodology.

The AFMRD Board of Directors considers the "support and spread of innovation in family medicine residency education" as a major component of its 2011 strategic plan. Defining "innovation" can be a challenge. Does it actually enhance residency recruitment, provide better service for patients, deliver better quality, or ensure our graduates can deliver the new models of care? Is it disruptive or incremental? Will "innovative" ideas actually result in a better family physician? How will we know?

Working with other family medicine organizations through the Council for Academic Family Medicine (CAFM), the AFMRD has developed an "Innovation Needs Assessment Task Force" to create and administer a needs assessment inventory. The task force's gap analysis of the current mechanisms to support mutual assistance and shared learning across multiple residency sites will help identify a strategy to measure and track the scope of innovation in the nation's residencies and family medicine departments. The task force will also create a communications strategy to disseminate the scope and impact of family medicine innovation to students, policy makers, and the public.

The AFMRD efforts in promoting innovation include enhancing inter-program collaborative efforts and providing program director input for the revision of RC-FM requirements that would more easily allow for innovative training. In addition, the development of Web-based platforms has been shown to be an effective means of supporting innovation and outcomes. TransforMED has created Delta Exchange, an interactive, asynchronous tool to share what's being learned and to engage other innovators. The AFMRD worked to secure free access to this for our members (http://www.transformed.com) to further enhance conversations about transformation and take advantage of this next generation interactive tool.

Is there funding out there to support innovation? The donations of $30 million by an anonymous donor to Harvard Medical School and another $20 million to Boston's Partners Healthcare for the express purpose of supporting innovation in primary care tell us yes. Since these donations went to 2 institutions that do not formally even acknowledge the specialty of family medicine (no clinical or academic department in either one) suggests that the builders of the old medical-industrial complex still hold sway in the psyche of many of our nation's power brokers. FM residencies need to become a network of "innovation exemplars" and better communicate these examples to those outside the discipline which may assist us in attracting more financial support.

What about upcoming ACGME revisions to the program requirements? Will barriers to residency innovation be reduced? We think the answer is yes, but with a caveat. The freedom of having reduced prescriptive, time-based, check-off requirements creates more space for innovative ways to train residents, but the burden of proving actual outcome competency measures is also more present. External accountability of our graduates will also inevitably increase. We