Family Medicine Updates

From the Association of Departments of Family Medicine

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WHERE WE'VE BEEN & WHERE WE WANT TO GO: ADFM'S 40TH BIRTHDAY MEETING

ADFM celebrated its 40th "Birthday" at our annual Winter meeting in Washington, DC with champagne, cake, singing and dancing, the return of 20 former members to help us reminisce, and reflection on where we have been and where we should be going. As incoming President Kevin Grumbach, MD, described in his keynote, "Finding Vision, Voice, and Leadership in Turbulent Times," ADFM has evolved over the past 40 years from a focus primarily on socializing and commiserating (the "golf and gripe club") to a purposeful and strategic focus with substantive annual meetings and strong collaborative partnerships within and external to family medicine. ADFM's mission is: "…devoted to transforming care, education, and research to promote health equity and improve the health of the nation" and our stated values include excellence, integrity, inclusion, respect, and compassion.[1] In these times of turmoil, fear, and partisanship, Dr Grumbach encouraged us to consider ADFM's role within the theory of collective impact, and left us with a call to action, quoting Don Berwick, MD, MPP, "… silence is now political. Either engage, or assist the harm. There is no third choice."[2]

Given this broader context, and the impact of current national policies and politics on health care, we offered a well-received preconference on Federal Advocacy, led by Hope Wittenberg, MA, Director of Government Relations, and Terrence Steyer, MD, Chair at the Medical University of South Carolina. As follow-up to this work many attendees made visits to their legislators and legislative staff during the meeting.

We continued our major theme of resilience from the past several meetings, and Tait Shanafelt, MD, Chief Wellness Officer and Associate Dean at Stanford School of Medicine shared data on burnout and resilience, focusing on individual and, more importantly, organizational approaches to physician well-being. Mercedes Alonso, MEd, MS, an organizational consultant, led an invigorating group exercise on how to build culture intentionally within our departments; Rusty Kallenberg, MD led the first-ever optional "book club" meeting focusing on culture and resilience in "Attending: Medicine, Mindfulness, and Humanity" by Ronald Epstein, MD; and the Building Research Capacity team shared ideas and encouraged discussion within departmental teams on creating a "culture of scholarship."

With an eye toward the future, other major sessions at the meeting included: Thomas Agresta, MD, MBI, from the Connecticut Institute for Primary Care Innovation,[3] presenting on ways in which leaders can interface with technology; a panel of members on innovative ways to excite and engage learners; and a panel of former ADFM members sharing about change management in turbulent times.

In recognition of this future state, where the importance of patient engagement and the patient's experience of care only continues to grow; and given ADFM's stated value of compassion, where "we commit to keeping the patient as the central focus," the ADFM Board has added a public member for the first time. We welcomed Julie Moretz, assistant vice president of Patient- and Family-Centered Care/Chief Experience Officer for Augusta University Health in Augusta, Georgia to our meeting and are already appreciating the "public" and patient advocacy perspective she brings.

As one tactic to begin to address our organizational emphasis on leadership development, particularly in the context of our strategic priorities of diversity, inclusion, and equity noted above, ADFM is working to revitalize its Fellowship program to align the program more tightly with the CAFM Leadership Development Taskforce recommendations focusing on women and those who are underrepresented in medicine, particularly in medical leadership.[4]

Additionally, ADFM is initiating a new "Associate Member" membership category for family medicine leaders who have an interest in promoting the well-being of medical school and/or teaching hospital departments, divisions, or sections of family medicine but who do not fit our standard criteria for membership. For the first phase of this growth, those who will be considered for Associate Membership include Family Medicine Division Chiefs and Vice Chairs, past Chairs and Administrators, and additional Administrators within a Department who would fit the standard membership criteria if there weren't already an administrator member for that Department. This will allow ADFM to expand diversity in membership at both ends of careers, allowing us to continue to learn from

the wisdom of those who have moved on from their chair and administrative roles and to support our goal of developing leaders for the future, especially women and those who are underrepresented in medicine. Learn more at http://www.adfm.org/Membership.

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References

1. Association of Departments of Family Medicine [website]. http://www.adfm.org/AboutUs.
2. Berwick DM. Moral choices for today's physician. *JAMA.* 2017; 318(21):2081-2082.
3. Connecticut Institute for Primary Care Innovation [website]. https://www.cipci.org/.
4. The Council of Academic Family Medicine. Leadership development taskforce final report to CAFM. http://www.adfm.org/Portals/50/Documents/2018%20Winter%20Meeting/Business%20meeting/CAFM%20Leadership%20TF%20report%20and%20appendices.pdf?ver=2018-02-17-112324-977. Published Dec 31, 2017.

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MEASURING AND IMPROVING CONTINUITY IN RESIDENCY PRIMARY CARE PRACTICE

Continuity relationships with the patients that we serve are a cornerstone of Family Medicine. Physician-patient continuity has been shown to be valued by patients, decrease overuse of unnecessary tests, decrease overall cost of care, and improve patient outcomes.[1] Frustration with a lack of continuity in residency practice along with poorly performing residency office-based practices can lead family medicine residents to choose practice settings after graduation that do not include continuity primary care. This deprives our health system of desperately needed family physicians.

The Accreditation Council of Graduate Medical Education requirements for family medicine mandate all family medicine residents to care for a panel of continuity patients. Further, The American Academy of Family Physicians Residency Program Solutions (RPS) Criteria for Excellence suggest that achieving benchmarks of continuity is one measure of a high performing residency program.[2]

To improve continuity, a residency program must first be able to measure it. The measurement of continuity can be complex. Metrics can be measured from the patient or the physician perspective and require physician attribution to a panel of patients.[3] Measurement from the patient perspective reports what percentage of visits were to their assigned physician. The metric from the physician perspective measures the percentage of visits made up of patients assigned to the physician panel. One metric used is the Usual Provider Continuity (UPC) which measures the percentage of visits to the assigned clinician.[4] Ideally, residency programs will query reports from their electronic medical record to automate the measurement of continuity. The RPS Criteria for Excellence suggest programs aim for a goal of 70% of routine patient visits with the patient's family physician.[2] A recent review shows mean UPC in residency program clinics of 56% with a range of 43% to 75%.[5]

Once a residency program has a reliable tool for measuring continuity, the program may implement efforts to improve. While improvement is challenging and complex, Gupta and Bodenheimer suggest the following ways to improve continuity: set goals and display results, increase the number of days each clinician is seeing patients in the office, improve same-day or next-day access for all clinicians, and enforce a practice.[3] Policy on continuity and access including training of telephone and front desk personnel. Residency programs across the country have demonstrated that improvement can be made and sustained in a residency practice.[4,6]

The AFMRD, in our mission to inspire and empower family medicine residency program directors to achieve excellence in family medicine residency training, has embarked on a collaborative with the University of California San Francisco Center for Excellence in Primary Care (CEPC). In 2018-2019 we are connecting 18 family medicine residency programs with the CEPC to invigorate the current and future workforce in primary care through the building blocks model for high-performing teaching practices. We hope this collaborative will inspire improvement in these and other residency teaching practices. Our residency practices, our residents, our family medicine workforce, and our patients will benefit greatly from a focus on improving continuity.

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References

1. van Walraven C, Oake N, Jennings A, Forster AJ. The association between continuity of care and outcomes: a systematic and critical review. *J Eval Clin Pract.* 2010;16(5):947-956.
2. American Academy of Family Physicians Residency Program Solutions. Criteria for Excellence. 9th Edition, 2015.
3. Gupta R, Bodenheimer T. How primary care practices can improve continuity of care. *JAMA Intern Med.* 2013;173(20):1885-1886.