The enthusiasm and engagement of attendees at the 2019 PBRN Conference was high from start to finish. Videos of the 2019 plenary presentations and conference resource materials are available on the NAPCRG website (https://www.napcrg.org/conferences/past-meeting-archives/).

We are looking forward to the 2020 PBRN Conference that will take place in Bethesda, Maryland next summer.

Hope to see you there next year!

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AFMRD Association of Family Medicine Residency Directors

From the Association of Family Medicine Residency Directors

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HIGH-PERFORMING PRIMARY CARE RESIDENCY CLINICS: A COLLABORATION

Primary care is essential to the functioning of a high-value health system. It helps achieve the Triple Aim: improved health care experience, improved health of the population, at decreased overall cost. However, primary care practice is challenging. Many residents and medical students see overburdened, high-stress practices and decide not to continue to care for patients in a primary care setting. We've proposed that in fact the goal in our health system is the Quadruple Aim, which is the Triple Aim plus joy in practice, that is, satisfaction for clinicians and staff.[1]

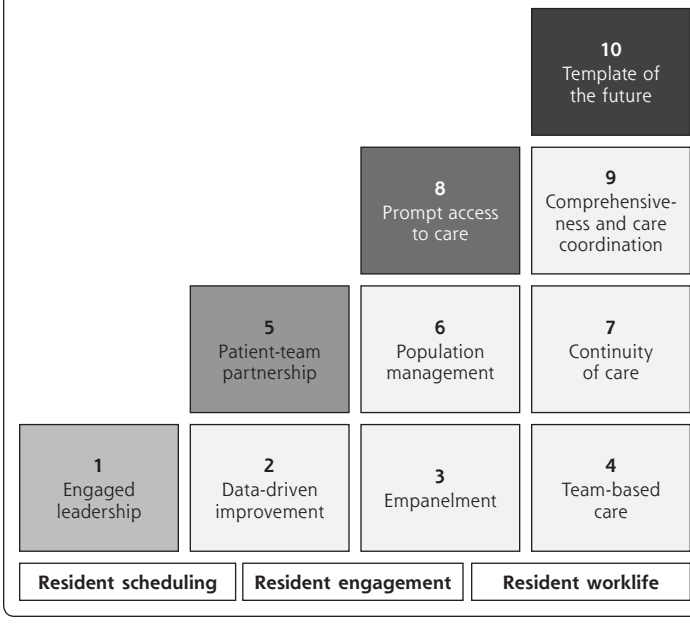
But how do we achieve the Quadruple Aim in our residency practices? How do we build excellent practices where residents are happy to work and provide excellent care for diverse patients? Two of us (M.K., T.B.) have visited a number of effective primary care practices over the last few years, practices we call "bright spots." Based on our findings from these visits we've described "The 10 Building Blocks of High-Performing Primary Care"[2] and after studying residency clinics, we added 3 more building blocks pertinent to residents: resident scheduling, engagement, and work life[3] (Figure 1).

Six action steps to fix primary care residency training are:

- Design resident schedules that prioritize continuity of care and eliminate tension between inpatient and outpatient duties
- Develop a small core of clinic faculty
- Create operationally excellent clinics
- Build stable clinic teams that give residents, staff, and patients a sense of belonging
- Increase resident time spent in primary care clinics to enhance ambulatory learning and patient access
- Engage residents as coleaders of practice transformation[4]

The Association of Family Medicine Residency Directors (AFMRD) (S.B.) partnering with the University of California San Francisco Center for Excellence in Primary Care (M.K., T.B.) embarked on a project of coaching and collaboration to help apply the 10+3 building blocks to our members' programs. In November 2017 we sent out the first call to programs to participate and selected 18 programs. In February 2018 with travel funding from AFMRD we held our first in-person meeting with these programs for a day and a half in Kansas City, Missouri. The collaboration continued with 6 interactive webinars over the next 8 months. Topics covered in the meeting and webinars included: prompt access to care, scheduling, advanced

Figure 1. Building Blocks of High-Performing Primary Care model for residency teaching clinics.



team-based care, continuity of care, access with continuity, interprofessional education and care, and resident engagement.

Participating programs rated the sessions highly. Eighty-nine percent of the programs rated the overall experience "excellent" (56%) or "good" (33%) at the midpoint evaluation. Comments from involved programs include: "an outstanding experience," "it has been wonderful to collaborate with other programs," "the collective passion in the room excited our group and provided the much needed impetus for new ideas and brainstorming…it's an exciting new wave for primary care and we are eager to be a part of it." Another participating group said: "We hope this initiative will continue to grow as we strive to continuously improve the ambulatory experience for our patients and our residents."

Based on the success of the first cohort, the board of AFMRD continued with another year of funding and 15 programs were selected from a competitive application pool for the second cohort which commenced February 2019.

Participating programs have shared their experiences in blog posts which can be found at: https://www.afmrd.org/p/bl/et/blogid=1014.

Across the country, family medicine residency programs are addressing the fundamental dilemma of a teaching clinic: harmonizing (1) the teaching mission which requires residents to be in many different rotations in order to learn the skills of a primary care physician, and (2) the patient care mission for which patients would like their physician to be available all the time. While it is not possible to perfectly accomplish both missions, many family medicine programs are making great progress for their residents and their patients.

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AAFP From the American Academy of Family Physicians

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NEW AAFP INITIATIVE ADDRESSES RURAL HEALTH CARE CRISIS

Rural America is suffering from a health care crisis, a product of inadequate funding, economic downturn, and lack of an appropriate health care workforce. In response, the AAFP is launching Rural Health Matters, an Academy-wide strategic initiative to improve health care in rural communities.

Through this initiative, the Academy will seek to

- Develop and implement an integrated AAFP rural strategy
- Establish the AAFP as a leader for rural health and rural physicians
- Influence policy and payment issues related to rural health
- Address educational needs and resources for family physicians practicing in rural areas
- Support recruitment of family physicians to rural areas, including by increasing student choice, the number of residency positions and support for residency programs
- Create policy, collaboration and resources to help family physicians improve rural health disparities

The challenge is vast. We have lost more than 100 rural hospitals in this country in the last 10 years, including 10 already this year. More than 400 other hospitals are at risk of closing. This has created medical and obstetric deserts where there is no medical care for hundreds of miles. Most of these have been in communities with largely minority populations. These closures have greatly affected those living in poverty and those with low incomes, especially in areas where transportation poses challenges. Women and children in particular have been experiencing the brunt of this change in the health care landscape.

It is more dangerous to deliver a child in the United States now than it was 20 years ago. There are many reasons for this increase, but the lack of medical care in many rural communities is a significant component. If you are African American or Native American or Alaska Native, your risk of dying is much greater. If you live in a rural community without medical care, your risk is much greater. If you are a minority without access to care, your risk is compounded.

The underlying reasons for this crisis are multifactorial but include the lower payment family physi-