Family Medicine Updates

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

Ann Fam Med 2024;22:358-360. https://doi.org/10.1370/afm.3156

MAKING THE FUTURE OF FAMILY MEDICINE BRIGHTER BY BREAKING IT FIRST...

Family medicine in the United States faces major challenges related to the discipline's future viability in its current form, despite convincing evidence of its crucial role in preventing illness and untimely death, and assuring more equitable distribution of health.[1] Efforts to sustain and invigorate the discipline over the years have largely failed.[2,3] To address these challenges, in 2021 NASEM commissioned a committee to make recommendations to "rebuild the foundation of healthcare."[4] Two subsequent reports found little progress in improving primary care.[5,6] The report released February 2024 demonstrates disturbing trends seen in Table 1.[6]

The Association of Departments of Family Medicine (ADFM) identified and planned its 2024 meeting to focus members' attention on the existential threats to family medicine and consider responses to ongoing threats. The meeting featured Professor Timothy Hoff, PhD, Professor of Management and Healthcare Systems at Northeastern University as the keynote speaker. Dr. Hoff's 2022 book, *Searching for the Family Doctor: Primary Care on the Brink* was the starting point for his call to action, asking department of family medicine leaders to respond to the current crisis with new and innovative strategies to improve family medicine's viability as a medical specialty, based on pursuing specific key areas to reinvigorate the discipline.[7]

In order to enhance collective innovation and discovery among our conference participants, we organized 4 facilitated discussion groups to address 4 key areas in a "hackathon" style brainstorming format.

Key Areas

1. Relational Medicine/Partnership Building With Patients. This group discussed enhancing and reimagining the doctor-patient relationship in a changing primary care delivery system, including the patient as a key team member involved in making health care decisions.
2. Digital Health Immersion. This group brainstormed how family medicine could embrace digital tools and technology to enhance relational care and clinical practice.
3. Advocacy for FM Within the Workplace. This group brainstormed the question of how we can more effectively advocate for family medicine both within the workplace and for family physicians as salaried employees, as more find themselves in this situation.
4. Career Sustainability/Wellness. This group brainstormed how to ensure career sustainability for family doctors in a way that guarantees a robustly satisfied family medicine workforce.

We used a nominal group technique process for the mini-hackathon, which included several stages: (a) idea generation, (b) group voting on ideas, (c) ranking of ideas, and (d) discussion of rankings. Throughout these stages, facilitators guided participants in focusing on key questions of "Through the specialty training, clinical practices, and research what does family medicine do now to address a specific topic" (eg, relational medicine) and "What isn't it currently doing that it should?"

The nominal group process yielded the following consensus-based action items for each of the 4 strategic areas discussed.

Relational Medicine/Partnership Building With Patients

1. Build trust by improving convenience and access and organize clinical services to meet patient needs and expectations.
2. Define the terms of the relationship and resource it appropriately. Build support and appropriate reimbursement of care and clinical expectations which allow the establishment and growth of the interpersonal connection.
3. Help patients understand and residents believe in the identity and ability of family medicine and the meaning and value of relationship, and how they prefer to connect and teach boundaries and limits.

Digital Health Immersion (Artificial Intelligence/Machine Learning)

1. Develop and use a chatbot with patients to collect history before patient appointments, enabling more efficient and effective visits.
2. Develop a panel management digital tool that can locate, identify, and contact patients who are falling through the cracks and in need of follow-up.
3. Improve electronic medical record (EMR) functionality to respond to ongoing patient requests with AI/ML facilitated inbox management.

Table 1. Trends in Primary Care, 2024

1. The primary care workforce is not growing fast enough to meet population needs.
2. The number of trainees who enter and stay on the professional pathway to primary care practice is too low, and too few primary care residents have community-based training.
3. The United States continues to underinvest in primary care.
4. Technology has become a burden to primary care.
5. Primary care research to identify, implement, and track novel care delivery and payment solutions is lacking.

Advocacy for Family Medicine Within the Workplace
1. Universal value proposition—partnering and speaking as one "primary care voice" (defined as family medicine, general internal medicine, geriatrics, general pediatrics)
2. Consistency in reporting and data usage—obtain reliable, actionable data that can then be used to show the value of family medicine
3. Collaborate with other departments and professions to advocate for positive change and necessary resources

Career Sustainability/Wellness
1. Leverage technology to demonstrate career flexibility
2. "This is what a family doc looks like" through social media (showing all the opportunities, values, relationships components, choosing your own path, flexibility)

Moving Forward: Urgency, Speed, and Enabling Conditions

Several of the themes identified were seen as crucial and will be challenging to implement given the changing landscape. Taking the example of digital health immersion, there was strong consensus that family medicine must develop and use digital tools more effectively to manage EHR information overload, identifying and connecting with hard-to-reach patients, and integrating artificial intelligence tools like chatbots to assist with pre-visit planning and patient care. Participants recognize that slow adoption of digital tools will not meaningfully improve practice at the rate needed to recruit and retain additional practicing family physicians. We need collective focus on digital adaptation and implementation with rapid testing, dissemination, and building on successful practices. For departments of family medicine specifically, this implies moving quickly over the next few years to incorporate digital health tools meaningfully into training, research, and practice, acknowledging these tools as an enhancer of family medicine work. For the other strategic foci involving advocacy, career sustainability, and relationship building, similar imperatives were discussed around implementation speed and quick adoption. Participants recognize that the very survival of family medicine depends on the field exhibiting a robust capacity to experiment and embrace change, even if there is uncertainty in how that change may ultimately play out.

At the meeting, participants also discussed several enabling conditions required to move these areas of innovation forward. Again, using digital health immersion only as one example, this means encouraging departments of family medicine to frame digital tools and technology such as artificial intelligence as a net positive for patient care, and for improving the work lives of family doctors. We also need to know and implement an appropriate panel size for family physicians taking into account patient complexity and implementation of digital tools to assist with delivering primary and secondary prevention measures. Newer family physicians need organizational support and everyday capacity to test and integrate digital tools and family medicine researchers and clinicians need to collaborate in real time to describe, measure, and define the benefits of such tools. For digital immersion and the other innovation areas identified here, we also as a discipline need to develop and promote a pro-innovation mindset across the traditional mission areas of clinical practice, education, and research. Innovation for our specialty must consume a significant portion of everyone's energy in family medicine for at least the next decade.

Given that family medicine is one component of increasingly competitive and integrated health systems, we are no longer functionally an independent discipline; we cannot accomplish these goals by merely working within our academic departments. We need to work within and across our respective health systems and other entities to shape improvements in primary care practice, with a focus on high quality and equitable health care delivery. We need to join our voices and influence to ensure that innovation in areas such as digital health, relational medicine, career sustainability, and workplace advocacy is prioritized across our academic health centers, collaborating with and influencing larger systems. We need to ensure that the innovation priorities associated with making primary care better and family medicine survive appear at the top of every health system's list of priorities. Broad institutional and multi-stakeholder support is critical for implementing these and other ideas that will ensure future viability of our specialty.

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Ann Fam Med 2024;22:360-361. https://doi.org/10.1370/afm.3158

TRANSFORMING FACULTY EVALUATIONS IN THE CBME ERA WITH ACGME CLINICIAN EDUCATOR MILESTONES

The assessment and evaluation of learners has been a mainstay of the Graduate Medical Education (GME) setting. However, the assessment and evaluation of faculty have yet to garner nearly as much attention. While this new era of Competency-Based Medical Education (CBME) emphasizes the learner-centric approach to residency training, it also highlights the importance of developing clinician educators (CE) who can role model the approach.

The national ACGME Resident and Faculty Surveys are validated instruments that provide one surrogate measure of CE effectiveness with a national comparator. The "Faculty Teaching and Supervision," "Resources," "Professionalism," and "Evaluation" sections all have questions directly related to common CE activities.[1,2] A lack of attention to the critical function of providing faculty with adequate assessment and evaluation of their work as educators could result in relatively low levels of compliance on these surveys. In addition, there is some evidence that a lack of adequate feedback may be contributing to the levels of burnout and difficulty retaining faculty.[3] As there continue to be many open residency faculty positions, this highlights the importance of developing a comprehensive and proactive faculty evaluation process.

The ACGME clinician educator milestones could be one instrument used to foster self-reflection and identify areas for improvement as a clinician educator.[4] As we ask our residents to self-reflect to help create their Individualized Learning Plans, we should also ask the same of ourselves and our faculty members as CEs. This is an important personal and professional development practice, and it also role models that we are forever in a growth mindset and willing to strive to be "master adaptive learners." The clinician educator milestones are "a series of sub-competencies designed to aid in the development and improvement of teaching and learning skills across the continuum of medical education."[4] These milestones can provide a tool for structured self-assessment for CEs and can be used as an instrument for a trusted peer to provide an external assessment. As these milestones are not (yet) an accreditation requirement, they can be used as a low-stakes opportunity for honest self-improvement and to identify targeted professional development. Five competencies have been identified:

1) Universal Pillars for All Clinician Educators
2) Educational Theory and Practice
3) Well-Being
4) Diversity, Equity, and Inclusion in the Learning Environment
5) Administration

The Clinician Educator Supplemental Guide provides examples of each milestone element to further assist CEs in developing their own personal improvement plan. Examples are broken down to further separate undergraduate medical education, GME, and continued professional development.[5] To improve as a CE, one has to be open to assessment. Some suggestions for assessment include direct observation, faculty-observed structured teaching, multisource feedback from learners, learner outcomes, OSTEs, and performance assessment and review.

The Society of General Internal Medicine Education Committee published a position paper calling for the use of these milestones to help CEs create their own individualized professional development plans to promote career success.[6] Additionally, just as the original resident milestones are an opportunity for program and institutional assessment, aggregating the milestones outcomes from CEs can provide a needs assessment to help create purposeful faculty development interventions. In family medicine, program directors could consider aggregating their core faculty CE milestones self-assessments to identify faculty development needs and to help mentor their core faculty.

Faculty development, assessment, and evaluation are essential to any successful residency program, especially with the new requirements and movement toward CBME. Using the ACGME clinician educator milestones to promote faculty professional development could provide the structure needed to help improve program performance in the "Faculty Teaching and Supervision" section of the ACGME survey. More importantly, using the CE milestones and increasing focus on faculty assessment and evaluation will likely help with faculty retention and well-being by highlighting specific elements to focus efforts in the otherwise nebulous area of faculty development.

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