Family Medicine Updates

From the Association
of Family Medicine Residency Directors

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INNOVATION IN FAMILY MEDICINE RESIDENCY TRAINING

"Here is Edward Bear, coming downstairs now, bump, bump, bump, on the back of his head, behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think of it. And then he feels that perhaps there isn't."[1]

Family medicine residency program directors often feel much like "Pooh." Mandated to travel down a prescribed flight of stairs; the direction of travel is seemingly out of their control. Inextricably linked with others with good intentions, but causing painful consequences nonetheless. Hurtling through their days without much time to stop and think of better ways, and sometimes doubting if their ideas for better ways to train future family physicians could ever really be implemented given all the obstacles.

One of AFMRD's organizational strategic aims is to "Promote, facilitate and disseminate innovation and quality in family medicine training." Quality is self-evident, but why is innovation important? The old training model was built for a different health care system. America's family medicine residencies can be sources of innovation in this time of change and can become incubators to make the Patient-Centered Medical Home a reality for all Americans.

The Preparing the Personal Physician for Practice (P^4) Residency Demonstration Initiative is a 6-year, 14-site study of a spectrum of innovations aimed at preparing and equipping graduates to thrive in the Patient-Centered Medical Home model of care. P^4 was inspired and initially funded by AFMRD and the American Board of Family Medicine. Each of the sites has formulated and is now testing their best ideas about what is needed to change the content, structure, and length of family medicine residency education.[2]

The AFMRD Board is optimistic that P^4 will prove to be a worthwhile investment. However, the Board also recognizes several facts:

1. It is more likely than not that the best ideas could eventually come from family medicine programs not involved in the P4 initiative. Perry Pugno has written that "the most important outcome of the P4 project has already occurred, namely stimulating innovative approaches to resident education throughout the nation's more than 450 family medicine programs."[3]

2. Innovation frequently starts at the grass roots, and can be planted by residents, faculty, and family medicine staff. No other specialty has its training programs already so well connected with real-world learning laboratories (our family medicine centers) for creating the Patient-Centered Medical Home.

3. Family medicine residency programs are reflections of the communities and even the resident physician populations they serve; although the findings from this initiative should be generalizable, it will be important for all programs to adapt based on their local needs.

4. "Change ultimately comes from within." The best ideas (and the passion to execute them) often come from within a smaller organization such as a residency program. AFMRD can be most helpful by supporting and developing program directors (through programs like NIPPD) to be empowered and effective in creating residency working environments in which innovation is valued and encouraged.

5. Innovation can seem a grandiose concept. However, innovations that may appear modest and incremental sometimes turn out to be more important than radical, bold changes. Getting different perspectives and using the collective wisdom of program directors will allow our organization to facilitate innovation in all of our programs.

AFMRD is working to support all directors and programs that desire to innovate. A plenary presentation at the 2008 Program Directors' Workshop (PDW) highlighted the potential of all our residencies to become learning communities, disseminating clinical and educational innovation by identifying our "exemplars."[4] AFMRD also created the "Rapid-Fire Innovative Ideas" session last year, which we anticipate will become an ongoing forum at each year's meeting. The 2009 PDW theme will be "Achieving Quality through Leadership and Innovation." The Board is also making plans as part of a revamping of the AFMRD Web site to include a platform specifically for innovation. AFMRD's ongoing financial support for the resident research section in *Annals of Family Medicine* is another way to support the next generation of family medicine researchers needed to analyze our specialty's educational and practice innovations.

What about accreditation issues? While many directors point to the 38 pages of program requirements as innovation-stifling, many P[4] innovations do not conflict with existing requirements. Our hope is that the ACGME will streamline their procedure for creating innovation, perhaps even rewarding creative programs.

The AFMRD Board is open to other ideas on what role the organization can play to disseminate our members' innovative ideas. As Steve Jobs, cofounder of Apple Computer has stated, "Innovation distinguishes between a leader and a follower."[5] As leaders in our training programs, program directors must make leading and encouraging innovation part of our job description.

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From the North American Primary Care Research Group

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THE PATIENT-CENTERED MEDICAL HOME: A DISCUSSION AT NAPCRG 2008

During the 2008 NAPCRG Annual Meeting, a facilitated open forum was held to discuss opportunities and concerns deriving from the contemporary interest in the United States in establishing the patient-centered medical home (PCMH), with a particular focus on important researchable questions. The PCMH was presented as a metaphor for redesigning the delivery of primary care. Several participants were recruited in advance to express opinions to stimulate discussion by the group. Three listeners noted comments on flip charts from which this summary was developed.

Some participants noted favorable reactions to the metaphor of the home, where, as Robert Frost penned, "they have to take you in." The national alignment of purchasers and payers with primary care clinicians to develop the medical home was seen as creating newsworthy, positive movement toward enhanced primary care, something quite different from "business as usual." The potential transformative effects of becoming patient centered were emphasized, including: elevating this notion to the national policy scene; involving families, teams, and communities in caring for patients who are actively involved in their own care; and tapping into consumerism with patients sharing decisions and making choices. Learning how to fully incorporate all the elements of the PCMH was seen as a rich academic opportunity to use multiple scientific methods to understand effects and to teach learners how to work together on behalf of all the people through/in the PCMH.

There was apprehension that the PCMH remains "in the belly of the beast"—not radical enough to escape from old "medical" models and provider-centeredness into the concepts of health and community linkage. Transforming primary care practice is very hard; it involves more than doing a few quality improvement cycles. Underlying genuine practice transformation are hidden assumptions and fears about primary care, physicians, values, and expectations that have not been sufficiently exposed; these threaten progress, possibly resulting in the PCMH becoming another passing fad. There is much ignorance—about how to actually achieve the attributes and functions of the PCMH and about how to measure the existence and performance of the PCMH—making sweeping claims and over-promising inadvisable. Balancing legitimate professional prerogatives, commercial interests, use of new technologies, and roles among patients and teams is very challenging. Mis-positioning the PCMH as a miracle that will solve conflicting interests could condemn the PCMH to not succeeding sufficiently to please anyone. Broader system changes, particularly financing arrangements, are necessary for the PCMH to work properly, and these are beyond the control of primary care, threaten powerful interests, and, thus, there is no guarantee that such changes will occur.

Not surprisingly for a group of investigators, many important issues were quickly identified, ranging from very specific questions to much broader topics representing possible programs of research:

- What IS a PCMH?
- What are its proper metrics?