

Residents as Change Agents in the Transformation of Primary Care Practices

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We in academic family medicine have a tremendous amount of work ahead of us during this period of major transformation of the health care system in general and primary care practice in particular. There are both great opportunities and daunting tasks embedded in this transformation, and I plan to use the President's Column pretty actively over the next year to give perspectives on this process. For this installment, I would like to focus on the important role of our residents as current and future leaders of the change process for practices undertaking this transformation.

Transformation of Primary Care Practices

Several things are clear to me both from my work and that of others in primary care practice redesign.

(1) Becoming a true, complete Patient-centered Medical Home (PCMH) is difficult work and requires a lot of time and effort, along with a robust practice improvement and change management process. This is an ongoing, long-term process, not one that can be accomplished in months.

(2) Few primary care practices are even close to being fully developed medical homes.

(3) Few primary care practices have an effective quality improvement and/or change management process.

(4) Both the change process and the PCMH clinical model require a major cultural shift in practices toward a less hierarchical and more team-based way of doing business.

(5) Many of our clinicians are pretty well set in their current model of practice and are resistant to change.

Residency Practice Redesign

I am in the middle of a 3-year project aimed at transforming the Colorado family medicine residency programs and practices to become medical homes, focusing on both practice transformation and curricular redesign. We are still early in that process, but several observations have emerged relevant to the topic of this paper.

(1) Our faculty members are not trained in the basic PCMH skills and do not have medical homes in which to practice. As a result, they are not experts in these areas. Despite our leanings toward being facilitative teachers, we all like to be experts and feel uncomfortable when we don't have a certain level of expertise to fall back on in our educational activities. This produces some resistance, either conscious or often unconscious.

(2) Faculty members are just like community clinicians—many of us are pretty set in our current approach to practice and are resistant to change.

(3) Residents are much less set in their practice patterns and are more open to and excited by the prospects of change in the health care system. They are often our best change agents in residency practices, bringing a great deal of energy to the change process.

(4) As pointed out by a resident in the most recent collaborative learning session for our project, there are generational differences that make the PCMH model more attractive in some ways for our residents than for our older faculty. The millennial generation in general likes working in networked teams, does not believe that they need to be the center of the practice, is used to accessing information through a variety of resources, and appreciates a more balanced lifestyle. All of these things make the PCMH an attractive model of practice for that generation.

(5) One of the biggest concerns for residents I have talked with through this project is that they totally embrace the PCMH model of practice, but they may not find medical homes in which to practice when they complete their training. Basically, to slightly paraphrase a line from an old song, "How are you going to keep them down on the farm after they've seen Paris?" This should also be a major concern for practices looking to recruit our residency graduates.

Implications for Residency Programs

This all leads me to assert that a key issue in upcoming years for

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family medicine academicians, and especially those dealing with residency education, is to prepare our residents to be agents of change in their future practices. Obviously, one of the most important things we need to do to accomplish this is to provide residents with medical homes to experience during their training. However, resident instruction and involvement in the quality improvement and change management processes necessary to transform our practices is also critical if they are going to be prepared to lead or actively participate in the change process in their practices. Quality improvement and change management receive at least some attention in most residency programs, often more through didactic sessions than practical experience. Although didactic training is good, residents can best learn these areas if they experience them actively during their training. This can be difficult to accomplish in current residency structures that lock residents into spending most of their time in block rotations that leave little or no time for activities in their family medicine centers other than direct patient care. While some programs have structured their curricula in more of a longitudinal model, sometimes allowing time for these activities, the current Program Requirements for Graduate Medical Education in Family Medicine make this somewhat challenging. However, this may be changing with the revised requirements that will emerge in a few months. I believe it will be crucial for residency programs to structure resident activities to al-

low them time to participate in and learn from active efforts to improve their practices and transform them into medical homes. This will both greatly facilitate the change efforts in the residency practices and provide the residents with the skills necessary for them to lead or assist such efforts in their own future practices.

There are further implications for our residency programs, the graduating residents, and the practices they will be joining. It is hard to be a leader for a change process when coming into an established practice as a new, relatively inexperienced person. The practices they will be joining may or may not be receptive to either implementing an improvement process or changing to become medical homes. Even if the practices are receptive, the model for leading such a change process has to be team oriented rather than totally driven by one person. Residents need to be trained in leadership of such a change process, including such topics as how to provide leadership without being in control and how to do the necessary work through a team process. Residents who are going through the selection/recruitment process and who strongly desire in their prospective practices a level of "medical homeness" or a willingness to move in that direction may need assistance in developing selection criteria that might include an assessment of whether the practice culture is supportive of change.

Implications for Practices

Finally, our clinicians and practices looking to recruit and inte-

grate our future graduates need to be prepared for a set of residents emerging from our programs who can potentially help with the practice transformations that will be needed for future survival. Our best and brightest graduates are going to be seeking out and choosing those practices that are adopting advanced models of practice or showing a clear willingness to move in that direction. They need to find good receptor sites.

Closing

In planning for the upcoming changes in the Program Requirements for Graduate Medical Education in Family Medicine, STFM has agreed to take a lead role in a Council of Academic Family Medicine task group aimed at supporting residency programs in adapting to the new requirements. While the shape and specific content of those new requirements are not known yet, it is likely that resident training in quality improvement and practice transformation will be included. We will certainly be discussing the new requirements when they formally emerge, likely in a future President's Column. In the meantime, however, preparation of our residency graduates to be positive agents for change and improvement deserves close attention from our residency training programs.

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