An Emerging Epidemic of Innovation in Family Medicine Residencies

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In 2003, Task Force 2 of the Future of Family Medicine Project published its findings on the training of future family physicians.[1] The Task Force concluded that given changes occurring within both the specialty and the health care system, the traditional family medicine curriculum, while successful in the past, will not meet the needs of future medical practice. Rather, educational processes of the future must train family physicians to provide patients with a personal medical home. This would require family physicians to use new technologies that facilitate evidence-based principles and process-oriented care while actively measuring patient outcomes. In addition, they must fully understand how to utilize a biopsychosocial model to create successful physician-patient relationships within the context of communities and families. This special theme issue highlights an emerging epidemic of innovation in family medicine residency education.

Six of the nine papers included in this special theme issue provide information about and findings from the Preparing the Personal Physician for Practice (P^4) Project, funded by the Association of Family Medicine Residency Directors and the American Board of Family Medicine (ABFM) Foundation and administered by TransforMED, a creation of the American Academy of Family Physicians. The innovations, hypotheses, and measures across all 14 participating residency programs are described in the paper by Carney et al.[2] This paper confirms that P^4 residency programs care, have important ideas, are willing to take risks, and aspire to improve. They undertook considerable change, not just minor revisions, in the length, structure, and content of training. Importantly, the P^4 Steering Committee allowed the family medicine residencies to propose their own education redesign ideas rather than being prescriptive, which has, we believe, fostered a passion and commitment of residency programs to undertake significant transformations. The P^4 paper by Garvin et al[3] reports the impact of innovations on the Match across all 14 P^4 programs and clearly shows that innovation does not hurt and likely helps attract strong residents to the discipline. The paper by Dysinger and colleagues[4] reports on different approaches for integrating population health, preventive medicine, and family medicine training in three residency programs, illustrating the strengths and challenges of such combined training. This paper forecasts a future where public health and primary care are destined to reunite, share data, and cross boundaries to work together in practices and communities to improve population health.

An important feature of these original research reports on P^4 activities is that residency programs partnered to collaborate on these papers that present their approaches and findings. The value of residencies working together can also be seen in the papers describing the I^3 and Colorado collaborative activities. I^3 is a PCMH practice transformation collaborative of 25 family medicine, pediatric, and internal medicine residencies in North Carolina, South Carolina, and Virginia. It is modeled after the Institute for Healthcare Improvement's Breakthrough Series Collaborative methods, where teams from participating sites engage

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in monthly Webinars, electronic Blackboard Web site data posting/information sharing, and four face-to-face meetings to learn from each other how they approach topics such as behavioral integration, health literacy, and transitions of care. The Colorado Family Medicine Residency Project is another regionally focused residency redesign collaborative also focused on the PCMH and distinguished by including every family medicine residency in the state (including a P[4] program) and by using customized coaching with modest financial support to support residencies as they redesign while sustaining 24 hour/day coverage of patients and learners.

In the first of the two papers from the I[3] collaborative, Reid et al[5] describe the achievements the 25 primary care practice sites have had to date in gaining PCMH recognition by the National Committee for Quality Assurance (NCQA), with nearly half currently recognized and another 36% plan to apply in 2011. Importantly, 64% of these programs credited the collaborative with helping them focus on practice transformation while faced with the competing priorities of primary care practice. Apparently, standardized measures and national recognition can help pull residency transformation forward through many impediments. The second I[3] paper, by Newton et al,[6] describes the successes these training programs have had in improving quality of care for patients with diabetes and congestive heart failure. It is gratifying when transforming training and care processes improves patient outcomes.

The paper from the Colorado collaborative, authored by Fernald and colleagues,[7] details the barriers experienced by family medicine residency training programs as they undertook significant change regarding both redesigning medical practices to be PCMHs and training residents about these important concepts. Practices and residency programs undertaking such change require courage, leadership, and persistence; and they face structural and cultural barriers for which they can use a little help, specifically from an enabling, reliable practice coach. Understanding the experiences and needs of these early adopters of change identifies critical needs for faculty development of those who follow. Enough cannot be said about the courage and commitment of members of these multi-site collaboratives, as they initiate an urgently needed transformation of the training of the personal physicians the nation seeks.

The last three papers in this special theme issue include powerful brief reports: one by Douglass and colleagues,[8] one by Mazzone and colleagues,[9] and one by Jones and Lima,[10] all of which focus on findings within their residency programs rather than across two or more programs. The Douglass paper[8] reports design details and early findings associated with restructuring training into a required 4-year time envelop. The length of training in family medicine has been controversial. This report moves beyond conjecture and speculation about potential effects of longer training for family physicians to evidence, and the Middlesex experience attests to the feasibility and favorable effects of family medicine residency training organized into a 4-year model.

An important focus of many P[4] programs and many medical students has been to allow for intentional diversification in training whereby residents meet core competencies required by the ACGME and additionally pursue knowledge and skills to strengthen their preparation for practice in the diverse communities and regions they aspire to serve. Using "Majors and Masteries," Mazzone and colleagues[9] illustrate how tailored educational approaches can be structured and implemented in family medicine residency training. Such flexibility in training is probably necessary to meet the needs of all of our country's diverse communities.

The paper by Jones and Lima[10] reports on the challenges faced by a residency program in a rural underserved setting when they decided to undertake considerable practice redesign that involved practice staff retraining, the elimination of the patient waiting room, and the use of ear phones for team-based care communication. They remind us that change is all about people and relationships, and people must be handled with care.

While collaborating within single institutions is necessary for transformations such as those now occurring in residency training across the country, the added benefits of cross-programmatic interactions are numerous, especially from an evaluative standpoint where an "n" of one has such limited generalizability. Innovation and evaluation in education is the scholarship of teachers. While it has been underappreciated, this line of discovery is an essential ingredient in translational research to improve patient outcomes and contain costs. Educational research is vitally important. It requires teams that include appropriately

trained educational researchers with expertise in study designs, measurement, and analyses working shoulder to shoulder with family physicians who understand the vital interface between clinical care and the discoveries that occur in learning. Educational research especially deserves greater legitimization through explicit financing by federal and state agencies, institutions sponsoring clinical education, and philanthropy.

Two other key messages emerge from this set of innovation reports. Educational redesign is central to achieving the critical need of our country for better health care, contained costs, and measurable improvements in health. Another message is also clear: a significant transformation can be initiated by innovative ideas, profession values, and volunteerism, but its maintenance and spread will require investments not yet being made. It will be the responsibility of all of us who are passionate about the discipline of family medicine to advocate for innovations that create the best and brightest physicians, to identify and navigate potential funding streams to support these efforts, and to work closely with accreditation bodies to allow the flexibility needed to continually advance the profession. It is time for this epidemic to be viral.

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