

Recommendations for the Future of Family Medicine

Where do you begin the enormous task of retooling family medicine and reforming health care? Family medicine's leaders offer a road map.

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Two years ago, leaders of the seven national family medicine organizations embarked on a serious re-examination of the specialty and the U.S. health care system when they initiated the Future of Family Medicine (FFM) project. The group's goal was ambitious: to develop "strategies to renew and transform the discipline of family medicine to meet the needs of patients in a changing health care environment." Now, work on the first stage of the project is complete. The result is a diverse examination of the specialty and 10 strategic recommendations that will serve as a guide for transforming the discipline.

No more doom and gloom

The project's final report and accompanying recommendations were published in the March/April 2004 issue of the *Annals of Family Medicine* (http://www.annfammed.org/cgi/content/full/2/suppl_1/s3). "I think the report represents the first positive we've seen in a long time," says James C. Martin, MD, AAFP board chair and chair of the FFM project leadership committee. "The recommendations will give family physicians a compass to direct us so that we can get off this hamster wheel and get reimbursed for the value that we bring to the system." The recommendations for a rearticulated vision of family medicine appear on page 36. They include the following:

- A new model of practice that is locally adaptable, builds on the core values of family medicine, stresses a team approach and is congruent with the six aims of high quality health care identified by the Institute of Medicine's Chasm Report¹ (i.e., safe, timely, effective, efficient, equitable and patient-centered);
- A more functionally designed office practice that incorporates advanced information technology, including just-in-time informa-

tion systems that allow physicians to retrieve the best evidence at the point of care, and a standardized electronic health record (EHR) that integrates easily into daily practice and is affordable to most family physicians;

- A model of family medicine residency education that is more flexible and emphasizes cultural proficiency, quality improvement, informatics, evidence-based medicine, practice-based research and the biopsychosocial model of care;
- A comprehensive lifelong learning program for family physicians based on continuous personal, professional and clinical practice assessment and improvement;
- New reimbursement models that sustain and promote family medicine and primary care practices.

Those involved with the project readily admit that successful transformation of the specialty cannot occur without system-wide changes to the present reimbursement models. "We're already getting the message out that payers, particularly Medicare, must pay for the value they receive from family physicians," says AAFP President Michael Fleming, MD.

KEY POINTS

- Leaders of the seven national family medicine organizations initiated the Future of Family Medicine project to develop a strategy to transform and renew the discipline of family medicine to meet the needs of patients in a changing health care environment.
- The collaborating organizations include the AAFP, the AAFP Foundation, the American Board of Family Practice, the Association of the Departments of Family Medicine, the Association of Family Practice Residency Directors, the North American Primary Care Research Group and the Society of Teachers of Family Medicine.

Currently, a special task force on reimbursement and financial issues is working to formulate a plan for a new model that will pay family physicians fairly. "However, we can't expect the system to just cut us a check," says Stephen J. Spann, MD, the task force chair. "In order to receive enhanced reimbursement, we're going to have to demonstrate and enhance the quality of care we deliver." A report from this group is expected in late 2004.

Next steps

The seven national family medicine organizations intend to share responsibility for carrying out strategic initiatives resulting from the FFM project. For example, the Association of Family Practice Residency Directors and the Association of Departments of Family Medicine will take the lead in bringing about changes in family medicine education, whereas the AAFP will head the effort to redesign the work and workplaces of family physicians. Any proposed changes will not occur overnight. They will be preceded by much discussion and a period of active experimentation, in which family physicians and their partners envision, test and evaluate the effect of innovations. "FPs are going 70 miles an hour so we want any transitions to be as seamless as possible," Martin says. "We can't succeed if we don't supply business plans, models and advisers who can work with physicians along the way."

The priorities highest on everyone's list include developing a new model of practice, integrating EHRs into practices and residency programs, and creating a unified strategy for promoting an awareness and understanding of family medicine.

New model of practice. While some elements of the new model will seem familiar to family physicians, such as a patient-centered approach to care, it will require family physicians to develop additional competencies in

relationship, information and process management (see "Traditional vs. new model of practice" on page 38). And while the new model is designed to be flexible enough to accommodate practice variation depending on geographic location and the needs of the community being served, two concepts will be emphasized: offering patients a "medical home" and an expected "basket of services."

A medical home is "a place you can go with any concern and receive, first, a healing relationship with a personal physician, and second, the comprehensive, integrated care that you need," says Larry Green, MD, director of the Robert Graham Center for Policy Studies in Family Practice and Primary Care and chair of the task force that helped to develop this new model. "We want to ensure not only that every person has access to a medical home, but that the ongoing relationship between a patient and physician isn't disrupted by administrative hassles with health insurance." Green hopes that patients will come to identify their medical home as a place where they can receive a full basket of services, either provided directly by their physician or coordinated by their physician and provided by another physician with which the practice has an ongoing relationship. These services are for both sexes, across all ages and health care settings, and include the management and prevention of acute illnesses and chronic diseases, preventive care, well-child care, primary mental health care and advocacy for patients within the health care system. "There's been a lot of confusion over the last few years about who does what medically," says Green. "The market research performed early on in the project showed us that people don't really know what family physicians do. Managed care folded us into a bucket called primary care and we lost our distinctiveness. Providing an expected basket of services is one way we can stand out."

The seven national organizations are also considering developing practice alpha sites to test the new model and establishing a self-sustaining national resource center that physicians can use to obtain very specific advice and recommendations about practice reengineering. "I think that by 2006 you'll see a real movement taking place," says Martin.

Electronic health record systems. If all goes as planned,



The Future of Family Medicine (FFM) project is a collaborative effort of the seven major national family medicine organizations to transform and renew the specialty.



Recommendations include developing a new model of practice that provides patients with a medical home and an expected basket of services.



Also included is a new model of residency education emphasizing evidence-based medicine, practice-based research and a biopsychosocial approach to care.



To read the full FFM report and recommendations, go to http://www.annfammed.org/cgi/content/full/2/Suppl_1/s3.

WEIGH IN ON THE RECOMMENDATIONS

"Whether the Future of Family Medicine report and recommendations will bring real change depends entirely upon what we – we, as in all of us – do with them," says AAFP President Michael Fleming, MD. To encourage dialogue, family physicians, patients, staff, educators and other health care professionals are invited to participate in an online discussion hosted by the *Annals of Family Medicine*. To read a copy of the full FFM report or post commentary, go to http://www.annfammed.org/cgi/content/full/2/Suppl_1/s3. Please send your comments to *FPM* at fpm@aaafp.org.

THE RECOMMENDATIONS

A compilation of the major recommendations from the Future of Family Medicine (FFM) task forces appears below. Findings and recommendations from a sixth task force focusing on finance and reimbursement issues are expected in late 2004. The FFM final report and an online discussion is available at http://www.annfamned.org/cgi/content/full/2/suppl_1/s3.

1. New model of family medicine

Family medicine will redesign the work and workplaces of family physicians. This redesign will foster a New Model of care based on the concept of a relationship-centered personal medical home, which serves as the focal point through which all individuals – regardless of age, gender, race, ethnicity or socioeconomic status – participate in health care. In this new medical home, patients receive a basket of services that are accessible, accountable, comprehensive, integrated, patient-centered, safe, scientifically valid and satisfying to both patients and their physicians. This New Model will include technologies that enhance diagnosis and treatment of a large portion of the problems that patients bring to their family physicians. Business plans and reimbursement models will be developed to enable the reengineered practices of family physicians to thrive as personal medical homes, and resources will be developed to help patients make informed decisions about choosing a personal medical home. A financially self-sustaining national resource will be implemented to provide practices with ongoing support in the transition to the New Model of family medicine.

2. Electronic health records

Electronic health records (EHRs) that meet standards which support the New Model of family medicine will be implemented. The EHR will enhance and integrate communication, diagnosis and treatment; measurement of processes and results; analysis of the effects of comorbidity; and recording and coding elements of whole-person care; as well as promote ongoing, healing relationships between family physicians and their patients.

3. Family medicine education

Family medicine will oversee the training of family physicians who are committed to excellence, steeped in the core values of the discipline, expert in providing family medicine's basket of services within the New Model of family medicine, skilled at adapting to varying patient and community needs and prepared to embrace new evidence-based technologies. Family medicine education will continue to include training in maternity care, the care of hospitalized patients, community and population health, and culturally effective and proficient care. Innovation in family medicine residency programs will be supported by the Residency Review Committee for Family Practice through five to 10 years of curricular flexibility to permit active experimentation and ongoing critical evaluation of competency-based education, expanded training programs and other strategies to prepare graduates for the New Model. In preparation for this process, every family medicine residency will implement EHRs by 2006.

4. Lifelong learning

The discipline of family medicine will develop a comprehensive, lifelong learning program. This program will provide the tools for each family physician to create a continuous personal, professional and clinical practice assessment and improvement plan that supports a succession of career stages. This personalized learning and professional development will include self-assessment and learning modules directed at individual physi-

cians and group practices that incorporate science-based knowledge into educational interventions fostering improved patient outcomes. Family medicine residency programs and departments will incorporate continuing professional development into their curricula and will initiate and model the support process for lifelong learning and maintenance of certification.

5. Enhancing the science of family medicine

Participation in the generation of new knowledge will be integral to the activities of all family physicians and will be incorporated into family medicine training. Practice-based research will be integrated into the values, structures and processes of family medicine practices. Departments of family medicine will engage in highly collaborative research that produces new knowledge about the origins of disease and illness, how health is gained and lost, and how the provision of care can be improved. A national entity should be established to lead and fund research on the health and health care of whole people. Funding for the Agency for Healthcare Research and Quality should be increased to at least \$1 billion per year.

6. Quality of care

Close working partnerships will be developed between academic family medicine, community-based family physicians and other partners to address the quality goals specified in the Institute of Medicine's (IOM) *Crossing the Quality Chasm* report. Family physicians and their practice partners will have support systems to measure and report regularly their performance on the six IOM aims of high-quality health care (safe, timely, effective, equitable, efficient and patient-centered). Family medicine residency programs will track and report regularly the performance of their residents during their training on the six IOM quality measures and will modify their training programs as necessary to improve performance.

7. Role of family medicine in academic health centers

Departments of family medicine will individually and collectively analyze their position within the academic health center (AHC) setting and will take steps to enhance their contribution to the advancement and rejuvenation of the AHC to meet the needs of the American people. A summit of policy makers and family medicine leaders in academia and private practice will be convened to review the role of and make recommendations on the future of family medicine in academia.

8. Promoting a sufficient family medicine workforce

A comprehensive family medicine career development program and other strategies will be implemented to recruit and train a culturally diverse family physician workforce that meets the needs of the evolving U.S. population for integrated health care for whole people, families and communities. Departments of family medicine will continue to develop, implement, disseminate and evaluate best practices in expanding student interest in the specialty.

9. Communications

A unified communications strategy will be developed to promote an awareness and understanding of the New Model of family medicine and the concept of the personal medical home. As part of this strategy, a new symbol

THE RECOMMENDATIONS *continued*

for family physicians will be created and consistent terminology will be established for the specialty, including use of family medicine, rather than family practice and family physician rather than family practitioner. In addition, a system will be developed to communicate and implement best practices within family medicine.

10. Leadership and advocacy

A leadership center for family medicine and primary care will be established, which will develop strategies to promote family physicians and other primary

care physicians as health policy and research leaders in their communities, in government and in other influential groups. In their capacity as leaders, family physicians will convene leaders to identify and develop implementation strategies for several major policy initiatives, including assuring that every American has access to basic health care services. Family physicians will partner with others at the local, state and national levels to engage patients, clinicians and payers in advocating for a redesigned system of integrated, personalized, equitable and sustainable health care.

a significant number of practices and residency programs will be using EHRs by 2006. "Anyone unwilling to adopt an EHR will not have the necessary tools to go into the future," says Wm. Jackson Epperson, MD, MBA, who practices in Murrells Inlet, S.C., and served on one of the FFM task forces. "They're not only key to business survival, but to patient care and service." Martin agrees that the EHR will become the central nervous system of the new model of practice. "None of the physicians I talk to deny the value of an EHR," he says, "but everybody says, 'I can't afford to make the wrong choice, and I don't have time to go look at them and play with them and see what's going to work best for me.'" In order to promote the adoption of information technology in family physician offices, the AAFP is engaging in several collaborative efforts, including the following:

- **The Partners for Patients initiative** (<http://www.aafp.org/x24906.xml>); a strategic business alliance with leading information technology companies willing to offer physicians discounts on EHRs and other information technology products. These companies have also agreed to help develop standards-based products that adhere to four basic principles: affordability, compatibility, interoperability and data stewardship.

- **The Doctor's Office Quality Information Technology (DOQ-IT) project** (<http://www.aafp.org/x24964.xml>); an initiative funded by the Centers for Medicare & Medicaid Services to help small- to medium-sized practices move from paper-based health records to EHR systems and to adopt computer-generated decision support tools, such as preventive service reminders and clinical guidelines for diabetes, heart failure,

coronary artery disease, hypertension, osteoarthritis, depression and preventive care.

- **The Continuity-of-Care record** (<http://www.aafp.org/x24962.xml>); a joint effort headed by the Massachusetts Medical Society to develop an electronic document standard for summarizing personal health information that physicians can furnish to a consultant and that patients can carry with them to promote safety, continuity and quality of care.

- **The Open EHR Pilot Project** (<http://www.aafp.org/x24963.xml>); a method to study the implementation and promote the use of EHRs in small- and medium-sized family medicine practices.

Communication. The market research conducted at the outset of the FFM project confirmed that while patients continue to value the kind of care family physicians deliver, they don't understand who family physicians are or what they offer. (For other key findings, see "Family Medicine Takes Center Stage," *FPM*, November/December 2003, page 43.) "We haven't been very successful thus far at creating a brand identity," says Epperson. "Congress, the Senate, the President, even the average person doesn't know what we do. In fact, the people who conducted the market research didn't even know what a family physician did before they got involved with this project."

Epperson and others involved in the FFM project believe that creating and communicating a brand identity is key to moving the specialty forward. To do that, the AAFP is developing a unified communications strategy targeting, among others, the public, health care policymakers, members of the medical community, and business and academic leaders. National media exposure is expected. "We want family physicians to know that we

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Findings and recommendations from a sixth task force focusing on finance and reimbursement issues are expected in late 2004.



Any proposed changes to the specialty will be preceded by a period of active experimentation in which physicians and their partners develop, test and evaluate the effect of innovations.



Three of the 10 strategic recommendations have been labeled "high priority" by those involved in the FFM project.



They include developing a new model of practice, implementing EHRs in practices and residency programs, and creating a unified communications strategy to promote an awareness and understanding of the specialty.



Physicians are encouraged to read the FFM final report and recommendations and provide feedback.



FFM project leaders say the real impact of the FFM report will be determined only by the degree to which people interact with it.

are advocating on their behalf to ensure the viability of the specialty,” says Fleming. “And we want to show patients that we can better serve their health care needs by adopting new models of practice and education.” Physicians can also expect to see symbolic changes, such as the use of “family medicine” instead of “family practice” and “family physician” instead of “family practitioner.”

No ivory tower exercise

At the outset of the FFM project, the specialty’s leadership decided that no part of family medicine was going to be excluded from the process. The project included physicians with a wide range of expertise, including those in academia as well as those with experience in “the plain old nuts and bolts of family medicine: paying the bills, dealing with insurance and trying to figure out the cash flow of a small business,” says Epperson. “This was no ivory tower exercise.”

Nor is it a fixed blueprint. “It represents a starting point,” says Kurt Stange, MD, PhD,

a member of the FFM Project Leadership Committee. “The real impact of the report will be determined by the degree to which people interact with it and the degree to which this interaction stimulates action.”

Physicians are encouraged to read the recommendations and provide feedback. “When I ask myself why anyone should pay attention to these recommendations, I think about myself on those days when I’m in the office until 8 p.m., not providing care for my patients, but doing paperwork,” says Martin. “My focus should be on meeting the needs of my patients and making the practice of medicine fun again. That’s the whole point.” **FFM**

Send comments to fpmedit@aafp.org and http://www.annfammed.org/cgi/content/full/2/suppl_1/s3.

1. Institute of Medicine. Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.

TRADITIONAL VS. NEW MODEL OF PRACTICE

Traditional model	New model
Systems often disrupt the patient-physician relationship	Systems support continuous healing relationships
Care is provided to both sexes and all ages; includes all stages of the individual and family life cycles in continuous, healing relationships	Care is provided to both sexes and all ages; includes all stages of the individual and family life cycles in continuous, healing relationships
Physician is center stage	Patient is center stage
Unnecessary barriers to access by patients	Open access by patients
Care is mostly reactive	Care is both responsive and prospective
Care is often fragmented	Care is integrated
Paper medical record	Electronic health record
Unpredictable package of services is offered	Commitment to providing directly and/or coordinating a defined basket of services
Individual patient oriented	Individual and community oriented
Communication with practice is synchronous (in person and by telephone)	Communication with practice is both synchronous and asynchronous (e-mail, Web portal, voicemail)
Quality and safety can be assumed	Processes are in place for ongoing measurement and improvement of quality and safety
Physician is the main source of care	Multidisciplinary team is the source of care
Individual physician-patient visits	Individual and group visits involving several patients and members of the health care team
Consumes knowledge	Generates new knowledge through practice-based research
Experience based	Evidence based
Haphazard chronic disease management	Purposeful, organized chronic disease management
Struggles financially, undercapitalized	Positive financial margin, adequately capitalized

Source: Future of Family Medicine Project Leadership Committee. The future of family medicine: a collaborative project of the family medicine community. *Ann Fam Med*. 2004;2(Suppl 1):S3-S32. Reprinted with permission.