



The Future of Family Medicine's Role in American Medicine

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In November of 2013, the Council of Medical Specialty Societies (CMSS) endorsed the National Quality Strategy (NQS). Described by the Centers for Medicare and Medicaid Services (CMS) as the “Three Part Aim,”¹ and referenced herein with the Institute for Healthcare Improvement’s (IHI) copyrighted phrase, the “Triple Aim,”² medicine now seeks to enhance the experience of care for patients, measurably improve care outcomes for populations, and reduce per capita costs of care. The specialties of medicine seem to now agree with the premises described in Family Medicine for America’s Health (FMAHealth) by Puffer et al,³ that the US health care system is fragmented, costly, and underperforming; that health care will increasingly be delivered through teams; that payment reform will and should be linked to quality; and that the promise of effective health information technology remains unfulfilled. Will other specialties likely agree with calls for family medicine to play a significant role in shaping a new health system, partner with other specialties to lead change, and act now? I suggest that the answer is an unequivocal yes. But can family medicine step up and meet these challenges?

I have the privilege and challenge of serving as CEO of CMSS, a role that seems appropriate for a generalist physician. I assumed my current role after serving on the staff of our own specialty society, the American Academy of Family Physicians (AAFP), before which I was an academic family physician, residency director, and rural physician. CMSS now has 44 member societies that in the aggregate represent 750,000 physicians in the United States. What brings the specialties together is a mutual commitment to facilitating a culture

of performance improvement in practice and modeling professionalism, which includes putting patients’ needs first.

Collectively, the specialties are already prioritizing several of the elements of FMAHealth. For example, there appears to be widespread recognition that a primary care foundation for the US health system is desirable. Emerging from the Future of Family Medicine project more than a decade ago, thousands of family physicians now embrace the concepts of a patient-centered medical home (PCMH). Still, medical “neighborhoods,” specialist’s roles recognized by NCQA as patient-centered specialty practices (PCSP), have been much slower to catch on. Payment reform, often competitively proposed by individual specialties, is an area of recent collective effort. Recognizing that new alternative payment models will be linked to quality improvement has brought the specialties together. Specialties even recognize that primary care is underpaid, which has been easier to promote since CMS implemented payment incentives that no longer appear to be a “zero sum game,” at least for physicians. Can family medicine capitalize on this historic cooperation in payment and delivery system reform to capture the commitment of a uniting profession? Will we lead, follow, or be pushed aside?

It is heartening to see that FMAHealth prioritizes one of the enduring attributes of family medicine: engaging patients, families, and communities as partners in their health.⁴ Along with performance improvement and linked payment reform, patient and family engagement is a national priority of the specialties

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aggregated as CMSS. Encompassing shared decision-making, patient education, patient access to health records, and asynchronous electronic communication, this partnership of public and profession is promising but nascent. The commitment “to engaging and empowering patients, their families, and communities, and health care professionals,” as described by Puffer et al,³ is family medicine’s to grasp or lose. Is family medicine ready to accept its birthright in community health to lead the profession of medicine into an era of partnership with patients and families? At our inception, family medicine responded to calls of a public commission⁵ and a professional committee⁶ by designing itself to meet society’s needs. Do we today recognize society’s needs and expectations, and the implications of designing a practice, and a delivery system, to actually function as patient centered?

Family medicine has succeeded in facilitating a rapid rise in the number and percentage of physicians using electronic health records, despite interoperability not being an element of the business models of electronic health record (EHR) vendors. FMAHealth references “big data” and specifically “registries.”⁷ Registries were introduced into primary care (family medicine, internal medicine, pediatrics) practices through the Robert Wood Johnson Foundation funded “Improving Performance in Practice” (IPIP) project in 2006.⁸ Since then, the use of registries in specialty practices has greatly outstripped those in primary care. In 2006, seven specialty societies sponsored registries (American Society for Reproductive Medicine, American College of Surgeons, Society of Thoracic Surgeons, American College of Cardiology, American College of Radiology, American Society of Plastic Surgeons, and American Society of Clinical Oncology). In 2015, there are 123 clinical data registries sponsored by 68 organizations, 90% of which are hosted by specialty societies.⁹ Registry development by specialties is the current highest national priority of the specialty society members of CMSS.

Performance-improvement CME (PI-CME), introduced by the AMA in 2005 and immediately adopted by the AAFP’s CME system to augment its national leadership in Evidence-based CME (EB-CME), offers only periodic and voluntary participation in measurement/improvement/re-measurement. ABMS Maintenance of Certification Part IV, assessment of performance in practice, has incorporated PI-CME since 2009, but it is required of

diplomates only once every 3 years. Registries hold the most convincing promise to foster a culture of performance improvement in practice, as they are tools that incorporate real-time data entry about whole patient populations exhibiting the attribute being measured. Family medicine is late in sponsoring a national clinical data registry. The Medicare Reform and CHIP Reauthorization Act of 2015 (MACRA) specifically promotes participation in clinical data registries as fulfillment of linking practice-based quality improvement with payment incentives. Registries measure performance, which means that they must incorporate meaningful nationally accepted performance measures for the specialists who participate. With more than 80 current electronic clinical quality measures applicable to primary care, will family medicine continue to rely on others to develop national benchmarks against which family physicians will be measured and therefore paid?

There is also agreement in GME policy between the recommendations of FMAHealth and the positions of the nation’s specialties.¹⁰ Such recommendations focus, importantly, on workforce numbers. Saultz et al remind us of a persistent internal challenge that transcends how many family physicians are trained: “The growing diversity of practice models has created uncertainty about the role of the family physician.”¹¹ The role of the family physician in the future health care system is indeed unclear to other specialists, to team members, and to students, let alone to patients. It should be possible to train sufficient numbers of family physicians for the needs of the emerging US health system, assuming that the curricular expectations are clear and consistent and that evaluation of trainees is formative and rigorous. Are we similarly clear and consistent in our expectations of our graduates? The specialty of family medicine was conceived to meet the needs and expectations of society, and it delivered. Are we clear on what society needs and expects of the generalist physician today and tomorrow? Without key stakeholders recognizing family medicine’s new brand promise, FMAHealth will be at best a marketing exercise.

Perhaps the most promising potential partnership, however, lies in what deGruy et al¹² refer to as a “culture of curiosity.” In generating the knowledge required for the transformation inherent in FMAHealth, there is an explicit call for partners from many disciplines on the one hand, and for the use of registries

on the other, both of which directly focus on the priorities of many specialties. Embedded is the key recommended action that envisions linking, even potentially merging the “culture of curiosity” with the “culture of performance improvement.”

“Every clinician practicing in the US can and should become a partner in the expanded primary care research workforce; we should set this as an expectation, and we should reorganize our research workforce accordingly.”¹²

Only two of the current specialty society clinical data registries in the United States are jointly hosted by two specialties (not including sub-specialties). Could family medicine, an early registry adopter through IPIP, but dormant since, rise to the emerging culture of performance improvement in practice and lead the other specialties into utilizing registries jointly as a national practice-based research enterprise?

The specialties of medicine agree with the basic premises, even though they are unaware of FMAHealth. While not inherently opposed, they are not waiting for family medicine to lead, nor do they perceive a societal need for FMAHealth. In some arenas, specialties invest in expensive silos, such as clinical data registries, which contain valuable data. In other arenas, the specialties recognize and prioritize a need, but are perhaps unknowingly waiting for breakthrough leadership, such as in the engagement of patients and families in their health care and their health care system. While committed to a culture of performance improvement, the specialties may not recognize that it can be wedded to a culture of curiosity. Although directly referring to the latter concept, perhaps deGruy et al summed up the historic challenge of FMAHealth in their closing comment:

“This ambitious agenda deserves our closest attention, our focused collective wills, and our most strenuous creative efforts. These efforts are more likely than ever before to be rewarded.”¹²

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