Revisiting the Foundation of Care for the Family Medicine of the Future

Goals for Summer 2025 Summer Retreat

- To define and debate the foundational principles of a clinical model of family medicine for next generation.
- To explore how these principles can be implemented.
- To identify next steps for strategic planning for the specialty, including payment reform, workforce, catalyzing innovation and adoption of new technology.
- To support networking and collaboration across the leadership of Family Medicine

Rationale and Background

In 2025, our patients and communities are facing decreasing life expectancy, worsening health outcomes, increasingly fragmented care and profound disparities. As a country, and as a specialty, we need new answers. We believe that a foundation of robust primary care and primary care teams is an important part of any solution. Given the significant changes in our patients and in the organization of health care, it is important to revisit the clinical model of family medicine and frame key principles that should drive the organization of family medicine practice and guide innovation and investment in the future. Of course, given the variety of communities and geographies we serve, there is no such thing as a pure "clinical model of family medicine"; our hope with this effort is to describe the specifications for the foundation of health care which will then translate to the needs of communities. The principles thus need to be foundational and generalizable; the implementation will be flexible. We also understand that it will be important to develop national strategies for payment change, workforce development, technology and other areas—but the first step is having a vision of what we want to create.

This conference is intended to frame and debate foundational principles for the model of clinical care for family medicine for next generation of clinicians and patients.

Conference Agenda

Day 1

Thursday, August 14, 2025

1:00-1:30pm *Welcome and Introduction to the Meeting*

- Welcome--Warren Newton, MD MPH (President, ABFM)
- Blessing for a time of peril and opportunity: Carlos Gonzales, MD (Board Chair, ABFM)
- Goals and organization of this meeting and the draft principles
- Guidelines for debates and discussions

Principles of the Model of Care for the Future of Family Medicine—next draft will be at every table.

1:30-3:15pm Improving Access, Continuity, and Patient Experience

Moderator: *Steve Lin MD, Stanford (President, STFM)*

Introduction: *Lack of access is an existential threat to our specialty and to our profession. How will family medicine address access? Is this feasible or practical? What should our goals be?*

Proposition: *Family Medicine commits to improving access to continuity of care and enhancing patient experience.*

Prevote

A. Improving Access

1. Managing What We Measure: Proposal for Metrics and Benchmarks for Access from the MP3 Collaborative: Warren Newton, MD, MPH for the MP3 collaborative, (President, ABFM)
2. The Imperative of Practice Redesign: Lessons learned Key Access Concepts from Bright Spot Practices: Marianna Kong, MD, UCSF
3. Maximizing continuity and minimizing delay across a large health system: Sam Weir, MD, University of North Carolina

4. Team redesign: MD/DO + APP teams with increased panel sizes: Jason Ramm, Baylor Scott and White
5. Discussion (20 minutes)

B. Continuity and Patient Experience as Balancing Imperatives

Moderator: Steve Furr, MD, Board Chair (AAFP)

Introduction: *Access is necessary but not sufficient. Balancing measures are continuity and patient experience. How to combine address all goals at the same time is a major challenge.*

1. Measuring Continuity: the contributions of personal physicians and teams: Bob Phillips, MD, MSPH (CPV Executive Director, ABFM)
2. Integrating virtual, urgent care into continuity of care: Richelle Koopman, MD, MS, Missouri (President, NAPCRG)
3. Improving patient experience through scribe/AI support of documentation: Grant Greenberg, MD, Lehigh Valley Network Health System
4. Discussion (15 minutes)

Final Vote

3:15-3:30pm ***Break***

3:30-5:30pm ***The Scope of What Family Physicians Do***

Moderator: *Sarah Cole, DO Mercy Health (Past President, AFMRD)*

The demands on family physicians are great, the result of the advance of technology, fragmented care, and needs unmet during the pandemic. In the spirit of "good strategic planning starts with what we choose not to do", these sessions ask ourselves the hard question of what aspects of caret, if any, we want to give up—and if we don't do it, who will?

A. How much should we prioritize clinical preventive services?

Introduction: *Much of what family physicians do is clinical prevention—primary, secondary and tertiary—the marketing study done for the Future of Family Medicine called this out and urged Family Medicine to champion prevention. Now, however, with the crisis of access, the burden of documentation, and continuing consequences of the pandemic, the question has come up whether we have time for prevention. Furthermore, governmental decisions took many vaccinations out of primary care and online prevention opportunities such as calcium scan are proliferating. To maintain prevention as a part of our portfolio thus requires an affirmative decision.*

Proposition: *Family Medicine should recommit to routine clinical prevention, such as vaccination and counseling about primary and secondary prevention.*

Prevote

- Pro: Carl Morris, MD , Washington Kaiser Permanante
- Con: Dean Seeheusen, MD, Augusta Medical School, (President, ADFM)
- Discussion for 20 minutes

Final Vote

B. Should family medicine and the family physician be responsible for addressing population health and the social drivers of health?

Improving population health is a key tenet of health care reform, but how to accomplish this is unclear. Some argue that traditional public health and health systems should lead this effort, but others argue that robust primary care should take on this role. As with clinical prevention, however, family physician time is limited, and practical issues such as availability of analytics, screening protocols, shared decision making and available community resources are critical.

Proposition: *Family Physicians and their teams should be responsible for improving population health and addressing social drivers of health.*

Prevote

- Pro: Melissa Stephens, MD, MS, Arkansas College of Osteopathic Medicine, (AAFP Foundation)
- Con: Joe Gravel, MD, Medical College of Wisconsin, (President, STFM)
- Discussion

Final Vote

C. Should family physicians continue inpatient care of adult medical patients?

Over the last generation, a decreasing proportion of family physicians take care of medical inpatients in the hospital; moreover, across the world, only family physicians in Canada and in the United States provide a substantial amount of hospital care. Many family physicians do not do inpatient work, underscoring that the time spent in the hospital takes away from access and continuity of care. However, a substantial proportion of the total cost of care comes from hospital care, and transitions of care remain a major national problem of both cost and safety. If we want to improve cost effectiveness of the overall health care system, we must take on hospital care for medical patients.

Family Medicine residents are trained to take care of patients in the hospital. Over the last 8 years, three years after residency, a consistent 9-10% of family physician residency graduates work as hospitalists, and about 25% of graduates combine continuity care with some kind of hospital care. Key issues include the evolution of hospital care, whether reform of hospital care is needed, the scale and clinical model of hospital care and connections with continuity practices.

Proposition: *Family Physicians should continue inpatient care of adults.*

Prevote

- Pro: Stephen Wilson, MD, MPH, Boston University
- Commentary: Erika Steinbacher, MD, Advocate Health
- Con: Tracey Conti, MD, MBA, UPMC
- Discussion

Final Vote

5:30-6:15pm ***Break***

6:15-7:30pm ***Reception and Dinner***

7:30-8:30pm ***Reflections on Family Medicine, its Future and Foundation***

Moderator: *Brian Kessler, DO, MS, Meritus College of Medicine) (Past President, ACOFP)*

- ***Our Care****: Ontario Primary Care Reform and Next Steps Tara Kiran, MD, Toronto*
- ***The Meaning of Professionalism for Diplomates and Patient Advocates*** *Annie Koempel, PhD (ABFM)*

Day 2 ***Friday, August 15, 2025***

7:00-7:45am ***Breakfast*** (*optional*)
Affinity Groups: Residents, Public Members; Others as desired—by age, practice setting, or "potluck."

8:00-8:40am ***Opening Session***

Moderator: *Richelle Koopman, MD MS—Missouri, (President, NAPCRG)*

What promises should family medicine make to the public?

The enduring commitment of general practice—and its successor family medicine—is to continuity relationships. This was framed by Fox in 1960, embraced by the new specialty of Family in 1969 and reaffirmed in the Future of Family Medicine initiative as the Patient Centered Medical Hom. As of 2025, however, there is increasing evidence of the positive impact of robust primary care on health outcomes for many patients and many diseases. As we engage patients, communities and policy makers, should we promise outcomes as well as continuity? Should family medicine commit to improving outcomes, assuming robust clinical teams?

Prevote

Propositions:

- *Family Medicine should focus its public message to patients, communities and policy makers on promising enduring continuity relationships--Raj Woolever, MD, Portsmouth Residency,. (President, AFMRD)*
- *Family Medicine should commit to improving health outcomes for the major diseases and conditions their patients suffer from, in addition to continuity. (Kate Rowland, MD, MS Rush University*
- *Discussion*

Final Vote

8:40-8:45am ***Plan for the Morning***

8:45-9:00am ***Break***

9:00-10:30am ***Break Out Sessions:***

ROOM A

Moderator: Dean Seehuesen, MD, Augusta (President, ADFM)

A. Comprehensiveness of Care

Comprehensiveness is the most important of Starfield's 4 Cs, but is challenging for contemporary family physicians to provide. While comprehensiveness has been conceptualized in many ways, from taking care of both physical and mental health to whole person care to taking care of 95% of the problems patients present with, family physicians are providing less of it. Now, in 2025, should we re-commit to comprehensiveness—to, for example, taking care of 95% of the problems patients present with? Is this feasible in contemporary practice? Should this be individual family physicians, their practices or their health systems? Moreover, if the specialty commits to comprehensiveness, how should family physicians assure the public that they can continue to do this over their careers?

A Dialogue on what implementing comprehensiveness means…

Prevote

- Introduction to the dialogue: *definitions and data on scope* (5 min): Andrew Bazemore, MD, MPH (Senior Vice President, ABFM)
- Proposition (pro) *Family medicine is losing comprehensiveness and we need to train and do more to promote comprehensiveness. (3 min)* Alan Katz MD Manitoba (President-Elect, NAPCRG
- Proposition (con) *We are asking too much of family physicians and we are doing well with comprehensiveness and need to embrace the team to help physicians* Alex Krist, MD, Virginia Commonwealth

- Fireside Dialogue among Bazemore, Krist, Katz (10 min)
- Discussion (15-20 min)

Final Vote

Should the specialty advocate for comprehensiveness to be a primary driver of how family medicine is funded, measured, and trained?

Propositions

A) Yes – Comprehensiveness at the individual-level should be central to our advocacy and system design.

B) No – We should focus on other priorities like access, continuity, or team-based care models.

B. Team-Based Care Theory and Reality: Can we implement and scale up?

Team-based care has been promoted for over 50 years, but the definition remains unclear and the implementation variable in primary care settings. Should family medicine commit to team-based care in as many settings as possible? If so, what are the most important components of team-based care and how should we do it? Is it practical to apply to all care family physicians provide?

Proposition: *Family Physicians should embrace team-based care in as many settings as possible, working closely with other professions to improve access, outcomes and cost effectiveness.*

Prevote

- Data collaboration trends --Andrew Bazemore, MD MPH (Senior Vice President, ABFM) (5 min)
- Team structure and function across a large system: David Rushlow, MD Mayo
- Lessons learned from integrating behavioral health: Kyle Knierem, MD, University of Chicago, MD

- Integrating pharmacists into primary care practice: Trish Klatt, Pharm D, BCPS, CTH, University of Pittsburgh
- Discussion

Final Vote

ROOM B

Moderator: Christine Hancock, MD (Board Chair Elect, ABFM)

A. What is the role of professionalism in a model of care for the future of Family Medicine?

Professionalism is traditionally defined as a set of core beliefs shared by the profession, along with specific behaviors, and there has been increasing attention to the development of professional identity over medical school, residency and practice. In 2004, the ABIM Foundation Professionalism Charter set professionalism at the center of medicine and over 100 medical organizations in North America and Europe signed off. Now, however, 20 years later, its foundational role is more controversial. Some students and residents report that it has been weaponized, and in practice professionalism is often honored in the breach, a "nice to have" rather than a central part of education and practice. Which is it? What should we emphasize?

Prevote

Propositions:

- *Professionalism is fundamental to the education and practice of family physicians over their careers and vital to our role in society and in healthcare (Andrea Anderson MD MEd, George Washington (Past Board Chair, ABFM)*
- *Professionalism is nice to have but distracts from more urgent issues for our specialty. (Jehni Robinson, MD, USC (Board Chair, ADFM)*
- Discussion (20 min)

Final Vote

B. Should family medicine commit to solving deserts of care?

Over the last approximately 10 years,"deserts" of care have been growing. Rural life expectancy began to drop in the 2000's, before the general population, and obstetric deserts have progressively grown over the last

number of years as the result of malpractice insurance expense, insufficient clinician payment, closure of rural hospitals and decreasing numbers of family physicians and others who want to deliver babies. Addressing this problem will be very challenging. For our specialty, deserts of care represent a challenge which is both moral and practical: should we commit to healing them? Will FPs actually commit their lives and careers to this work? What other resources are necessary, and will they be available in the community?

Proposition: *The specialty of family medicine should commit to addressing deserts of care.*

Prevote

- Framing the Problem: Obstetric and other deserts--Yalda Jabbapour. MD Director, Robert Graham Center (AAFP)
- Pro: Making the Case for Commitment--Greg Cohen, DO (ACOFP)
- Con: Talk is cheap; this is a distraction! --Shawn Martin, MBA--Executive Director (AAFP)
- Discussion

Final Vote

ROOM C

Moderator: Saruj Misra, DO (ACOFP)

A. Should Family Medicine Continue to Commit to Performance Improvement?

The ABFP required chart audits as a part of its first recertification, emphasizing that knowledge of good clinical care was not enough: Diplomates had to demonstrate good care. With maintenance of certification arriving in the early 2000s, performance improvement was built into ongoing certification and, in the early 2010s, into residency education. However, in recent years, ABIM initially declared PI optional, with the rationale that what difference individual physicians can make is limited, that the burden is substantial and that systems change is more

important. A recent article in JAMA made this argument more explicitly, questioning the overall value of the effort nationallyt. In 2025, should performance improvement continue to be a priority for our specialty?

Proposition: *Family Medicine must continue to embrace performance improvement in residency education and in practice.*

Prevote

- Pro: David Price, MD (ABFM)
- Con: Sarah Cole, DO Mercy Health (Past President, AFMRD)
- Discussion

Final Vote

B. Should family medicine embrace community involvement and engagement?

Community involvement and engagement was a wellspring of family medicine in the 1960s, and it continues to some extent to this day. Practically, however, sustaining community engagement is difficult in an age of employed physicians and decreasing support for volunteerism. Should we recommit to community engagement, and if so, how best to do this? How should this be built into education and practice?

Proposition: *Family Medicine and family physicians should embrace community involvement and engagement over their careers.*

Prevote

- The Case For Commitment to Community: Brian Kessler DO MS Meritus SOM (Past Board Chair, ACOFP)
- The Case Against Involvement in Communities: Colleen Fogarty MD MSc, Rochester (President Elect, ADFM)
- Discussion

Final Vote

10:30-10:45am ***Break***

Revisiting Our Promises
(Large Group/Large Room)

10:45-11:30am **Moderator**: Warren Newton, MD, MPH (President, ABFM)

Revisiting the Principles of the New Model of Care

- Reflections on what we have learned
- How should the principles be revised?
- Discussion

11:30am-12:00pm Next Steps

What will be necessary to implement this model of care? What do we need to develop specialty wide strategies for? What are the priorities?

Possibilities include:

- Payment Reform
- Workforce Development: FPs and Beyond
- Embracing Technology
- Catalyzing and Sustaining Innovation
- Advocacy
- Building a coalition
- Others?

12:00-12:45pm ***Lunch***

Box lunches available. Guests may pick up box lunches and leave. All organizations will provide written reports on their work since February, including any work they've done on residency redesign, research, AI in primary care, medical student recruitment, and POCUS. Over lunch, there will be brief oral organizational reports from AFMRD, ACOFP, AAFP Foundation, ABFM (12:15-12:45pm)

Family Medicine Leadership Council Meeting

1:00-2:00pm	*Advocacy: What is the proposed Administration for a Healthy America? What will it include, what will happen to HRSA and AHRQ activities? How can we advocate? Shawn Martin MBA, Executive Director (AAFP)*
2:00-3:00pm	*How can Family Medicine residencies be more attractive for medical students in the match? (panel with Raj Woolever, MD, Portsmouth Residency (President, AFMRD) Jehni Robinson MD USC (Board Chair ADFM), Molly Clark, PhD. Mississippi, (President Elect, STFM*)
3:00pm	Adjournment