Lessons From the P4 Project

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Over 15 years ago, a national planning effort called the Future of Family Medicine Project recommended a redesign of family medicine's clinical model based on what was later called the Patient-Centered Medical Home (PCMH).[1] Soon after the final reports of this project were published, an experiment was commissioned to study how these changes might be implemented in a national sample of family medicine practices. The original plan was to include at least two family medicine residency clinics in this experiment, but the study's investigators soon realized that residency clinics were different in important ways from community practices. In fact, the problems facing residency programs in initiating the PCMH are unique. So the study, soon named the National Demonstration Project, was initiated without any residencies in the sample.[2] But this left a major question unaddressed: how will residency programs adapt to the changing clinical model? To answer this question, the American Board of Family Medicine (ABFM) chose to fund a separate study of residency transformation, later named the Preparing the Personal Physician for Practice (P4) study. A national advisory committee, chaired by Drs Larry Green and Sam Jones, was appointed to oversee this work and all existing family medicine residencies accredited by the Accreditation Counsel for Graduate Medical Education (ACGME) were invited to apply for the study. Forty-four full applications were solicited after considering initial applications from 84 programs. Fourteen programs were selected by the steering committee to participate in the project and each proposed a set of innovative changes to their programs. So the P4 experiment was a case series of 14 residencies, each undertaking their own transformation projects. The steering committee selected a national evaluation team to systematically evaluate the change process in these programs. The project completed data collection in 2014 and has produced 39 published papers in the peer-reviewed literature describing various aspects of their findings.

In this issue of *Family Medicine*, we publish the final report from this experiment summarizing its findings and recommendations.[3] By any definition, the P4 project ranks among the most ambitious educational experiments undertaken in the history of our discipline, and Carney and colleagues have done a fine job of summarizing its findings. At the start of P4, fewer than one-fourth of the ACGME-accredited residencies in the nation chose to apply to be part of the project. It is interesting to consider why the participation was not more robust. Some of the programs that did not apply were in the process of leadership changes. Others were struggling with local issues. Some were probably concerned about whether funding for the project would be adequate. But an overriding concern was that curricular change would deter residency applicants and programs were, and continue to be, highly concerned about improving their match results. The programs that did participate in P4 faced significant challenges. The resources funding the study were largely spent on creating a comprehensive evaluation program and few resources were provided to the programs themselves. By any measure, participating in P4 added huge amounts of work for the faculty and residency directors in these programs. There was substantial uncertainty about how applicants would view program participation

and there were concerns about how the ACGME review process would view programs that chose to deviate from the traditional residency model. So our discipline owes a debt of gratitude to these 14 programs and to every resident and faculty member who worked in them during the study. Rarely has so much work been done by a relatively few people to benefit so many.

Now that the P4 project is completed, what should be our take-home lessons? Carney and colleagues have clearly summarized the findings of this study; every residency faculty member in the nation should study their paper carefully. Four of their findings are particularly important:

1. A collaborative of 14 very different programs was able to successfully work together with few outside sources of funding to create new knowledge about family medicine residency education. Since P4, networks of residencies have undertaken additional studies, including the ABFM-funded Length of Training Pilot study[4] and the I3 Collaborative in Virginia and North and South Carolina.[5] Such collaboratives were untested before P4.
2. Innovation in the structure and content of family medicine residencies can be undertaken without jeopardizing accreditation status and actually makes programs more attractive to medical students. Few programs today worry that innovation will scare away applicants.
3. Creating a team-based model of care in a residency setting is hard work and requires sustained effort over multiple years. It also requires a new educational approach based on faculty learning with residents rather than faculty teaching as experts.
4. Rigorous evaluation methods are hard to develop and expensive to implement, but rigorous evaluation shows that residents in the P4 programs outperformed their contemporaries in other programs. While this might have occurred because the programs recruited stronger residents, the higher scores on in-training and board certification examinations are persuasive.

The P4 study also offered intriguing evidence about the length of training even though only three of the programs experimented with lengthening residency beyond the traditional 3 years. Residents from 4-year programs entered practices after graduation that included a significantly broader scope of practice than those from traditional 3-year programs. While this finding will need to be confirmed with additional research, it is particularly important at a time when many leaders are concerned about shrinking scope of practice and physician burnout in our discipline. Recent reports suggest that broader scope of practice is associated with lower health care costs[6] and a lower prevalence of physician burnout in residency graduates.[7]

P4 may well be the most important educational research project ever undertaken in American family medicine. Those who signed up to participate in this project took a step into the unknown. They worked hard over a period of years and exposed their programs to real risks. In retrospect, it is clear that their effort has benefited all of us. We now know that residency innovation attracts the best students, that it can be done without extensive resources, and that it produces measurably better graduates. We have also learned that a centralized evaluation process can conduct rigorous educational evaluation on a national scale. The leaders of P4, the American Board of Family Medicine, the evaluation team led by Drs Patricia Carney and Patrice Eiff, and all of the faculty and residents in the participating programs are to be congratulated for this important work.

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