FMAHealth: A Work in Progress

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In its 50-year history, the discipline of family medicine has undertaken just two major strategic planning efforts. The first was launched after the collapse of capitated managed care and came to be known as the Future of Family Medicine Project (FFM). The resulting reports from this project, published in a special issue of the *Annals of Family Medicine* in 2004, have proven to be important historical benchmarks for our specialty.[1] For example, the report on practice transformation[2] introduced a new model of team-based care, eventually leading to the concept of the patient-centered medical home, and the report on medical education[3] called for competency-based education and a period of innovation in residency education leading to the Preparing the Personal Physician for Practice (P4) study.[4]

The second comprehensive review of our discipline began in 2013 after passage of the Affordable Care Act. This was originally called the Future of Family Medicine 2.0 and later came to be known as Family Medicine for America's Health (FMAHealth). FMAHealth was launched "by eight family medicine organizations to strategically align work to improve practice models, payment, technology, workforce and education, and research to support the triple aim."[5] Its goals were further defined in six papers published in September 2015 in a special issue of this journal.[6-11] The task of leading FMAHealth was delegated to a board of directors nominated by the family medicine organizations. The FMAHealth Board appointed seven tactic teams (technology, practice, payment, workforce education, research, engagement, and health equity) to organize this work.

In this issue of *Family Medicine*, we publish a series of articles describing the progress of these tactic teams 4 years into the 5-year project. Many of the most talented people in family medicine have worked on various aspects of this project. Their work addresses research capacity,[12-15] workforce goals,[16-20] and new models of clinical care.[21-26] These articles are a sample of the work that has taken place over the course of FMAHealth. There is much to be proud of here. Some of the papers represent a renewed commitment to time-tested principles. Others offer new insights into how our discipline is evolving during a time of unprecedented change in American medicine. The papers were submitted after an open call for submissions for this issue. They arose from groups of people working on tasks that broadly fall under the mandates of the tactic teams. It is commendable that FMAHealth has stimulated innovation at a grassroots level rather than simply proclaiming a new approach to our work from the broader view of national organizations. But the strength of this work is also its weakness. We can be proud of what is being done, but we also need to acknowledge what is missing. We did not receive a single paper about residency education. The special issue contains no report regarding the communications plan that has accounted for over half of the money invested in FMAHealth. Finally, the papers in this issue are hard to tie together into an overarching theme; they provide little strategic insight about a vision for our future.

When FMAHealth started, we had no way of knowing that the implementation of the Affordable Care Act would be stalled by repeated attempts to delay its adoption in many states. We had no way of anticipating attempts to repeal it at a national level. When FMAHealth started, about 20% of American family physicians were not yet using electronic health records, and the use of data to improve care was more an aspiration than a reality.[6] Osteopathic residency programs were still accredited by a system completely separate from allopathic residencies using different rules and procedures to assure quality training. The Patient-Centered Outcomes Research Institute was a new program and was still untested as a source of funding for family medicine research. A lot has changed in the past 4 years, but the questions facing our discipline are, if anything, more critical now than they were then. The stakes remain high for FMAHealth; there remains a sense of urgency for answers to critical questions that will determine our future and perhaps even our survival.

So what are these pressing strategic questions? Consider the following:

1. A growing percentage of the nation's family physicians are employed by integrated health systems. How are these new business relationships altering the traditional doctor-patient relationship? Do patients still choose their physicians or do they choose health care teams and how does this matter for those caring for them? Should family physicians be accountable to their patients or to their employers? Is it remotely feasible to claim loyalty to both?
2. There is growing evidence that the broad generalist scope of family medicine is narrowing. More family physicians are limiting their practices to adults, or to women, or to those with sports injuries. Fewer family physicians are providing hospital or maternity care. Are these trends to be welcomed or do they threaten the economic efficiency of our care? Is specialization within family medicine required to attract the next generation of family physicians or will such changes deter student interest?
3. Should every residency in our field be capable of training a family physician for any American community or is it better to allow programs to be more locally and individually focused? Can a graduate from a suburban community residency still attain the skills needed to practice in an isolated rural area or will fellowships after residency be required to attain these skills? Do we still have a common and shared quality standard for the skills and attributes of a graduating resident?
4. We have embraced the notion of health care teams and interdisciplinary care in the patient-centered medical home, but what specific roles should be played by the family physicians on these teams? If the scope of our clinical work is indistinguishable from physician assistants and nurse practitioners, is the additional cost of having physicians on these teams justified?
5. There is growing evidence that social factors play a greater role in the health of a community than health care itself. If this is the case, how can we justify spending what the country currently spends on health care at the expense of funding for education and social programs? If we think health care should be less expensive, what exactly are we doing to bring this about?

These are serious questions and I'm quite sure you could add others to the list. Our discipline has only engaged in strategic planning twice in our history. FMAHealth was created to provide guidance about big issues, and $20 million were invested in the effort. Maybe we have no control over these issues. Maybe the best we can do is to react to the world around us. Maybe all we need is an expensive communications plan to tell everyone how important we are. But that is not how the founders of our discipline saw things. They envisioned a discipline that would lead the profession of medicine and insist on change. They saw our primary moral obligation as protecting the people we serve from a health care system that was failing to put the public interest ahead of personal gain and corporate profit. Can anyone argue that this role is no longer needed? FMAHealth officially ends on May 31, 2019. Will it provide us with a strategy to address our future as a collective whole, or will each of us have to sort things out on our own?

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