LETTERS
TO THE EDITOR

"Family Medicine's Task in Population Health: Defining It and Owning It" Begins With the Community

TO THE EDITOR:

As family physicians, researchers, and educators who have been engaged in population health at the local, state, and national level for more than 3 decades, we would like to thank Drs Hollander-Rodriguez and DeVoe for their commentary on "Family Medicine's Task in Population Health: Defining It and Owning It"[1] and offer our perspectives for those who are either beginning the journey of working with their community, or like us, working to continually enhance those relationships.

We believe that population health is owned by the population, beginning with those residing in the community, as well as public health departments, community-based organizations, businesses, schools, and faith-based organizations, to name a few. As family physicians, we have important roles within this larger community, but there are a few key points to bear in mind.

One lesson we have learned is the need to begin by learning from and listening to the community. The US Department of Health and Human Services publication, *Principles of Community Engagement*, on which we worked, offers practical guidance, including:

> Remember and accept that collective self-determination is the responsibility and right of all people in the community. No external entity should assume it can bestow on a community, the power to act in its own self-interest.[2]

A second lesson is the need to partner with and build on what is already underway. When possible, reach out to the local or state public health department and review their community health assessment. Many cities and states are deeply engaged in population health activities, often with a particular focus on health equity, have robust data supporting multiple programs, and welcome partnerships with family physicians. Indeed, many health officials *are* family physicians! This focus on partnerships is also one of the themes of the report of the (then) Institute of Medicine, *Primary Care and Public Health: Exploring Integration to Improve Population Health*,[3] as well as the subsequent work, *The Practical Playbook: Public Health and Primary Care Together*,[4] both of which, and especially the latter, offer additional guidance and potential connections.

In working with these larger collaboratives, we have found that family medicine does not own population health, even among the traditional physician specialties. Our prior work identified population health milestones of many specialties,[5] including some unusual suspects. We are also inspired by colleagues such as Dr Mona Hanna-Attisha, who identified the Flint, Michigan water crisis and continues to work for its resolution while serving as pediatric residency director for the Hurley Medical Center program.

There is enormous opportunity for family physicians, individually and collectively, to improve the health of our communities. It is indeed time to seize the moment and join the movement that is already well underway, and to which we can collaboratively add our voices, data, skills, and commitment to learn how we can improve the health of all.

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Family Medicine and Social Determinants

TO THE EDITOR:

We would like to respond to the commentary by Drs Hollander-Rodriguez and DeVoe on the role of family medicine in addressing population health.[1] We agree there is a need for the health care system to address population health and its social determinants. We disagree, however, on their proposal to add skills to our already overstretched residency training programs. The skills the authors proposed included

> …community engagement, patient empowerment, community organizing, collaboration and team work, relationship leadership, informatics, data analysis and creative problem solving and the skills for conducting community assessments and for identifying adverse social determinants of health in our patient populations.

This list includes skills that most family physicians will never use. It is true that they are all important skills that are needed to effectively address population health, but there are other professionals with much more extensive training in these areas, who can better apply them in agencies that address population health issues. We should not try to make all family physicians population health experts. Recognition of and respect for the various competencies of other professionals, and collaboration with them is preferable to trying to take over their roles.

The vast majority of family physicians provide care on a daily basis to individual patients. What should we be training them to do to maximally serve a constructive role in addressing population health? We should emphasize the basic aspects of population health that are included in family medicine curricula and the patient-specific clinical skills that contribute to the population's health. We would organize these competencies as:

1. Collaboration with population health agencies
   - Communicating with local and state health departments and other agencies that assess and address population health
   - Accurately reporting reportable diseases and conditions and unusual disease clusters
   - Accurately recording vital statistics (on which a large part of community health assessments are based)
   - Referring patients to community resources that can help address an individual's adverse social determinates of health

2. Clinical prevention competencies
   - Fully implementing evidence-based clinical prevention guidelines (screening, immunization, counseling, and chemoprophylaxis)
   - Effectively counseling patients to achieve lifestyle changes
   - Providing guideline-based medical care of sexually transmitted diseases, tuberculosis, and other diseases important to the public's health

3. Cost-effective stewardship
   - Developing and implementing a quality improvement plan
   - Interpreting and critiquing medical literature (basic epidemiology and statistics)
   - Providing evidence-based medical care for highly prevalent chronic diseases
   - Avoiding unnecessary and costly testing, ineffective treatments, and excessive use of antibiotics

Until we can assure that most family physicians are performing this list competently and consistently we should not be adding competencies for which we can, at best, only partially train our residents. Those family physicians who want to take a more active role within the system, population, and community levels and in our political systems would be well served to obtain many of the skills listed by the authors by way of additional training, including certificate or degree programs.

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Response to "'Family Medicine's Task in Population Health: Defining It and Owning It' Begins With the Community" and "Family Medicine and Social Determinants"

TO THE EDITOR:

We welcome and agree with Drs. Michener, Bradley, Martinez-Bianchi, and Andolsek in their comments on the importance of community engagement and collaboration in the conversation around population health and the role of family medicine.[1] Our title's emphasis on "owning" population health[2] was intended as a rallying cry for our specialty to not eschew the current opportunities to improve the health of our communities. We would reiterate that we should be partnering with anyone and everyone who works to improve the health of groups of people.

Highlighting the importance of a community-engaged approach is an essential ingredient in this work and we appreciate the way that Michener, et al emphasize this element. Whether we are working on population health, advocating for policy change, or working in research, we face dilemmas and quandaries in how best to do this work.[3] We must ensure that we have engaged deeply, avoided token participation, and adequately included individuals and communities. Listening generously, learning from the community, and reflecting on the process with humility are not approaches unique to family physicians, but it is with gratitude that we recognize these as virtues we strive to cultivate in ourselves, our learners, and our teams.

The letter from Drs Campos-Outcalt and Pust[4] suggests that the majority of family physicians will not use the skills needed to address population health and so we should focus on the care of individual patients in residency training. Their suggestion that most family physicians will never need or use skills in community engagement, patient empowerment, community organizing, collaboration and teamwork, or the skills for conducting community assessments and identifying adverse social determinants of health saddens us deeply. Not only are these skills identified as necessary in the ACGME Family Medicine Milestones,[5] they are identified as ideal in the selected role definition that informed strategic planning and communication efforts of the Family Medicine for America's Health (FMAHealth) movement.[6] The foil definition that stated "the family physician is not responsible for patient panel management, community health, or collaboration with public health" was rejected.

Drs Campos-Outcalt and Pust list one of their desired competencies for residents as "referring patients to community resources that can help address an individual's adverse social determinants of health." Collaborating with and referring patients to community resources is important and necessary, but not sufficient for promoting health equity. Overall, their approach suggests a minimalist version of family medicine that avoids the comprehensiveness, adaptability, and community-responsiveness that have been suggested as necessary for rural[7] and underresourced settings. This is reminiscent of the debates held about the role and relevance of maternity care in residency training and the existential crisis we face around comprehensiveness in general.[8]

To mitigate the existential angst for trainees and practicing family physicians alike, we would turn to Kurt Stange's holarchy of health care in which he proposed a pyramid akin to Abraham Maslow's. In Dr Stange's pyramid, we address fundamental health care needs but also move up into the higher levels of integrated and prioritized care that include community and system needs.[9] Drs Campos-Outcalt and Pust suggest that we should not add more to the plate of our trainees until they have mastered more basic levels of care, but we would argue that trainees need us to articulate the vision of what it means to be able to foster healing in our health care system. Unless we keep our goals at the aspirational level of community-engagement, fostering healing, and working toward health equity, we will lose our way as a specialty.

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Reply to "Supporting Family Physician Maternity Care Providers"

TO THE EDITOR:

Drs Avery, Reed, and Skinner's letter regarding our article "Supporting Family Physician Maternity Care Providers" illustrates how collaboration between providers can improve outcomes in maternity care and reduce health care costs.[1] Lack of access to care is a key contributor to the maternal mortality crisis, and supporting family physician (FP) maternity care providers is essential to improve access to care.[2] FPs' roles in rural maternity care have been well documented in other studies.[3,4]The innovative approach to maternity care in West Alabama as described by our colleagues is a success story in provision of care for a rural, underserved community, and provides an excellent example of the kind of collaboration to which our article refers.

Our article discusses a variety of modalities for achieving and maintaining the skills necessary for FPs to provide maternity care, including operative skills, and also includes a table with examples of innovations in training and retention for rural FPs. Rather than requiring fellowships for all FPs, we recommend that health care systems promote the tiered training model.[5] The skill sets described in this model (Table 3 in our article) can be acquired during a family medicine residency or fellowship, depending on a given program's structure. Some FPs may even acquire these skills in practice with appropriate collaboration and mentorship from physicians in the community.

It is essential that family medicine be included as a partner to improve maternity care outcomes in communities, especially those with pronounced disparities. FPs with and without advanced maternity care skills, midwives, and obstetricians all bring distinct contributions to solving maternal health disparities and access, and our collaboration is of paramount importance to the future of maternal health.

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