Duke University’s Family Medicine Residency program is working hard to train family physician leaders who can function as adeptly as clinicians as they do as healthcare change agents. The program’s dual focus on physician leadership development and ambulatory/team-based care, make it one of the state’s most unique training programs.

**Program History**

Duke’s residency program began in 1972 as a joint effort between Duke University Medical Center and Durham Regional Hospital. The program initially trained 13 residents per year, but in 1991 consolidated at Duke University Hospital. Since then, the program has continued to refine and adapt itself to the changes in the healthcare environment and the specialty. To date, the program has graduated 348 physicians, four of which are medical school department chairs.

In 2006, the program announced that it would stop accepting new residents. This decision led to considerable reaction at the state and national level. The redesigned 4-4-4 program began recruiting new residents in late 2007 for its 2011 class.

**Physician Leadership Training**

When Duke introduced its new training curriculum, one of the program’s cornerstones was a commitment to physician leadership development. Its vision was to develop residents’ leadership skills for driving change not only in the clinical setting, but also in the communities and professions they serve.

“We want our residents to develop skill sets to be change agents when they graduate: physicians who can work with their local community to help affect positive change on the population they work with. That requires leadership skills and training,” explained Dr. Brian Halstater, Residency Program Director. “We’re constantly evolving and trying to find better ways of doing that.”

To achieve this, Duke’s initial approach consisted of having its third-year residents participate in departmental coursework tied to the university’s Clinical Leadership Masters program. While that led to progress, the program recently adapted its strategy and is now embedding leadership development training across its entire curriculum.

Halstater explained that although it is still relatively early to ascertain all of the impacts of this effort, he noted progress is already evident. He pointed out that at least a third of Duke’s residents are currently involved in leadership positions within the department and Duke School of Medicine’s committee structure and several are involved on state and national level leadership posts, with more in the pipeline. Duke residents are active with the AAFP/NCAFP and also within other organized medicine or community efforts. Recent graduate Dr. Matthew Kanaan serves as NCAFP Resident Director, and 2011 graduate Dr. Meshia Waleh served the NCAFP and was Resident Delegate to the AAFP Congress of Delegates.

Dr. Mo Shahsahebi, Duke’s current Chief
with the Patient Centered Primary Care Collaborative (PCPCC) and others has the potential for greater teamwork as we assist our members to put the right team together for their individual practice settings.

In a well-functioning team, everyone has a sense of ownership in the outcome, each person has a role, and everyone is a part of something larger than themselves. It should be this way in our practices and it also must be this way in our own professional organization. If elected, I may hold the title of President-Elect, but it is going to take a broad team of our members and staff to help pave the way for a bright future.

**NCAFP: With the Accountable Care Act ruled constitutional, what do you see as the biggest challenges facing the specialty in the next 24-months as reforms continue to role out?**

**CLF: I see many challenges, including educating our members on the broad implications of ACA, motivating our members to remain engaged and active in important policy discussions that will take place, as well as a number of political challenges. Regardless of the Supreme Court decision, the next presidential election or other outside forces, we all know our healthcare system has to change. The current system is unsustainable. It’s also clear that as family physicians, we are a key part of the solution, and we must be prepared to “lead the way.” Whether the Supreme Court ruled in favor of or against the ACA, the AAFP would have had challenges but more importantly, I believe, opportunities. The Patient Centered Primary Care Collaborative and many other sources, including private and public payors, now see the importance of primary care as foundational to our future health care system. Fortunately, the ACA has several key features that the AAFP believes are, and will remain, important to our organization, including health coverage for all.

While we can control our own future by truly transforming our practices, it will be crucial for the AAFP to help members understand the rules surrounding the ACA and any other new models or legislation, whether it’s Accountable Care Organizations or other payment mechanisms. The AAFP, state chapters and individual members have to stay engaged and active wherever discussions are held and policy determined, to be voices and advocates for our members and our patients. On the state level it is going to be important to have ongoing dialogues with hospitals and other larger entities to secure primary care input and leadership on whatever ACO type structures may occur. Nationally we have to look at the positive aspects of the ACA and help to maximize their benefits and to improve on the negatives as we see them, working with all to improve the lives of our members and patients.

Politically, this will be a challenge because even among our membership there are different opinions on the ACA, from those who are opposed to it versus those who partially or fully support it. The coming 24-months will see much political discussion, based unfortunately on partisanship rather than what is in the best interest of the people, our communities and the nation.

We will continue to struggle with the finances of healthcare as well as these political battles, but we as members and an organization must stay involved to help steer decisions in the right direction. Family Physicians need to stay focused on our positive contributions to any system and to patients in providing the most cost effective, efficient, highest quality care.

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**‘Duke Residency’ from p. 16**

Resident and the NCAFP’s Resident Director-Elect offered his perspectives on Duke’s leadership training. “With the leadership activities we do, we are taking a whole different approach to family medicine. Ultimately, when we talk about being change agents, it’s the effect on the macro of healthcare versus the micro,” explained Dr. Shahsahebi. Dr. Shahsahebi went on to explain that in order to impact communities and populations, physician leaders must understand both public health and health policy. Duke fosters residents training and experiences in both areas.

Since rolling out this new effort in 2007, Duke’s leadership development initiative has led to shifts in its recruiting approach. Many of the program’s current residents have previous leadership experiences or strong interests in population health or community-level engagement. And the type of physicians who are attracted to the program, as well as the ones the program ultimately identifies as strong candidates has also changed.

“We are very clear in the recruiting process as to what we are and what we are not. One of the reasons this program works is because all of us - our department and our residents - are all moving in the same direction to affect change in a similar way,” said Halstater.

**Team-Based Care Central**

Leadership development takes many forms at the program. The program’s strong emphasis on team-based clinical care serves as a great example. Residents are both active participants on the residency’s care teams, but also get experience in leading these teams as well. This supports the program’s mission to producing residents who are experts in ambulatory care, but who can also lead and drive clinical and community change.

“Family doctors are used to doing everything themselves. But with the complexity of health care and the need to bring in more services, bringing in the team approach has been very helpful,” noted Dr. Halstater.

Dr. Halstater explained that the entire university is committed to developing team-based care approaches. The Family Medicine Center that the residency calls home, a Level III recognized PCMH, has undergone a top-down redesign of its entire patient workflow process. The program has operationalized a host of team-based best practices, complete with re-configuring individual exam rooms and adopting a brand new EMR.

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**PCMH Integral**

Duke embraces patient-centered approaches in all aspects of its clinical operations and embeds PCMH training across its entire curriculum. The program has already re-certified under Level III of the new 2011 PCMH standards and approaches its PCMH training in a holistic fashion.

“Our residents embrace PCMH because they live it. They’re involved in the day-to-day operations of the program, practice in care teams and really learn by doing,” explained Dr. Halstater.

To get residents started off on the right foot, all interns (4 annually) go through a comprehensive PCMH orientation that puts the program’s care processes in context, explains PCMH terminology and its key constructs. As residents progress through their individual training, each learns how it everything fits together.

**Research & Quality Improvement**

Duke residents conduct a significant amount of research that seeks to bridge and integrate their clinical training, leadership development and community health focus. Many resident-led research efforts analyze clinical data and/or practice pattern data in an effort to improve interventions, physician collaboration and outcomes within the community. Residents gain valuable experience in discovering issues and translating their findings into real-world solutions that are implemented in the clinic (or within Duke’s primary care network). The ultimate goal is to create impacts at the community and population level and support the program’s change agent philosophy.

“Our program lays at the crossroads of public health and family medicine, hoping to improve population health. It is an exciting journey, as faculty are learning together with residents the concepts of population health management, and how to implement innovation, and look together at new opportunities and tools that have come our way after the passage of the Affordable Care Act,” noted Dr. Viviana Martinez-Bianchi, Associate Program Director.

As family physicians continue to embrace team-oriented approaches in the clinic, future payment models and delivery mechanisms might well rely on their ability to lead and impact a much larger population or community. That will require new and different skills, ones that Duke-trained family physicians will already know.