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|  | THEMES/Sub-Themes | 2025 Future State | How to Prepare in GME |
| Changing Health Care Needs |
| 1 | Patient Internet Usage and Wearable/Portable Devices | 1. Majority of patients are internet savvy. Search: 1) symptoms; 2) health concerns; and 3) health care providers
2. Technical access will be uneven
3. Wearable/portable health devices will be very common and used for monitoring many health care concerns
	1. Result in fewer office visits
	2. Infrastructure changes for health care organizations -- incorporate downloading of data from devices
 | Curriculum: How patients use the internetMindset: Not everyone will have access to technology (health care disparities)Curriculum: How to integrate wearable/portable devices into health care workflow |
| 2 | Demographics: Baby Boomers | 1. All Boomers will be 65+
2. Complex and chronic care needs
3. Prefer frequent contact
4. Social support needs
 | Curriculum: Geriatrics1. Remote care
2. Home care
3. Community-based care

Mindset: Millennials will care for patients with significantly different expectations and desires from themselves |
| 3 | Demographics: Generation X | 1. Prioritize convenience and cost over relationship
2. “consumer-oriented”
 | Curriculum: “Consumer-oriented” health care1. Urgent Care & Retail Care
2. Team for health care will be across organizations
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| 4 | Demographics: Millennials | 1. Diverse
2. Technically proficient
3. Prioritize convenience in health care over cost
4. Health systems will adapt (target market)
 | Curriculum: How to practice medicine with the confines of a health systemCurriculum: Technical proficiency (internet usage; virtual visits) |
| 5 | Racial/Ethnic Diversity | US population will be more diverse than even | Curriculum: Providing care for different cultures and how to practice inclusion |
| 6 | Patient contact with Health Care Providers | 1. Less frequent face-to-face visits
2. Team-based care the norm
3. Virtual visits (phone/computer)
 | Curriculum: Virtual Visit (differ from face-to-face)Mindset: Increased expectations for training physicians to operate as part of team |
| 7 | Public Health Care Quality Information | “Consumer-oriented” approach to health care and will be using the health care quality rankings for individual providers and hospitals  | Curriculum: Quality metrics for physicians |
| 8 | Big Data | 1. EHR (electronic health records) will interface with each other and create “big data”
	1. Genomic profiles
	2. Biometric data
	3. Device data
2. The HCOs will fund the research into big data; smaller CBIs will learn from the experience of the HCOs
 | Curriculum: How to mine the big data for patient care management decisions |
| 9 | Patient Access to Their Own Health Care Data | 1. Most patients will have access to their own patient care data
2. Data will be portable and carried by the patient from provider to provider
 | Mindset: Comfort level with patients who have most of their patient data available to them in real-time*NOTE: Not all patients will be health care data-savvy.*  |
| Changes in Health Care Delivery |
| 10 | Physician and Health Care Teams | Health care teams will be the normArtificial Intelligence (AI) will be part of the health care team practice:1. Diagnoses
2. Managing care
3. Care coordination
 | Curriculum: How to work with AI to make health care team decisionsMindset: Can we trust AI?  |
| 11 | Retail Health Care | Urgent care centers, Pharmacies and Big-Box stores will provide emergency care; chronic care and disease management (asthma, hypertension, CHR) with limited physicians providing the care | Mindset: How to communicate/work with patients who carry their own patient care data |
| 12 | Hierarchy of Health Care Teams | Health care teams will not be hierarchical | Curriculum: Communication Skills for physiciansMindset: Physician does not need to be the leader of the team |
| 13 | Medical Knowledge and Standardization of Clinical Care | 1. Clinical care pathways
2. Structured, standardized care plans
3. AI will guide diagnosis, care decisions
 | Curriculum: How to develop/evaluate clinical care pathwaysCurriculum: How to integrate AI into health care managementMindset: Can we trust AI?  |
| Evolution in Health Care Systems |
| 14 | Health Care Financing and Disparities | Higher co-pay/deductible* Needed to pay for catastrophic care
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| 15 | Acute Care | Rehab will be added to acute care patient care management* Much of this care will be remote
 | Curriculum: Collaborative team care skills |
| 16 | Health System Mergers | Large Health Care Organizations (HCOs):Prioritize Productivity/Efficiency* Workforce planning
* Critical pipeline for new physicians
* Cost of GME will be questioned
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| 17 | Health Care Payment and Delivery Models | Service lines vs Specialty-based departments* Bundled payments
* Capitated payments
* Pay for performance
 | Curriculum: Clinical performance measurementCurriculum: Continuous quality improvementCurriculum: Interprofessional teamwork skills |
| 18 | Health Systems and Population Health | HCOs are proficient at using patient data to manage population health management | Curriculum: Computer-based practice skillsCurriculum: Ethical/professional concerns with using patient data |
| 19 | Health Care Professionals and Population Health | Routinely use aggregated patient data to measure safety/value | Curriculum: Deployment of data/analytical toolsCurriculum: Individual, team, and organizational performance goals |
| 20 | Bundling and Commonization of Health Care Services | Increasing bundling of health care services | Curriculum: Health care payment modelsCurriculum: Communication with team (asynchronous) |
| 21 | Strategic Planning | 1. Long-term (>5 years)
2. Strategic workforce goals
3. Physician training/recruiting
 | Curriculum: Organization missions and goals |
| Evolution in the Role of the Physician |
| 22 | Cost-Efficient Health Care | Physicians are evaluated on their cost-efficient health care practices* Marketplace transparency
 | Curriculum: Health care financial system; core principles of cost-conscious practice; and role of value in health care decision-makingRecommendation: partner with health care organization for this curriculum |
| 23 | Work-Life Balance | Employed by HCOsSelf-sacrifice → Balance | Curriculum: Recognize and address burn-out |
| 24 | Physician Employment | Most are employed by HCOsIssues:1. Enacting change
2. Adapt to rapidly evolving documentation and care processes
3. Require high levels of skill:
	1. Leadership
	2. Communication
	3. Adaptation
 | Curriculum: Function of documentation and care processes; value of HCOCurriculum: Leadership, communication skills and adaptation |
| 25 | Artificial Intelligence | Will be used frequently in the background (e.g. decision support) and foreground (patient care and manage decisions)* Large HCOs will invest in research

Issues:* Trustworthiness
* Safety
 | Mindset: AI will need be trustworthy and safe. This may a difficult transition for all members of health care team. Digital natives may get their sooner. Curriculum: How to use AI effectively |
| 26 | Specialization | Focus will change to service lines from specialization departments* Bundling and capitation
 | Mindset: adapt to a different training modelCurriculum: Function in patient care team |
| 27 | Accountability for Faculty with Clinical and Educational Responsibilities | HCOs will have a strong business interest | Curriculum: Coordinating faculty development that “defines and upholds common standards of professionalism” |
| 28 | Compensation for Faculty with Clinical and Educational Responsibilities | * HCOs will be highly involved in compensation plans.
* More consistency across the nation in faculty compensation plans
 | SIs will need to partner with their HCO to coordinate compensation for faculty |
| 29 | Medical Literature | More medical journals:* Smaller self-published, online, and open access journals will appear
* Millennials will use blogs, podcasts, and other media
 | Curriculum: Conflicts and dualities in interest; critical thinking skills to evaluate literatureMindset: Electronic, self-directed and individual approaches to accessing and incorporating medical literature |
| Evolution in the Role of Other Health Care Professionals (eg, RNs, NPs, PAs, Clinical Technicians, Pharmacists, Social Workers) |
| 30 | Remote Delivery of Health Care | * Diversified scope of practice and levels of specialization of other health care professionals
* Increase in health care being provided in communities, retail outlets, and homes
* More aspects of care delivered by interprofessional team members who communicate by electronic means
 | Curriculum: Training in team-based care coordination, development of communication and leadership skills, telemedicine  |
| 31 | Roles of Other Health Care Professionals | Blurred lines of roles and responsibilities between health care professionals, including physicians* New team members (technology-based assistants, artificial intelligence) will emerge to fulfill new and existing roles and responsibilities
* Development of common leadership, communication, and patient care skills amongst health care professionals to ensure patient-centered care
 | Curriculum: “Teaming,” integration of technology and AI to complement physician role, shared educational experiences by different types of learners |
| Evolution in Graduate Medical Education |
| 32 | Clinical Productivity and Faculty Educational Effort | Employers financially support faculty involved in GME, and those who are not financially supported will be unlikely to volunteer time due to increased clinical demands | Quantify value of educational efforts, align strategic goals of organization to GME and workforce development  |
| 33 | Resident/Fellow Learning Styles | More than half of workforce in the U.S. will be comprised of Millennials. Learners entering GME in 2025 will have been educated in learning environments that are electronic, engage in self-directed learning and adapt to individual learning needs. | * Curriculum: develop curricula and educational tools to support learning styles and preferences of Millennials
* Faculty development: create awareness and develop skills in new curricular approaches and educational resources and materials to align with learner expectations and improve medical knowledge and patient care
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| 34 | GME Educational System | Learning environments are aligned with learners’ expectations for optimal learning experience which include the following attributes:* Electronic
* Interactive
* Allow for self-directed learning
* Address individual learning needs
* Create just-in-time learning
 | Curriculum: integration of additional learning formats and methodologies beyond the traditional didactics and teaching rounds, such as social media, to better engage residents in learning |
| 35 | Duration of Residency/Fellowship Training | * No changes in the duration of residency/fellowship time requirements for completion.
* Increased experimentation in competency- and outcomes-based training not based on time requirements.
 | Development of individualized educational plans for residents and fellows focused on skills acquisition. Ensure availability of clinical and educational resources for learners of all levels. |
| 36 | Structure of Educational Experiences | GME structured around continuity of care, longitudinal patient care experience, and population health management | Curriculum: Re-design of resident/fellow schedules to allow for more longitudinal experiences vs. specific block experiences. Longitudinal experiences will allow residents to better develop skills needed for new healthcare delivery models. Skills such as quality improvement and use of health care information technology. |
| 37 | Compensation Models for GME Faculty | Increased transparency in how physicians’ efforts, both clinical and non, are supported and defined | Quantify value of educational efforts, align strategic goals of organization to GME and workforce development |
| 38 | Transparency of GME Financial Support | Increased transparency in how Sponsoring Institutions support GME faculty | Ensure physician compensation defines, measures, and incorporates educational value and productivity. Continuously measure value of GME to patient care missions of the clinical learning environment. |
| 39 | Recognition of Other Health Care Professionals as Faculty | ACGME recognizes role of other health care professionals who teach residents | * Other health care professionals may be recognized as core faculty depending on specific Review Committee requirements.
* Greater focus on interprofessional education and team-based care which may be led by non-physicians.
* Include other health care professionals who teach residents in faculty development activities.
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| 40 | Simulation and Other Educational Resources | Simulation labs and other educational resources are shared resources among Sponsoring Institutions and smaller health systems | * If cost of simulation and other learning tools remain high, institutions should form partnerships to provide appropriate and cost-effective simulation experiences for learners.
* Curriculum: greater integration of simulated training and assessment tools that support educational experiences which promote productivity and efficiency of team-based and systems-oriented health care
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| 41 | Scholarly Activity | A wide variety of activities besides just peer-reviewed publications recognized as scholarly activity by the ACGME | GME programs should capitalize on strengths of faculty and residents in scholarly activity pursuits in order to pursue various forms of scholarly activity and foster research opportunities in other areas, such as health systems science and educational research. |
| 42 | Faculty and Distance Learning | GME faculty includes a mix of local faculty, as well as regional, national, and international faculty who participate remotely | * Many GME faculty will remain embedded in the same clinical learning environment as the residents.
* Due to changes in health care delivery models and technology, GME programs should consider providing remote access to faculty expertise that may not be able to be obtained in the clinical learning environment.
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| Uncertainty in GME Funding |
| 43 | Funding Sources of GME | Uncertainty in the level of GME funding contributed by the federal government, but some level would continue to be provided | Invest in own GME programs to align with physician workforce needs and strategic goals of the organization. |
| 44 | Accountability and GME Funding | Increased transparency and accountability will be required for GME federal and state GME funding | Prepare for changes to GME funding models by identifying and measuring GME educational and clinical outcomes. |
| The Role of GME in the Continuum of Medical Education |
| 45 | Alignment of Undergraduate, Graduate, and Continuing Medical Education | Educational methods are increasingly aligned across UME, GME and CME | Collaborate with medical schools and health systems in educational planning for physicians in practice-based learning and improvement and systems-based practice. |
| 46 | Medical Student Attributes | Medical schools matriculate students with high levels of achievement in increasingly diverse academic disciplines and interests, and not just scientific skills | Align GME recruitment strategies to increase assessment of applicants with diverse academic and personal backgrounds, and multicultural nature of patient populations. |
| 47 | SI Models | The majority of Sponsoring Institutions are not medical schools | Smaller SIs can collaborate and/or affiliate with larger health system or medical school SIs which can provide educational resources and shared learning networks. |
| 48 | Transitions from Medical School to Residency | Smooth transition from medical school to residency training | * Collaborate with medical schools to better prepare students for clinical readiness, as well as concepts of well-being and resiliency.
* Integrate “boot camp” sessions into orientation and/or beginning of first year training to build clinical skills and prepare interns to provide safe care to patients.
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