Methods Overview for Teaching Ambulatory Care:

In July 2010 the SRFMR Faculty made re-designing its ambulatory care curriculum a key strategic priority for the next 1-3 years, as a commitment to better prepare its family physicians of tomorrow for practice in what Dr. Pugno defines as a "patient-centered, high-performing health system." Our re-designed PCMH Ambulatory Care Curriculum focuses on the 2nd and 3rd elements described by Dr. Pugno. The 1st element (a fourth year) is beyond the scope of the residency currently though the Residency Collaborative may consider in parallel long term strategic planning.

The major shifts in our teaching paradigm is to:

1) **Make the Resident's PCMH a core curricular experience with more time spent without increasing the panel sizes or "clinical work" to ensure time and resources are used to master practicing as a personal family physician .**
2) **Emphasize the ambulatory experience as a clinical *learning* module with adequate time for time intensive visits practiced on the New Model platform adding multi-modal communication, team based care, and alternative means for learning and caring for their population of patients during scheduled Panel Management Time, Group Medical Visits, and Chronic Care.**
3) **Increased preceptor supervision, teaching, and facilitation of the New Model experience for the resident.**
4) **Formalize Resident Physician Leadership in the Medical Home with three months spent in the R3 year as Chief for their module team**.

Below are highlights of the longitudinal curriculum broken down into R1, R2, and R3 curriculum. It strongly supports a competency based, learner-centered experience for our residents in the ambulatory care center throughout the three years. Appendix C details the Curriculum Development and Evaluation.

First Year Curriculum

The first year curriculum remains much the same, emphasizing the establishment and solidification of basic clinical skills. This is even more crucial then in the past, as providers of first contact, family physicians must be diagnosticians---an ever more difficult task in the complex medical world of the 21st-century. With team based care being physician led, family physician residents must become competent to understand the most complex of patients. The residency period must continue to emphasize such learning with focus on the traditional rotations in medicine, pediatrics, behavioral medicine, surgery, and obstetrics. Given the need for patient and family centered care, obstetrics and gynecology must remain core experience regardless of the resident's eventual long term plans.

What changes in the first year?

1) The first year will change in its ambulatory care experience as the continuity practice will be *at least* three sessions per week, even if they are only 1-2 hours in length (20-25% of their resident time). A panel of patients of 150 by the end of the year is anticipated with initial familiarization of multi-modal means of managing one's population of patients individually and as a team. (eg, office visits, telephone visits, secure messaging, group medical visits, chronic care team care). Continuity as a *personal care physician* will be optimal within *team continuity*. The Department of Performance

Excellence will provide quarterly metrics on clinical quality, patient experience, and other dimensions of a high-performance family medicine center.

Priorities in the first year will include learning basic manual skills, procedural skills development, as well as ACLS, ATLS, PALS, and ALSO with care of the sick, complex patient being a focus.

2) Panel Size 150 by end of year; 75 assigned at start of year. The Department of Performance Excellence (DOPE) will aim to provide panel populations with a balance of demographics and disease conditions (eg, 10-15% pediatrics; 10-20% adolescents, 20-40% reproduction aged women; 20-30% adult males, 15-25% geriatrics; 5-15% diabetics).

3)Leadership and Professional Development will be used to teach fundamentals of practicing in a PCMH, basic leadership and teamwork skills, and initiate longitudinal educational planning including scholarship activities. LPD will emphasize appropriate developmental skills matched to the R1 level that link to later years of training (included in the Resident's Individualized Growth and Development Plan-RIGDP).

4)Evaluation: in addition to quarterly metrics providing feedback on ambulatory care practice performance (PCMH Resident Report Card posted to New Innovations), each resident will have quarterly meetings to with the Chief of Ambulatory Care and their advisor. Competency based educational milestones in areas of ambulatory care will be assessed with timely feedback to assure success will be part of each semi-annual evaluation and tracked.

Second-Year Curriculum

The second-year curriculum reinforces the underpinnings of family medicine values with a *core curriculum* supporting advanced inpatient skills and ambulatory skill development. Exposure to outpatient components of *subspecialty care* with an increase in procedural competencies they begin during the first year. Emergency Medicine, Critical Care, Prenatal Care and Ambulatory Gynecology are specific foci with continued maturation of ambulatory continuity experience.

What changes in the second year?

1) The residents' continuity practice expands to 25-35% of the resident's time being spent in daily family medicine practice hours.

RRC waiver will be obtained so that 1/3 of the time could be spent doing non face to face visits (telephone, e-mail, virtual) so that panel management (population based health, prevention, chronic care, and acute care) is done daily to maximize the continuity experience for the resident and patients served.

2) Panel Size grows to 150-300. The Department of Performance Excellence (DOPE) will provide panel populations with a balance of demographics and disease conditions (eg, 10-15% pediatrics; 10-20% adolescents, 20-40% reproduction aged women; 20-30% adult males, 15-25% geriatrics; 5-15% diabetics).

3) Leadership and Professional Development: curriculum will include Change Management, Leading Teams, and Team Based Care. R2s will co-facilitate (paired with

an R3) adequate volume of Group Medical Visits to become skillful, approximately once per month.

Third-Year Curriculum

The third-year curriculum will complete **core requirements** such that residents can graduate successfully at the end of the year having completed well documented milestones for advancement with regular competency testing in ambulatory care. Months for Chief of Medicine, Obstetrics, Pediatrics, and elective away will require a decrease in ambulatory clinic care responsibilities but the 35% continuity practice will continue.

What changes the third year?

1) **Leadership and Professional Development**

A) New Chief of Ambulatory Care: This position is analogous to the Chief for OB, Pediatrics and Medicine experiences. R3's will spend three months being Chief Ambulatory Care scheduled during appropriate months when senior rotations permit such focus and presence. .

The Chief co-leads their ambulatory care team (12 residents) working with the Clinic Lead Physician, Medical Director, and Director of Ambulatory Care Curriculum ensuring resident participation in PCMH Lectures, Huddles, teamwork; preparing for team meetings, monitoring team and individual PCMH Resident Report Card from the Department of Performance Excellence, participating in policy development and implementation (attending Partnership Council Meetings and Provider Meetings), communication, quality improvement projects and other PCMH activities.

The Chief performs an evaluation of the residents (see evaluation tool-appendix G) with the Lead Physician quarterly.

B) The third year will bring forward an emphasis on preventive care, public health, community medicine, quality improvement and chronic care management.

C) Each R3 will do one Team Based Quality Improvement project coordinated with DOPE.

2) **Panel Size 300-450.** The panel will be assessed at the start of the third year and selectively grown to meet the educational needs identified. For example, if geriatrics, adult medicine, maternity care, or pediatrics are identified as needing more experience, patients will be selectively assigned to the R3's panel. This will start in the spring to allow adequate time for experiences.