Residency Guide for Population Health and Value-based Care: BLOCK SCHEDULE

For programs that follow a block scheduling model or have residents seeking a focused value-based care education, the schedule below offers a flexible structure for engaging with the AAFP's curriculum.

In the block schedule, sessions are grouped into five main categories that residents may work through: Basics, Caring for Patients, Role of Teams, Technology and Data-driven Improvement and Community Engagement. Scan the QR code for more information about value-based care for residents and to get access to the courses.

Topic	Session Title and Length	Learning Objectives	Relevant ACGME Requirement
Basics	Value-Based Care: Patients, Populations and Whole Health (30 minutes)	Define Value-Based Care (VBC) and its importance in health care transformation; understand key concepts such as patient attribution, population health management, risk adjustment, quality/performance measurement and cost management; implement strategies for whole health care that enhance VBC success; demonstrate a successful conversation with a patient that uncovers facts about your patient population.	Whole person care approaches: 4.4.a.1.a .
Caring for Patients	Continuity (15 minutes)	Explain the importance of continuity for the patient and care team experience; define continuity from the patient perspective and the clinical team perspective; describe best practices to improve continuity of care, including engaging clinic staff to support continuity of care.	Panel size adjustment: 4.11.c.5.i. Team-based care coverage: 4.11.c.5.j.
	Pills to Prevention - Transforming Chronic Care Conditions (54 minutes)	Shift the focus from managing chronic conditions to a prevention approach; promote healthy behaviors such as diet, exercise, stress management and smoking cessation; demonstrate the practical application of the LSM assessment tool.	Preventive care for children: 4.4.a.10.
	Improving Adherence to Prescribed Medications (20 minutes)	Explain common reasons patients do not take their medications; describe strategies for addressing patients' concerns; apply medication reconciliation with patients.	Consulting multiple information sources: 4.4.a.15.
Role of Teams	Closing Care Gaps Through Respectful Engagement (20 minutes)	Describe the importance of patient engagement in VBC success; explore the various reasons for ambivalence from a patient perspective; apply the HEAR Technique to explore ambivalence and respectfully engage in challenging conversations.	Care and end-of-life goals discussions: 4.8.g.
	Introduction to Complex Care Management (10 minutes)	Define Complex Care Management (CCM); describe how the population served by a CCM program will influence its core components and staffing; identify metrics used to evaluate the success of a CCM program; describe team-based approaches to support patients with complex medical or psychosocial needs.	Care of older adults with multiple chronic conditions: 4.11.l.1.
	Who's on Your Team? Understanding Job Roles and Expanding Your Impact (16 minutes)	Explore how team roles may be redesigned to meet the needs of patient populations; discuss how to support staff taking on new roles; appraise evidence and case examples of effective collaboration and roles on the care team to improve patient management and outcomes.	Care team leadership: 4.11.d.

Topic	Session Title and Length	Learning Objectives	Relevant ACGME Requirement
Role of Teams	Leading Effective Teams (38 minutes)	Review how different challenges in the workplace impact leading teams effectively; explore four key strategies and common tactics for leading effective teams; apply information about leading effective teams to their own workplace.	Care team leadership: 4.11.d.
Technology & Data Driven Improvement	HCC and Risk Coding and Documentation (30 minutes)	Examine basics of risk adjustment processes including HCC coding and how it impacts family physicians; identify how to make your risk adjustment and HCC coding relatively "easy"; develop an evidence-based risk adjustment/HCC action plan for your practice.	Preventive care coordination and risk level identification: 4.4.a.5.
	Risk Assessment-Clinical and Social (30 minutes)	Identify high-risk patients using predictive analytics; tailor care plans based on risk levels; reduce hospital readmissions through risk stratification; implement lifestyle medicine strategies to prevent hospital admissions and readmissions by providing resources to manage chronic health conditions.	Preventive care coordination and risk level identification: 4.4.a.5.
	Using Data to Care of Populations (47 minutes)	Identify strategies to improve use of data in population health and VBC; discuss the tools and resources available for performance and quality improvement with practical examples; address health equity using data driven approaches to improve care for your patients.	Performance improvement: 1.8.k.
Community Engagement	The Role of Primary Care in Addressing Social Needs (30 minutes)	Implement strategies for preventative care, which is important in primary care.	Ensuring resources: 4.10.
	Patient and Community Engagement to Improve Health Outcomes (45 minutes)	Understand the importance of community engagement in improving population health; learn how to involve the community in independent practice or practice with a large system.	Advisory committee diversity: 1.8.h.1.

Additional Learning

Residents with further interest in value-based care and payment can explore 10 additional courses independently.

1. Primary Care Payment 101: Getting Value-Based Payment Right

LEARNING OBJECTIVES: Consider how value-based payment should be designed to support primary care success most effectively; assist physicians to advocate with payers and/or within their organizations for what they need to be successful under value-based payment; describe how well-designed value-based payment can support optimal care through primary care teams.

2. Residency – Program Directors and Residents

LEARNING OBJECTIVES: Identify three educational and accreditation factors that support BHI implementation in residency; compare two ways that BHI implementation processes must be adapted to the residency educational environment; administer practice assessment processes to facilitate BHI operational design that aligns with residency and family medicine practice needs; generate two actionable strategies to establish, grow and/or maintain BHI in their home program.

3. Engaging Patients and Communities as Partners in Practice Transformation

LEARNING OBJECTIVES: Define patient and community engagement in health care; describe practical approaches to engage patients as partners in practice improvement; explain how to translate patient feedback into sustainable improvements in care.

4. Empanelment: Connecting Patients and Care Teams in a Robust and Meaningful Way Through Empanelment Workflows and Communication
LEARNING OBJECTIVES: Explain in plain language why empanelment is foundational to practice improvement; describe how to start the process of empanelment; explain how to calculate ideal panel size and weighting and balancing panels; describe how to address "shadow panels"

5. Proactive care – How is it Different for Teams and Patients
LEARNING OBJECTIVES: Integrate proactive care within the health care team; demonstrate how proactive care enhances health outcomes and lowers costs.

6. The "In-Between Spaces" - The Role of Care Management in Value-Based Care
LEARNING OBJECTIVES: The course will focus on the importance of managing patient care outside of the clinic, highlighting the roles and responsibilities of care managers within the care team. It will emphasize the significance of risk stratifying patients and provide strategies to apply risk stratification effectively, ensuring that resources are targeted appropriately to deliver the right care to the right patient at the right time.

7. It Starts With "Why" – Understanding and Engaging Your Patients
LEARNING OBJECTIVES: The course will focus on the importance of identifying a purpose as a key driver of success in behavior change and how to discuss this with patients. It will cover evaluating a patient's readiness to change and formulating meaningful goals with them. Additionally, the course will provide practical tips for behavior change that can be applied to patients, the care team and oneself to improve health and well-being.

8. From Tension to Teamwork: Building Bridges Between Family Physicians and Health System Leadership for Enhanced Patient Care
LEARNING OBJECTIVES: The course will focus on developing, initiating and maintaining open communications with health system leadership. It will cover strategies to magnify these communications, focusing on the needs and perspectives of patients and family physicians. Additionally, the course will help you understand and appreciate the responsibilities, perspectives and challenges of health system leadership as they pertain to primary care practices. Finally, it will examine ways to leverage health system resources and support structures to improve the physician and patient care delivery experience

9. Transformational Leadership – Sharing a Vision, Ongoing QI and Change Process Leader
LEARNING OBJECTIVES: The course will focus on effectively setting and communicating your vision for ongoing change. It will help you develop leadership skills to advocate for and lead process changes that support advanced team-based care. Additionally, the course will cover evaluating challenges to adopting change management principles, including organizational resistance and workflow adjustments, and strategizing solutions to overcome these barriers.

10. Change Management
LEARNING OBJECTIVES: The course will focus on reviewing Kotter's 8 stages of change management and applying these strategies in common practice situations. It will include examples of implementing change in a clinical setting using Kotter's 8 stages and provide guidance on how to return to your clinical practice and implement change more successfully in a systematic way.