

# Building Blocks of Primary Care and RC-FM Requirements

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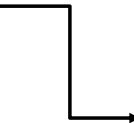


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## Objectives

- Understand the principles and concepts of the Building Blocks of Primary Care and the ACGME Review Committee for Family Medicine (RC-FM) requirements
- Implement strategies and activities that are consistent with the Building Blocks of Primary Care and RC-FM requirements
- Develop plans for future educational experiences that enhance family medicine residency training

## Tenants for Our Discussion

- Joint Principles of PCMH (or similar model) foundational to care and education
  - ACGME Program Requirements for Family Medicine evolving
  - Students interested in both foundational and innovative programs
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- Personal physician and ongoing relationship
  - Physician directed medical practice
  - Whole person orientation
  - Care coordinated and/or integrated
  - Quality and safety are hallmarks
  - Enhance access to care
  - Payment appropriately recognizes added value

## The Personal (Family) Physician

- Personal doctors for people of all ages and health conditions
- Are reliable first contact for health concerns and directly address most healthcare needs
- Through enduring partnerships, family physicians help patients prevent, understand, and manage illness, navigate the health system and set health goals
- With their staff, they adapt their care to the unique needs of their patients and communities
- Use data to monitor and manage their patient population, and use best science to prioritize services most likely to benefit health
- Are ideal leaders of healthcare systems and partners for public health

## Building Blocks of Primary Care

- Engaged leadership
- Data-driven improvement
- Empanelment
- Team-based care
- Patient-team partnerships
- Population management
- Continuity of care
- Prompt access to care
- Comprehensiveness and care coordination
- Template of the future



Bodenheimer, 2014

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## **“Can Primary Care Teams Improve Patient Access and Reduce Physician Burnout?”**

- Creating stable teams in residency training
  - To succeed requires a new residency teaching program paradigm
  - Not “hospital first, clinic second”
  - Clinic first
    - Ambulatory learning is top priority
    - Creating operationally excellent clinic is paramount
    - Clinic is curriculum

Bodenheimer, 2014

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## RRC-FM Requirements

*“Outstanding medical education can only occur in an environment of high quality patient care.”*

- Understand “spirit” of requirements
- Requirements not obstacle to innovation

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## RRC-FM Requirements

- Family Medicine Practice (or FMP)
  - Core education experience
  - Specialty care
  - Interdisciplinary experience
- Promote characteristics associated with high quality of care
  - Cognitive skills (board pass rate)
  - Experience (patient volume)

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# RRC-FM Requirements

## Principles for new program requirements

- Knowledge base + experience = competency
- Increased flexibility and support for program directors
- Provide flexibility for longitudinal curriculum or alternative approaches for education besides rotations
- Focus on “Patient-Centered Care”
- Allow FMP-site to provide greater spectrum of experiences
- Clear minimum standards

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# RRC-FM Requirements

Principle of comprehensive, continuous, and compassionate care provided by highly competent family physician who provides high quality care to a population to residency education

... therefore, the revised requirements emphasize education of residents in an environment demonstrating that “continuity of comprehensive care for the diverse patient population family physicians serve is foundational to the specialty.”

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# RRC-FM Requirements

- Patient population must include a wide range of ages and variety of clinical conditions, including chronic diseases sufficient to learn and understand the value of family medicine
  - all required patient population must be present in the community
- Empanelment**
- understand patient population in order to have "intentional education"
  - more than numbers

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# RRC-FM Requirements

- Must be at least one FMP site to provide foundation for educating residents and provide family medicine models.
    - Space must support comprehensive, coordinated patient care
- Continuity of care**
- Comprehensive and care coordination
  - Access to care

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# RRC-FM Requirements

- Population of patients cared for by resident and program core to educational experience
  - “Family Medicine Practice”
    - Acknowledges that family physicians care for patients, populations, and communities
    - Provides experience in comprehensive and continuous care, as well as population health.

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# RRC-FM Requirements

- FMP site must have a mission statement describing dedication to education and the care of patients within the community as it relates to the greater community and the community served by the residency program.

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# RRC-FM Requirements

- FMP site must involve all members of practice in ongoing performance improvement, and must use of outcomes in clinical quality, patient safety, and financial performance.

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## RRC-FM Requirements: Family Medicine Practice

- ~~FMC~~ (now FMP site)
  - Model ambulatory practice
  - Focus on patients who present to facility
  - In past, only these patients could be counted for required continuity visits
- FMP
  - Acknowledges care beyond walls of building
  - Provides comprehensive and continuous care to individuals and populations
    - Experience team- and systems-based care, including specialty care



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# RRC-FM Requirements

- Residents should participate in and assume progressive leadership of appropriate care teams to coordinate and optimize care for continuity patients.
- Curriculum should prepare residents to be active participants and leaders in their practices, their communities, and the profession of medicine.

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# RRC-FM Requirements

“Residents should complete two scholarly activities, at least one of which should be a quality improvement project.”

Data-driven improvement

- Provides common sense approach to quality health care
- Manages human performance using systemic, data-driven and integrated approach
- Provides a structure for self-directed learning and improvement

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# RRC-FM Requirements

- “. . . at least one FMP site to serve as foundation for educating residents”
- “Clinic first”
  - Ambulatory learning is top priority
  - Creating operationally excellent clinic is paramount
  - Practice is curriculum

Time spent weekly in specific setting:	%
Hospital-based patient care	17.0
Office/Clinic-based patient care	81.8
Other	25.9

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## Essentials of Clinic First Model:

- FMP that functions as a PCMH
  - “The Practice is the Curriculum” and “Patients First”
- Large, Diverse patient population
  - FMC population is a key driver of the education
  - “The Patients are the Curriculum”
  - Population management/QI, team-based practice
- Skilled FM Faculty who enjoy teaching
  - Less ‘farming out’ to other specialists
- Additional time in the FMP enhances the continuity relationship with patients and fosters a sense of **ownership** and **responsibility**
- PCMH Leadership skill development

## Clinic First: One Program's Experience

1. Quality improvement
  - Principles steer decision making
  - Concrete learning experience needed
2. FMP and associated site foundational
  - Create/maintain model practice
  - Schedule rotations around clinic
3. Didactic sessions address 20 – 30 top clinic diagnoses/issues
4. Rotations and other education augment activities associated with FMP

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## Clinic First: One Program's Experience

- *"The Family Medicine Center as the 'Center' of Resident Education."* Society of Teachers of Family Medicine Annual Spring Meeting. Chicago, IL. April 1998.
- "Quality Improvement in Education and Practice." Society of Teachers of Family Medicine Annual Spring Meeting. Denver, CO. April 2001.

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# The Fairfax Experiment

- 8-8-8 program began in 1972 as a Longitudinal /Clinic First Model
  - **Central Concept**
    - “Train residents where and how they will practice” Fitzhugh Mayo, MD
    - “Supervised practice with educational enhancements” Bill Carter, MD
- Community based, University affiliated, private corporation
- Two Hospitals: One Tertiary & One Community
- One Family Medicine Practice separate from hospital
- Diverse Funding Portfolio
  - Hospital, State, Patient Revenue

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# The FM Practice

- Level 3 NCQA recognized PCMH since 2008
- ~ 6 Educational Faculty FTE ( 20 Faculty bodies)
- Enhanced Access: Walk-in clinic and Telemedicine
- **‘Team’ Concept**
  - Part-time Psychologist & Psychiatrist; 3 FNP’s; 1 PA; 2 Pharmacists
  - Faculty and residents see patients along side each other
  - PGY-2 & PGY-3 form a Partnership
  - 2 Partnerships share office on their Nursing Unit
  - 2 – 3 nurses work with the Partnerships
    - Each resident has an assigned nurse or MA; enhances continuity
    - Schedules open ~ 6 months in advance

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## The Curriculum

- Functionally, a 1 – 2 program
- **PGY-1:** Standard Block rotations; hospital focused
- **PGY 2 & 3:** residents in the FMP most every day
  - Outpatient focused rotations to satisfy RC-FM requirements
- “Areas of Concentration” are an option
- Significant % of teaching is done by the FM faculty
  - Identity: “Clinician – Teacher” and “Clinician – Learner”

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## Residency Design – PGY 2 & 3

	One to Four Weeks at a time				
AM	<div>1/3 FM Hospital Svc      1/3 Office      1/3 Elective</div>				
Noon	<i>Conference</i>				
PM- PGY 2	Office Patients	Lecture	Office Patients	Office Patients	Office Patients
PM- PGY 3	Office Patients	Office Patients	Lecture	Office Patients	Office patients

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## Outcomes

- Historically high Board Pass Rate
- Residents graduate with 2,400 to 2,600 FMP encounters
- Graduates are highly recruited in the region
- Graduate Survey:
  - Excellent preparation for practice
  - No trends for what graduates would change

## The Graduate Education of Physicians 1966 (Millis Commission)

- Called for a “physician who focuses not upon individual organs and systems but upon the whole man...he who but knows only the diagnosis or treatment of a part often overlooks major causative factors and therapeutic opportunities”
- Need to focus “not upon individual organs and systems but upon the whole person, who lives in a complex social setting”
- Comprehensive care such as delivered by family physician high calling, different from specialization, and “not inferior in training, in rewards, or in position within the house of medicine”

## **The Graduate Education of Physicians 1966 (Millis Commission)**

- Simple rotation among several services not sufficient
- New body of knowledge should be taught in addition to medical specialties that constitute majority of program
- Opportunities for individual variations should be present
- Level of training should be on par with other specialties (i.e. two-year graduate program insufficient)

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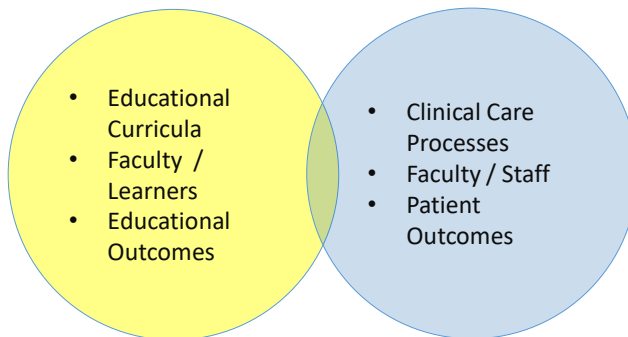
## **Program Requirements for Graduate Medical in Family Medicine: Reasons behind the July 2014 Revisions Review Committee for Family Medicine**

- *“With the revisions of our requirements, the committee wants to the emphasis that high quality family medicine resident education needs to occur in an environment of high quality family medicine patient care. As such, we can be confident that a graduate of a family medicine residency program has the attitude, knowledge, skills, and experience to provide high quality care to individual patients as well as to populations of patients.”*



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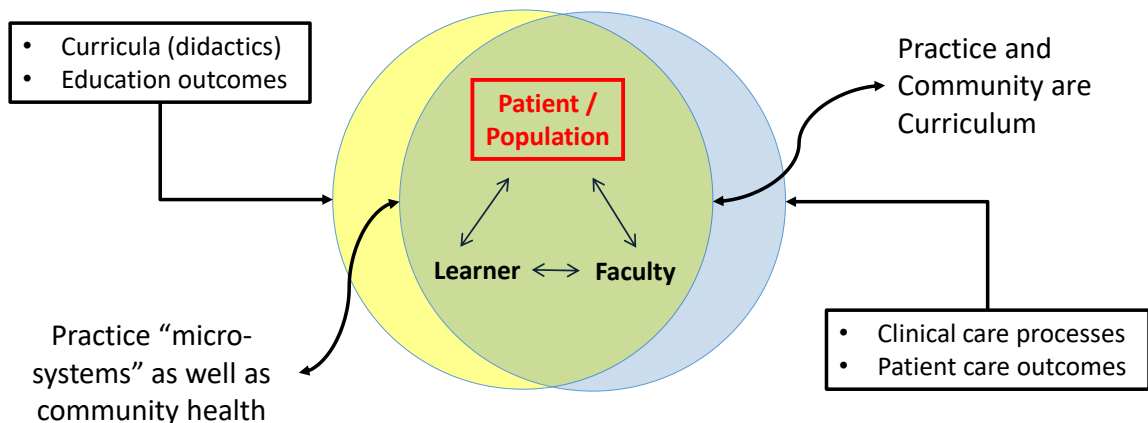
## Traditional Perspectives in Teaching Hospitals



***Separate “Educational” and “Clinical Care” Cultures and Systems, Including Oversight***

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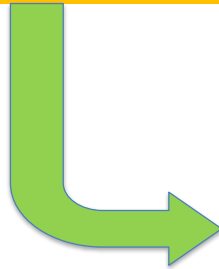
## Excellence in Educational Outcomes and Clinical Care Goals - Intimately Interdependent



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*"High quality medical education can only occur in an environment of high quality patient care."*



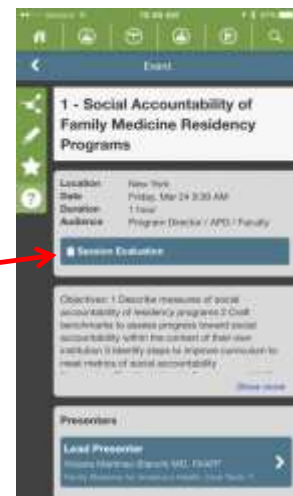
*When it comes to providing high quality patient care and medical education:*

*"Culture beats strategy;  
Environment beats location;  
Attitude beats skills."*

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Please  
complete the  
session evaluation.

Thank you.





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