



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS

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Recommended Curriculum Guidelines for Family Medicine Residents

# Physician Leadership in the Patient-Centered Medical Home

*This document was endorsed by the American Academy of Family Physicians (AAFP).*

## Introduction

This Curriculum Guideline defines a recommended training strategy for family medicine residents. Attitudes, behaviors, knowledge, and skills that are critical to family medicine should be attained through longitudinal experience that promotes educational competencies defined by the Accreditation Council for Graduate Medical Education (ACGME), [www.acgme.org](http://www.acgme.org). The family medicine curriculum must include structured experience in several specified areas. Much of the resident's knowledge will be gained by caring for ambulatory patients who visit the family medicine center, although additional experience gained in various other settings (e.g., an inpatient setting, a patient's home, a long-term care facility, the emergency department, the community) is critical for well-rounded residency training. The residents should be able to develop a skill set and apply their skills appropriately to all patient care settings.

Structured didactic lectures, conferences, journal clubs, and workshops must be included in the curriculum to supplement experiential learning, with an emphasis on outcomes-oriented, evidence-based studies that delineate common diseases affecting patients of all ages. Patient-centered care, and targeted techniques of health promotion and disease prevention are hallmarks of family medicine and should be integrated in all settings. Appropriate referral patterns, transitions of care, and the provision of cost-effective care should also be part of the curriculum.

Program requirements specific to family medicine residencies may be found on the

ACGME website. Current AAFP Curriculum Guidelines may be found online at [www.aafp.org/cg](http://www.aafp.org/cg). These guidelines are periodically updated and endorsed by the AAFP and, in many instances, other specialty societies, as indicated on each guideline.

Each residency program is responsible for its own curriculum. **This guideline provides a useful strategy to help residency programs form their curricula for educating family physicians.**

## Preamble

The concept of the patient-centered medical home (PCMH) has grown over the last decade and is now recognized by a large number of primary care organizations, including the following:

- American Academy of Family Physicians (AAFP)
- American Academy of Pediatrics (AAP)
- American Osteopathic Association (AOA)
- American Medical Association (AMA)
- American College of Physicians (ACP)

Organizations such as the Primary Care Collaborative (PCC) (formerly the Patient-Centered Primary Care Collaborative [PCPCC]) have been formed in an effort to promote progression of this concept. In 2007, the *Joint Principles of the Patient-Centered Medical Home* emphasized the need for comprehensive and coordinated care; quality and safety; access; and a personal physician. Knowledge of guidelines from each of these large organizations is a vital aspect of the family medicine residency curriculum.

Residency graduates are faced with an increasingly complex spectrum of medical practice opportunities and most new physicians will experience practice changes as the health care environment evolves. Within each practice setting, physicians may be faced with accreditation and regulatory requirements, personnel decisions, quality metrics, and access standards. Accordingly, new physicians need to possess the leadership skills, attitude, adaptive capacity, and knowledge to help create a health system that embodies the concept of the PCMH.

## Competencies

At the completion of residency training, a family medicine resident should:

- Demonstrate an understanding of basic physician leadership attributes necessary to effectively lead a comprehensive care team (Interpersonal and Communication Skills, Professionalism)
- Demonstrate a basic understanding of PCMH guidelines and concepts, to include the National Committee for Quality Assurance (NCQA) PCMH accreditation requirements and the Institute for Healthcare Improvement's (IHI's) Triple Aim (Systems-based Practice)

- Demonstrate an understanding of and appreciation for staffing requirements, full-time equivalent (FTE) measurements, empanelment methods, and quality metrics and how these components harmonize with a focus on patient-centered care (Interpersonal and Communication Skills, Systems-based Practice)
- Demonstrate a basic understanding of the administrative, legal, and financial processes required to run a clinic (Professionalism)
- Demonstrate the ability to foster the PCMH focus of coordinated care in a holistic approach within the framework of the individual, family, and community (Systems-Based Practice)

## Attitudes

The resident should develop attitudes that encompass:

- The importance of physician leadership in the medical home
- Comprehensiveness of practice as the hallmark of being a family physician to ensure clinician well-being and quality of care
- The importance of professionalism in leading collaboration of support staff and the clinical care team to meet patient needs
- The importance of knowing the cultures and communities one serves in order to meet their needs
- The importance of enhancing patient-centered care by achieving quality care metrics
- Willingness to innovate in an increasingly complex health care environment
- The importance of lifelong learning and the pursuit of improved quality care with ever-evolving evidence-based best practice standards

## Knowledge

In the appropriate setting, the resident should demonstrate the ability to apply knowledge of:

1. PCMH guidelines and resources
  - a. AAFP PCMH checklist
  - b. PCPCC *Joint Principles of the Patient-Centered Medical Home*
  - c. NCQA PCMH standards
  - d. ACP PCMH resource website
  - e. DNV, Joint Commission, or other hospital-based PCMH accreditation standards
  - f. IHI Triple Aim
  - g. Agency for Healthcare Research and Quality (AHRQ) patient-centered medical neighborhood
  - h. Community health needs assessment (CHNA)

i. Payor PCMH accreditation standards

2. Clinic leadership

- a. Crafting of a vision for patient care within the clinical care team to facilitate an environment of trust
- b. Development of emotional intelligence (EQ) and connection with support staff
- c. Empowerment of clinic support staff to contribute ideas and feedback
- d. Development of oneself as an expert in practice management and the PCMH
  - i. PCMH practice management
- e. Inclusion of the “voice of the patient” in decision making through patient focus groups or advisory councils
- f. Empanelment
  - i. Determination of proper panel sizes
  - ii. Models of risk assessment used to determine patient complexity
- g. Access/template management
  - i. Determination of types and ratio of appointment types
  - ii. Matching of access to demand through various types of appointments, open scheduling, and same-day visits
  - iii. Determination of the equity of access to address health care disparities
- h. Team-based care
  - i. Definition, clarity, and expansion of roles and responsibilities of team members, including mid-level providers, mental health professionals, and support staff
  - ii. Utilization of team members to the top of their abilities, education, and licenses
  - iii. Establishment of staff involvement in quality improvement (QI) procedures
  - iv. Evaluation of team members and feedback from team members
  - v. Routine meetings and daily huddles
  - vi. Establishment of a foundation for office workflow based on team members’ expertise
- i. Complex care management
  - i. Determination of patients who are high utilizers
  - ii. Referral and test tracking
  - iii. Care coordination and transitions of care
  - iv. Behavioral component in the patient plan, to include trauma-informed care
- j. Health information technology (IT) and new innovative approaches to health care delivery

*Refer to Curriculum Guideline on Medical Informatics (AAFP Reprint No. 288).*

  - i. Electronic health record (EHR) options and impact on practice
  - ii. Meaningful use measures
  - iii. E-prescribing, virtual patient care, practice website design, and online patient education for two-way electronic communication
- k. Productivity and financial management
  - i. Relative value unit (RVU) generation and coding

- ii. Pay for performance and Centers for Medicare & Medicaid Services (CMS) Quality Payment Program
  - iii. Capitation and sub-capitation models
  - iv. Cash flow (see “d. Finances” under “3. Administrative and legal background” below)
  - v. Basic business case analysis for PCMH
- l. Development of methods for performance measurement and/or QI
- i. Engage clinicians and staff in QI activities
  - ii. Obtain patient experience feedback for data
  - iii. Utilize performance data to assess health care disparities
  - iv. Use validated tools and evidence-based medicine to improve patient care
- m. Quality metrics
- i. Access, continuity, outcomes, and patient experience measures
  - ii. Healthcare Effectiveness Data and Information Set (HEDIS) Measures
  - iii. Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (AAPM)
- n. Holistic assessment of patients and their environment
- i. Assess mental health and substance use in relation to trauma-informed care
  - ii. Collect information on social determinants of health to identify gaps in care
  - iii. Use the CHNA so the appropriate resources can be provided to the community
3. Administrative and legal background
- a. Legal
- Refer to Curriculum Guideline on Risk Management and Medical Liability (AAFP Reprint No. 281)*
- i. Quality assurance and risk management
- b. Personnel management
- i. Employment contracts, to include performance expectations, compensation, benefits, and liability coverage
  - ii. Estimation of staffing requirements
  - iii. Recruitment, retention, and termination
- c. Facilities
- i. Rent, lease, or own
  - ii. Location and marketing
  - iii. Inventories and supplies
  - iv. Special services: office-based procedures, immunization storage, radiology, lab, financial counselors, and social workers
  - v. Medical records
    - 1) Health Insurance Portability and Accountability Act (HIPAA)
    - 2) Chart audits

- d. Finances
  - i. Cash flow, to include billing, accounting, and overhead management

## **Skills**

In the appropriate setting, the resident should demonstrate the ability to independently perform or appropriately assign to another individual within the practice:

1. Basic leadership: ability to communicate a vision for the practice and empower the development of models that promote growth despite ever-changing requirements of systems-based practice
2. Management of clinical care teams to optimize employee engagement
3. Communication with support staff and colleagues
4. Management of a registry through use of highly reliable and efficient teams
5. Analysis of quality and patient experience metrics
6. Use of CHNA to prioritize resources
7. Development and execution of clinic quality/process improvement projects
8. Fostering of innovative approaches to health IT and clinical care
9. Analysis of coding and RVUs
10. Cash flow analysis, accounting, reimbursement, and billing skills

## **Implementation**

This Curriculum Guideline should be taught during both focused and longitudinal experiences throughout the residency program, with increasing emphasis in the latter half of the residency. These guidelines should be integrated into the schedule of conferences and other teaching modalities, such as group discussions, case examples, community medicine projects, and scholarly activity. Residents should gain hands-on experience by being involved in on-site practice management in a family medicine center or similar environment. Additionally, residents should be involved in practice transformation policies and workflows as a way of implementing what they learn and integrating it with experience.

Residencies with clinical activities that are limited to only one model of practice should make special effort to expose residents to other practice types. Each family medicine resident should be able to demonstrate the ability to work with various individuals involved in practice management, including demonstrating an understanding of their

relationships to practice needs, office personnel, practice management systems, consultants, and various other resources available in the community.

## Resources

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## **Website Resources**

Agency for Healthcare Research and Quality. Talking Quality: Reporting to Consumers on Health Care Quality. [www.talkingquality.ahrq.gov/content/reportcard/search.aspx](http://www.talkingquality.ahrq.gov/content/reportcard/search.aspx)

American Academy of Family Physicians (AAFP). [www.aafp.org](http://www.aafp.org)

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Centers for Medicare & Medicaid Services (CMS). Medicare and Medicaid Promoting Interoperability Program Basics. [www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/basics](http://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/basics)

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Institute for Healthcare Improvement. Triple Aim for Populations. [www.ihl.org/Topics/TripleAim/Pages/default.aspx](http://www.ihl.org/Topics/TripleAim/Pages/default.aspx)

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Pennsylvania Association of Community Health Centers. [www.pachc.org/](http://www.pachc.org/)

The Joint Commission. [www.jointcommission.org/](http://www.jointcommission.org/)

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U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2030. <https://health.gov/healthypeople>

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