UW DFMCH ReCHARGED Strategic Planning Task Force on Residency Education Proposal

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In 2012, The Napier Group, led by Dr. Rod Napier, began working with department leadership to identify barriers to optimal functioning of our department and to begin goal setting for our department's future. Over the next few years, a series of conferences were held which resulted in the formation of several task force groups, each with a different focus area. Our group's focus is residency education.

Through an Opportunities conference and a Vision conference which involved input from a cross-section of stakeholders, the following goals were identified:

> *To begin the process of growing statewide and DFMCH programs by 50% over the next 10 years in order to better meet statewide primary care needs using new and responsive financing methods. Educate these learners directly and intentionally on leadership, advocacy, population and community health, and communication skills in order to better equip them for their future roles as members of an inter-professional health care team; to engage residents with patients and families to improve the experience of care and to improve the health of their communities while delivering care in the place and manner that patients value most.*

Our task force has taken these goals, vetted them with additional stakeholders, and sought input from a variety of internal and external sources about how we might best go about implementing changes that will allow us to meet the goals set forth by our department. We wish to train family physicians who will meet the needs of our patients and also reflect the patient population we serve; we value creating a more diverse physician workforce and recommend for residency leadership to partner with those working to further diversity and inclusion across the DMFCH and our state.

I. Description of the Issues:

The residency education task force was charged with a vision statement that included two distinct but concordant goals: a residency expansion of 50% over ten years across all DFMCH residency programs and development of new curricula in "leadership, advocacy, population and community health, and communication skills" across all programs. We believe the case for residency expansion is strong, in order to fill the deficit of primary care physicians in the state of Wiscossin, particularly in rural areas. We also believe that diligence and willingness to maintain and build new relationships with stakeholders across the state will ultimately overcome what sometimes appear to be daunting regulatory and financial barriers to expansion. On the issue of curricular reform, our personal discussions with statewide and national colleagues and surveys of local residents reinforce that new areas of mastery will be required of the future family physician. Although the makeup of our task force (which included several individuals deeply involved in the Madison program's curriculum development) may shape some of our outlook, we hope to provide a framework for new resident learning objectives in community health and advocacy, leadership activities, and faculty development that could be adopted and supported across the state.

1) There is a deficit of primary care physicians in the state of Wisconsin with continued growing need; this deficit and need is particularly felt in rural areas.
2) Regulations and financial barriers exist which limit our ability to simply add more residents to programs at will.
3) We must ensure that we are training residents to grow the evolving skill set needed to be excellent family physicians now and in the future.
4) We wish to continue to attract engaged learners as applicants to our programs and to provide these learners with both the structure and flexibility to meet their diverse needs.
5) We wish to attract and retain faculty who are energized by and committed to teaching residents in proven as well as new and responsive teaching methods.

Residency Expansion:

Wisconsin currently has a deficit of approximately 100 primary care providers. This number has not decreased over the past years and is anticipated to increase as the population ages and has an increased demand for health care services coincident in timing with an increase in expected retirements in our state's physician population. Graduating Family Medicine trainees currently provide the majority of physicians who help fill this gap. Currently existing Family Medicine residencies in our state graduate 80 new family physicians per year. Historically, 56% of new residency graduates tend to seek post-residency employment within 100 miles of where they trained.[i] This percentage holds true for the percentage of UWDFMCH residents who remain in the state of Wisconsin.

The majority of Family Medicine residencies are funded via a combination of funding streams including revenue from patient care provided by residents while supervised by faculty, federal GME funds through Medicare payments to teaching hospitals and state funding. In the Madison Program new funding is the limiting factor in expansion within the residency; under current guidelines each residency is only able to have 1 rural training track. CMS will only fund the original RTT; a second RTT is considered an expansion and does not garner an additional federal GME subsidy. Other family medicine residency programs in Wisconsin have limiting factors such as number of faculty available, stability of systems, and funding. There are talks at the federal level which may allow for changes in the legislation lifting the 1 rural training track cap, but this will unlikely be decided and placed into effect in the upcoming fiscal year.

Curriculum Development:

For the Madison program, the residency rotation schedule currently rigidly splits our learners' time between the hospital and outpatient settings. Residents spend the majority of their first year (internship year) working in the hospital, and much less time learning how to care for their own continuity patients in the outpatient setting. Time in their continuity clinics increases during their second year of residency, but as a consequence of the current structure residents often lack a feeling of partnership with their outpatient clinic panel until well into their second year of training. The majority of our trainees are planning a career of mostly outpatient medicine; many maintain both inpatient and outpatient practices with rural practices being more likely to expect inpatient care to be part of their new-hires' intended scope of practice. Skills that are becoming increasingly important for family physicians to possess in their planned practice settings include the ability to lead interdisciplinary teams, work within and partner with the communities they serve, manage a panel of patients with (often multiple) chronic diseases, and deliver care to patients in a manner which is most useful and meaningful to them. With our current structure, we are not preparing our residents with the complete skill set they will need to practice as family physicians in the future.

These themes are reinforced by data culled from the 1 and 5 year postgraduate surveys as well as from interviews with stakeholders currently affiliated with the DFMCH. Recent graduates identify "time in clinic" and experience with "practice management" as most helpful parts of their training. One respondent particularly valued "outpatient panel management, skills to work in teams effectively, self-care, ways to identify and try to prevent burnout, enthusiasm and support of my geriatrics interests, good inpatient skills." The importance of supporting individual interests while helping residents build a solid foundation in inpatient care and general family medicine is a common theme. Recent graduates seek "more robust time for community, population and health systems learning given the importance of this is the context of primary care practice." Recent graduates also want more direct instruction on "social determinants and maintaining longitudinal community alliances with different organizations" and "financial practice aspects of medicine." The theme of teaching more specialty rotations/topics within our

own clinics rather than with specialists also arose. Recent graduates want to maintain the strengths of the program while moving forward with curricular changes that will enhance their preparation for their future practices.

If we stay stagnant with the current structure, we also run the risk of ceasing to attract top applicants to our program. Residency applicants have given us feedback over the last 2-3 years that they are looking for programs that will train them well with community health and leadership skills. Approximately 50% of our graduates go on to practice inpatient hospital medicine in some form; the other 50% do not. Even for those who do, the majority of their career is spent in the outpatient setting. Applicants and residents have asked for opportunities to individualize their training to fit their needs and to train in settings that resemble what their future practices will entail.

Our task force has concluded that change is in order, as is the need to build a structure that will allow for future adaptation, individualization, and ongoing transformation.

II. Best & Current Practices:

Residency Expansion:

Other state approaches to expansion of GME

GME expansion is an issue that has generated national discussion and several states have initiated programs to assist with meeting state workforce needs that have included GME expansion. Recently, physician workforce needs in Georgia was recognized as critical. In Georgia, the state has increased the medical student enrollment by 600 and will have increased the GME positions in the state by 400 by 2018. This was accomplished by state dollars being used for new program start-up and a focus on development of programs in settings with no prior GME. This will result in new federal GME funding and some continued state support. (Acad Med. 2015;90:1264–1268). In North Carolina, there has been a recognition of a need for more rural family physicians. Again the state is looking at funding an initiative with the two public medical schools in the state to develop a pipeline program with scholarship support for students from rural and underserved areas for both their premed and medical student education. With the educational scholarships, there would be a required service payback in rural North Carolina. With this, there are sequential plans to expand family medicine GME opportunities that focus on rural practice. (personal communication 6/14/16). These initiatives bear similarities to initiatives underway in Wisconsin with state support to expand medical student education at both of the medical schools in the state along with funding to expand GME in the state through WRPRAP and the WI DHHS. Parallel to the state initiatives, the Graduate Medical Education Initiative originated in Colorado and now has nation-wide participation. This group is working on the federal level to promote change that will likely require legislative action to

promote more effective federal funding of GME and improve the specialty mix of physicians through the education of a greater number of primary care physicians.

Statewide GME Engagement of the UWSMPH DFMCH

As the DFMCH engages in a strategic plan around GME and possible expansion, a state-wide perspective of the department's activities and opportunities was discussed; a summary of this follows. In considering each aspect of our proposal, our task force wishes to highlight the importance of GMEC as a forum for continued sharing with and learning from other programs..

Changing times and landscape of GME

The statewide GME activities go back to the early days of the department with programs being developed in Appleton, Eau Clare, Milwaukee, Waukesha and Wausau. Over time with the changes in health care systems within the state, the Waukesha program became aligned with the Medical College of Wisconsin (MCW), the Milwaukee program aligned with Aurora and the DFMCH had programs in Madison and the other three upstate communities. In response to a need for rural physicians, programs in Eau Clare, Madison, Wausau developed 'Rural Training Tracks' or 1-2 programs in Menomonie, Baraboo and Antigo respectively. These programs were designed so that the resident primarily spent their first year of residency in the core program site and then the final two years at the rural site. With challenges in sustaining student interest/applications and funding challenges, only the Baraboo 1-2 Program was sustained. Recently, with additional changes in directions of health care systems and program opportunities, the Wausau Program identified clinical opportunities with the Aspirus Health System and aligned with Aspirus for clinical operations and continued to have an academic partnership with the DFMCH for its academic sponsor. The Appleton Program, formerly known as the Fox Valley Family Medicine Residency realigned changing the academic sponsor to MCW and was renamed to the Mosaic Family Medicine Residency. The Eau Clare Family Medicine Program was challenged with being a considerable distance from Madison and efforts to establish a more collaborative partnership with other health systems in Eau Clare were unsuccessful to date. The decision was recently made to no longer recruit or admit residents after July 2016 and it is anticipated that this program will end with the graduation of the last residents in 2019.

In light of the programmatic changes outlined above, there were discussions about expansion opportunities in the Wausau Program. The clinic is a relatively new building in Wausau but with competition for patients in that setting, it seemed unlikely that expansion with the need to increase patient numbers to meet accreditation numbers was wise. Wausau has ACGME approval to have Westin as a second continuity clinic site for two residents. A second and third

year resident are currently assigned there and have been having a good experience. Wausau would like to expand by at least one resident and possibly two when they are past the ACGME citation for Board pass rates. An expansion of the Wausau program could be adding more residents at Westin, identifying another Aspirus site in the metro Wausau area, or considering a rural track. The program has a history of supporting a rural training track in Antigo. The Antigo Medical Community is very interested in being more engaged in resident education. During this next time period, exploration of options to expand in Westin and utilized opportunities in Antigo could and should be explored.

Baraboo has been a very successful rural training track and has had excellent national recognition for its accomplishments. Currently is supports two residents per year. There has been discussion about expansion in Baraboo and/or in conjunction with opportunities in Portage. While these discussions seemed hopeful, regulations around definition of new vs expansion of programs as well as definitions of rural vs urban were found to limit opportunities for new federal GME dollars. With lack of funding the interests in expansion options have waned.

Collaborations:

The DFMCH has a history of supporting family medicine education and residency training through collaboration with other programs providing academic, research and administrative expertise. Examples of this are the ongoing relationship and participation of the Aurora Family Medicine Residency in the DMFCH GME Committee. The Aurora Program, in addition to being part of the Aurora GMEC, found it helpful to continue to participate in the GMEC discussing changes in residency education and to continue an academic partnership with the UW. This academic support to the Wausau program and continuing to be part of the DFMCH GMEC has allowed for them to benefit for the opportunities their local health system, Aspirus, offers while continuing with the academic support from the DFMCH. Recently Gundersen Health System established a new family medicine residency. While Gundersen Health had a strong reputation for excellence in GME and are the institutional sponsor, family medicine was a new residency specialty. As with Aurora, they have been partnering with the DFMCH GMEC and benefited for the sharing of academic and administrative experience in hosting a family medicine residency. Below is the memorandum of understanding outlining this relationship. As other new programs develop, the opportunity to support the planning and implementation of new programs using the knowledge and experience of the DFMCH can and should be shared throughout the state.

MEMORANDUM OF UNDERSTANDING

-- *between the University of Wisconsin, School of Medicine and Public Health, Department of Family Medicine and Community Health (UW-DFMCH) and the Gundersen Lutheran Medical Foundation (GLMF) Family Medicine Residency Program*

The Gundersen Health System (GHS) has a long history of leadership and accomplishments in medical education in partnership with the University of Wisconsin School of Medicine and Public Health (UW-SMPH). In particular, GHS has an essential role as the UW-SMPH's western academic campus for medical student education. GHS also institutionally sponsors ACGME residency programs in Internal Medicine, General Surgery, and Transitional Year.

Consistent with that history, the UW-DFMCH commits to supporting the success of Gundersen Lutheran Medical Foundation's Family Medicine Residency Program (FMRP) by serving as the program's academic partner. This collaboration complements GLMF's role as the institutional sponsor of the FMRP and is fully consistent with both the Gundersen Health System's commitment to educational excellence and the University of Wisconsin's commitment to the "Wisconsin Idea" of service to all of the citizens of the state.

The core elements of this collaboration are:

- support for residency faculty as educators and academic physicians
- sharing resources that advance Family Medicine resident education
- promoting medical student interest in Family Medicine graduate medical education within both UW-DFMCH academic sponsored and UW-DFMCH sponsored residency programs
- collaboration in service to our communities
- highlighting the accomplishments of residents, graduates, and faculty

This collaboration provides the opportunity for all substantive GLMF Family Medicine Residency Program faculty to have academic appointments within the UW-SMPH as adjunct clinical faculty in the UW-DFMCH subject to review and approval through UW-SMPH processes and procedures for faculty appointments and promotions.

Examples of activities specific to our residency programs that reflect the value of this collaboration are:

- acknowledgement of this academic collaboration in materials, publications, and the internet presence of both the GLMF FMRP and the UW-DFMCH
- including the GLMF FMRP on the UW-DFMCH website with a link to the program's web site, and similar placement of a link to the UW-DFMCH within the GLMF FMRP website
- joint medical student recruiting activities at state and national venues
- participation of the GLMF FMRP program director and educational specialist as colleagues on the UW-DFMCH's Graduate Medical Education Committee
- sharing of curriculum and of opportunities for residency clinical rotations at any UW-DFMCH residency site for any UW-DFMCH associated resident depending on available capacity and program approval.
- involvement of faculty and residents from the GLMF FMRP as part of the UW-DFMCH's statewide osteopathic educational program

- eligibility of GLMF FMRP residents and projects in UW-DFMCH recognition opportunities such as the McGovern-Tracy Scholars program and the Davis Quality Improvement award
- participation of GLMF FMRP residency faculty in the UW-DFMCH statewide faculty development program and other relevant departmental activities
- availability of collaborative research initiatives for residents and faculty
- exploration of shared community service projects

Funding of direct costs for any of these collaborative activities will be by mutual agreement.
It is recognized that the GLMF Family Medicine Residency is fully governed by the policies and procedures of its sponsoring institution, GLMF, as implemented through GLMF's multi-specialty Graduate Medical Education Committee. It is the intent of this Memorandum of Understanding to strengthen the collaboration between the GHS, GLMF, UW-DFMCH and the UW-SMPH to enhance graduate medical education in Family Medicine throughout the state.

This Memorandum will have a three year term beginning on September 1, 2015. Either party may suggest modifications or extensions at any time that can be incorporated if agreed to by the other party. In addition, either party can terminate this agreement with 180 days notice.

FQHC

Another area of potential collaboration/partnership is with Federally Qualified Community Health Centers. The DFMCH has a good working relationship in Madison with ACCESS CHC. There are other CHCs in the region (Beloit, Cashton) that could potentially engage in GME. On the federal level, there have been funding options or Teaching Health Centers. Today, the future of this funding is uncertain. It is another area however that could be explored and potential plans developed in order to be in a position to apply for funding through this opportunity should the federal government continue and expand THC funding.

Curriculum Development:

Acknowledgement of the need for the previously mentioned changes is not new. In fact, Drs. Merenstein and Schulte proposed similar changes in 1990 in their article entitled "A Residency Curriculum for the Future."[ii] They called for an emphasis on increased flexibility in training, increased ambulatory care training rather than hospital based training, community oriented primary care, and increased curricular control by family medicine faculty. More than twenty five years later, we are still seeking these same changes.

To gain an understanding of the ideas and opinions our own faculty and other stakeholders (future employers of our residents, health systems leaders) have of the issue, members of our task force conducted a series of interviews; the following common themes emerged:

- We seek dedicated leadership training to help learners truly lead an inter-professional health care team. Specifically, the skill of learning how to interpret and incorporate information gleaned from other members of the team in order to create an optimal plan of care for the patient should be taught.
- We value training in an inter-professional setting so that learners may best develop the skills they will need to work in such a setting.
- We wish to be intentional about teaching advocacy, in regard to advocacy for our patients as well as for our specialty.
- We wish to be intentional about how we practice, model, and teach community health and community engagement so that we do so in a manner that is meaningful to the populations we serve, sustainable, and collaborative.
- We wish to allow for individualization of and flexibility with our curriculum so that we may meet the needs of our diverse learners.
- We seek to move toward a more longitudinal curriculum in order to train learners in a model that more closely resembles the practices they will have as family physicians.
- We recognize the above priorities will take dedicated commitment of both time and resources. Faculty will need training, too. As one stakeholder said, "It can't be an add-on." We must take care not to dilute what is useful and meaningful in our current curriculum. Rather, we will need to be thoughtful about the relative value of various training experiences. The majority of faculty felt comfortable giving up some of the in-hospital coverage our residents provide in favor of making room to meet some of the above goals.

A handful of training programs across the country have successfully transformed their structure and curriculum to better prepare residents for their careers as future family physicians, incorporating many of the above tenets. Members of our task force had the opportunity to discuss the benefits and challenges of two such models with the program directors of two programs which have enacted such changes, the Group Health Family Medicine Residency (Seattle) and Community Health Network Family Medicine Residency (Indianapolis). Two further examples, Duke Family Medicine Residency and UW Baraboo, give additional avenues to approaching implementation of a longitudinal curriculum.

Group Health Family Medicine Residency (Seattle):

At the core of the structural and curricular changes the Group Health Residency made was the desire to build residents' identities as family physicians first and foremost. They espouse a "clinic first" policy and structure their curriculum such that each resident carries a consistent

patient panel of about 400 patients (22% of a 1.0 FTE GHC physician) for whom they serve as the primary care physician throughout their residency. Rather than focusing the R1 year on in-hospital training, Group Health's first year residents spend 4 to 5 half-days per week in clinic. This allows them to build their identities as PCPs for their patients, get comfortable in the clinic setting, and then augment what they have learned with well-chosen inpatient experiences (and other experiences outside of their clinic home). They are in clinic less frequently during their R2 and R3 years but because senior residents see more patients each half-day than do R1s, the residents ultimately have steady patient care availability across all three years providing their patients consistent access to their resident PCPs.

Rather than covering the inpatient services in a block schedule format with residents spending several weeks on one inpatient service before rotating to the next, GHC uses a longitudinal format in which any given resident may have a combination of inpatient medicine or OB, clinic, community work, and elective time all in the same week. They feel residents are better able to integrate the skills they learn in various settings to continue to enhance their development into effective family physicians. GHC has seen improved resident satisfaction and less burn-out with this model. The total number of clinic half-days and total visit numbers have increased; inpatient volume has been unaffected. GHC has noted a positive effect on recruitment since implementing these changes.

A few things to note about the GHC program are:

- They do not provide 24/7 coverage of all the in-hospital services in which they partake. Rather, they have strong working relationships with the hospitalists who cover their patients when residents are not available to do so.
- They have obtained an exemption to the ACGME face to face encounter requirement such that their face to face requirement is 1400 visits rather than 1650. They are allowed to count 3 virtual visits as equivalent to 1 face to face visit to help them reach a total of 1650 visits for each resident
- They begin electives half way through the R1 year
- Three years of lead time and very careful tracking were required to enact these changes.

<u>Community Health Network Family Medicine Residency (Indianapolis)</u>:
The Community Health program also focuses on a longitudinal curriculum; however their structure is different from that of the GHC program. The Community Health Network (CHN) curriculum is divided into four modules among which residents rotate every six weeks. They are: acute care, chronic care, preventive care, and an individualized module. Subspecialty rotations are incorporated into the chronic care module while emergency department and surgical experiences are part of the acute care module. Obstetrical training is part of the preventive care module. Electives and night-float coverage are part of the individualized module. Throughout

all the modules, residents are in clinic a minimum of 2 half-days per week, but usually 5 half-days per week on most weeks. During the chronic care module, Friday afternoons are reserved for inter-professional, team-based education. Time is spent during these sessions on intentional instruction regarding leading an inter-professional health care team and on active practice management.

CHN's new structure and curriculum have contributed to improved clinic continuity for their residents and patients, highest In-Training Exam scores in over a decade, improved match success, and improved faculty and resident satisfaction. Like the GHC program, CHN residents do not provide around-the-clock coverage of all the inpatient services.

Duke Family Medicine Residency (Durham, NC): In 1996, because of financial pressures from their institutional GME office and health system, the Duke Family Medicine Residency Program halted recruitment for one year. At the time, the program had only a single inpatient service and a single clinic (with a primarily public insurance population), and a small 6 resident class size, with the result that their clinical operations (residency and other) were not self-sustaining. They restructured and reopened one year later, having eliminated the program's inpatient service and developed a new weekly curriculum for residents on population health, quality improvement and leadership course. Currently, their residents achieve a flexible and individualized leadership/advocacy and population health experience, as well as meaningful training in community health and engagement. This flexibility and depth of experience is made possible by reduced inpatient commitments: their residents have 8 months of inpatient time during their intern year and 4 months during their second year. These rotations are embedded within other services at the hospital (i.e. General Medicine, General Pediatrics, etc.) or at neighboring institutions (i.e. UNC Family Medicine Residency inpatient service). Because they are guests on other services, they have no night-time coverage of any services. Their program highlights how a reduction in inpatient coverage allows maximal flexibility and maximal availability for weekly half day conferences in population health, quality improvement, community health and leadership. It is noted that this is a small program whose clinical operations were not self-sustaining at the outset, but also that this has helped Duke FMRP occupy a niche in residency education that attracts a racially and ethnically diverse pool of extremely talented and bright residents.

UW – Baraboo Longitudinal Curriculum

The Baraboo RTT has utilized longitudinal curriculum for PGY2/PGY3 since its inception in 1996. Modeled after the Sparrow/Michigan State University Family Medicine Residency, the longitudinal curriculum provides flexibility for the adult learner. While all residents must meet the requirements as set forth by the GME governing bodies, ACGME, ABFM, CMS, etc. longitudinal schedules allow them to learn "outside of the block". Work/Life balance and the management of self are high priorities for the longitudinal learner. Self-scheduling (within parameters) is a key component for this form of self-directed learning. A standard longitudinal

week consists of inpatient rounding, call, several clinic half-days, a few half-days with various specialties, seminar, hospital admissions, and potentially a continuity delivery or two. During a longitudinal week, residents practice full-spectrum family medicine, similar to the style of "real-world" practice.
Unopposed learning is a beneficial piece of the longitudinal model in smaller, rural residency programs. With fewer residents, the local preceptors tend to have increased availability to teach. With larger, urban-centered residency programs, adapting from a block schedule to a longitudinal schedule may pose a challenge, but it is not out of reach. In addition, incorporating longitudinal curriculum moves learning toward a more patient-centered approach than specialty-centered. Core clinical competencies are then met across multiple disciplines, while developing long-term relationships with community preceptors. Developing those long-term relationships may positively impact the residents' decision to begin independent practice within or near the area in which he/she trained.

Option of expanding Family Medicine Residency to 4 years: In 2012, the ACGME embarked upon a 6 year pilot to explore extending the length of family medicine residency to four years instead of three with plans to explore how a longer training period might better prepare family physicians for their careers. This pilot is currently underway and the four year option has been popular among residents in some of the pilot programs. However, many family physicians have voiced concerns that expanding residency to four years will lead to decreased interest in family medicine as a specialty, and a worsening of the shortage of family physicians in practice.[iii] In our department, one or two year fellowships after completion of the three year residency have been a popular option for those residents wishing to expand upon their skills and training in a specific area (academic medicine, research, integrative medicine, sports medicine, geriatrics). The fellowships have sufficiently filled the needs of residents wishing to expand their skills. As such, the task force feels expansion to four years would not be of net benefit to our programs or department at this time.

Option of exploring partnerships with more rural/small town FQHC:
Members of the task force explored the option of having our learners spend outpatient clinic time at an FQHC in Beloit, Wisconsin. This FQHC serves a very medically underserved population in a setting that is not as well-resourced as Dane County. Future partnership with this FQHC may be possible, but they are not ready to accept learners at this time.

III. Option:

Residency Expansion:

The Madison family medicine program has a strong national reputation resulting in an excellent applicant pool both in quantity and quality. Based on this and in light of the demand for family physicians, pursuing options to expand the Madison program seem to align opportunity with

meeting the needs of Wisconsin. Please see the attached document entitled "Statewide GME Engagement of the UWSMPH DFMCH" for a discussion of other options for state-wide expansion and collaboration.

Our recommendation for a Madison area expansion is two-fold, with either one or both choices as options:

1. Expand Belleville clinic by 2 residents per year with a focus on training physicians for small town/rural practice utilizing a pilot longitudinal curriculum and partnership with a secondary site; we have considered pros and cons of a distinct NRMP match number for this program. We envision that residents in this branch will maintain Belleville as their primary "home clinic" and also reap the benefits of time spent in a continuity practice in a secondary rural site (likely ½ day every two weeks). The RRC mandates that 51% or greater of a resident's clinic time must be spent at their primary site and that residents may spend up to 49% of their clinic time at an accessory site that is "under the control of the program director." The focus of this endeavor would be a "clinic first" structure, similar to the Group Health model. Flexibility in scheduling would allow residents to have stable clinic continuity days rather than having the clinic schedule is dependent on the inpatient rotation schedule. This would allow the residents to have a more consistent presence in clinic even during the R1 year and to develop their identity as a small town/rural family physician early on in their training. Belleville has historically been an attractive clinic option for residents who seek a small town/rural practice; we predict this model would only serve to enhance interest in training and practicing in this setting. In addition to building the resident's identity as an engaged member of the health care team at their primary clinic site (Belleville), this model would give the resident a true continuity experience at an accessory site rather than the brief time spent on a rural rotation in our current model.

2. Secondly, we believe expansion to another site in the Madison area would be beneficial to the residency as a whole and to increase the number of graduating Family Medicine Physicians in the state of Wisconsin. Adding 4 total residents per year would help the UW Madison program increase by a third of the total residents. Madison is a highly sought after location and tends to match strong residents. Not only would we increase the number of residents graduating in Wisconsin, but it would ensure high quality well trained family physicians would be entering the work force. Developing a community clinic as a teaching clinic for 2 additional residents per year would also help alleviate the service burden on residents and help free up time to develop a longitudinal curriculum. Training residents in a community clinic would serve to train residents in the model in which they will ultimately practice: this could be done in a UW affiliated clinic or an

Access clinic. The clinics should be evaluated based on several factors listed below. The clinics should be evaluated by the (Action Committee) and the selection criteria could be expanded upon as that group feels would be most beneficial.

1. Faculty interest: The quality of teaching in community clinics depends on both the variety of cases that a clinic has and mostly on the interest and passion for teaching that the clinical faculty possess.
2. Patient demand: The site must have the capacity to secure the 1100 clinic visits for each resident.
3. Procedure volume: A clinic where providers are doing procedures and feel comfortable providing them competently will be better able to train residents.
4. Space: The clinic must have space for resident offices and exam rooms. As well as a separate space for staffing patients.
5. Diversity: We would aim to train culturally competent physicians from a diverse cultural and ethnic background. In order to accomplish this having a diverse staff, patient panel, and providers would be ideal.
6. Team based care: Having RN based diabetes and hypertensive management as well as APP's working in teams to help providers care for a panel of patients, would be ideal in training residents for current health care settings and to set them up to be managers and innovators in population health

Clinic	NSVD	Colp	IUD	Circ	Fren	Joint Injections	Skin	Colons	Vas
Odana	46	37	86	23	8	34	>200	100	41
Beaver Dam	13/6c	-	9	44	6	109	144	-	10
Portage		1			-	14	73	-	
Sun Prarie	52	11	62	57	2	49	162	-	19
Deforest	21	23	72	38	-	100	138	-	23
Yahara	19	13	76	11	-	44	169	-	18

We explored this option using Odana clinic as a model as faculty at Odana have expressed a clear interest in increasing their involvement with teaching our residents and Odana has many features that would make it an attractive teaching site. Odana is recognized as a clinic that has been innovative in care management and quality improvement. Odana functions as a medical home with well-developed care teams and RN care coordination. Time is already set aside in the Odana clinic work flow for team based care in a way that is not yet as streamlined at our residency clinics. The high number of procedures physicians at Odana perform makes it an attractive option for resident learning; clinic volume obviates concern for clinic visit numbers. An added benefit of developing Odana (or a community clinic with similar strengths) is that

introducing our residents to our community clinics by direct involvement would help create a group of physicians who may want to work in the UW Health community clinics in Madison and the surrounding areas after completing residency. Being on the west side of Madison there are diverse patients and it draws from both rural Wisconsin and the more urban near west side of Madison. Lastly, training clinicians in a community setting would not be new to Odana who does a lot of medical student and APP training.

Factors requiring further consideration and input:

Capacity:
Patient visit numbers: the addition of two residents requires assurance that there are adequate visits to assure that each will have the requisite minimum 1650 visits over 3 years, (i.e., a total of 3300 visits). Will there be an additional 1100 visits per year available for residents at Belleville and Odana and will the practice meet RRC mandates for demographic distribution? Preliminary discussions with Dr. Lochner, Belleville medical director, indicate that visit numbers would be readily attainable but more formal investigation of this is needed if the steering group elects to move forward with exploring this option.

Faculty: In regard to expansion at Belleville, Belleville would have the same number of residents as Northeast, Verona, and Wingra so would need a comparable faculty complement to cover staffing, mentoring, and other educational support responsibilities. Currently, Belleville's staffing/teaching FTE is 0.7 whereas clinics with 4 residents per year have a teaching FTE of approximately 1.2. Expansion will affect the patient visit capacity, as well. What is the optimal faculty configuration to support residency expansion and how can that be achieved? Several factors weight in to the decision to hire physician faculty in addition to or instead of APP faculty; overall needs warrant further exploration. Especially if we pair with an accessory rural site, the possibility may exist to pull in community preceptors to staff/teach at Belleville as well. For the Odana model, our department would have to model the effects of having some faculty time used as teaching time. We must consider that there is more flexibility in supervisory rules when a faculty member is supervising just one resident as opposed to several at one. A cost analysis of faculty time would be needed, as well.

Staff: Growth in the number of residents and faculty with corresponding increase in patient visit numbers will likely require more staff. What would be required?

Space: Are there remodel needs that should be identified at Belleville or Odana? What other infrastructural needs would have to be met to accommodate an increased number of residents?

Resident recruitment: Would either of these options be viable from a recruiting perspective? Would one or unique match numbers be advisable? Would Belleville expansion negatively impact Baraboo's ability to recruit residents?

Curriculum Development:

In addition to the benefits discussed above, residency expansion would facilitate curricular improvement. A common feature of both the Group Health Cooperative and Community Health Network residency programs is a commitment to a higher volume of outpatient rather than inpatient medicine during the first year and throughout residency. This commitment reflects a philosophical view of the evolving identity of Family Medicine that was expressed by numerous stakeholders during interviews. From a practical standpoint, our Task Force felt that it also provides a flexibility that our current programs lack, which is to ensure that residents have consistent, protected, and longitudinal opportunities to take part in population health learning, community engagement, organized and inter-professional chronic disease management didactics, and leadership and advocacy training. We wish to maintain and build attention in our curriculum toward issues of racial, socioeconomic, gender based and other disparities that affect health care and the family physician's role in helping to mitigate the effects of these disparities.

Our Task Force recommends affirming such a commitment by the Madison residency program, the statewide UW residency programs, and UW-affiliated programs. Specifically, we recommend each program explore one of the options listed below in the context of their local health system and finances:

1. Reduction in the number of required inpatient weeks during the 1st year by reducing night or afternoon coverage for inpatient services (thereby reducing the number of required residents on service at a time)
2. Reduction in the number of required inpatient weeks during all years by increasing the number of residents per program (thereby spreading inpatient coverage requirements among a larger pool of residents)
3. Critically reviewing existing non-inpatient experiences during all years to maximize efficiency and reduce less rich clinical and non-clinical experiences.
4. Explore the possibility of applying for an exemption to the 1650 face to face visit rule in order to better train learners in the non-face-to-face aspects of patient care, including a focus on community engagement and population health.

These changes would benefit the faculty, residents, and patients of the DFMCH as well as the system at large in the following ways:

1. Our department will be better able to meet our mission of adequately training, both in volume and in preparation, family physicians to meet the primary care needs of our state.
2. Our residencies will remain competitive in attracting top applicants to our programs due to our heightened ability to meet the needs of our learners regardless of their future practice plans.
3. Our department will better support and engage our community faculty as teachers, adding a desired dimension and sense of investment in our teaching mission to their work.
4. Our residents will have increased exposure and involvement with our community clinics, potentially increasing their desire to work in this setting in the future.
5. We will be able to increase resident engagement with their practice communities as we move toward a more longitudinal curriculum.
6. We will have increased capacity to meet the learning needs of our residents with the ability to individualize curriculum based on the resident's needs and interests.
7. Expanding the number of residents we train will allow us to reinstate the resident-to-resident "intern partner" support while still providing sufficient coverage to our inpatient services. This support has been identified as very important to resident mental health and wellbeing.

In the backdrop to this discussion of residency expansion and curricular change is a tension that our Task Force recognized between the scope of practice of rural physicians and the evolving skill sets required by family physicians in urban and suburban communities.

This tension in its most stark form is exemplified by the schism that arose within the Royal Australian College of General Practitioners several decades ago because of debates surrounding fellowship and procedural training for physicians intending to practice in remote rural sites in Australia.[iv] Although the geographic scale of rural practice in Wisconsin and the Midwest is less than Australia, our medical students and residents are aware of the divergence between residency training programs that emphasize a broad scope of practice and procedural skills and those that focus on primary care, population health and community medicine. This represents an identity crisis of sorts for our residency program in weighing potential options for expansion and curricular change, which our Task Force wishes to highlight.

We recognize that curricular change will require time and effort dedicated to scheduling and evaluation of the changes we make. Though the overall feedback we have received from our learners and other stakeholders heartens us that moving forward with these changes is the appropriate path for our department (and specifically for the Madison program), we recognize that some learners may prefer a more siloed approach to how they learn. We have evaluated the pros and cons of each recommendation. For example, though some programs have ceased

covering inpatient services 24/7, we have concluded that this change would likely have negative effects on the education of learners in the Madison program and on relationships with some of the non family medicine teachers; therefore, we are not recommending this particular change. John Wheat has been working on a longitudinal, more outpatient focused curriculum for the Wausau program and is also considering the decision to step away from 24/7 inpatient coverage. Though the needs of each program may differ, we are eager to learn from the challenges and success of our colleagues. Together with the recommendations we make for change comes a recommendation to evaluate the hoped for and potentially unintended effects of the changes we make.

An additional benefit of expansion in conjunction with new curricular models that allow residents to build their identities as family physicians with a secure base in their clinic practices early in their training exists in regard to resident well-being and mental health. The proposed changes would lessen the day-night switching and bring residents back to their clinic homes more regularly, allowing them to build relationships with their faculty, teams, and each other more consistently. Because our complement of first-year residents in the Madison program will be larger than usual for the 2016-2017 academic year, we will be able to try a model that incorporates some of these positive changes (see R1 template 2016-2017 and Resident Well-Being Survey attachments).

IV. Financial Requirement:

Residency Expansion:

With regard to fiscal considerations for each option, when considering a reduction in coverage of inpatient services, programs should consider the effect on revenue streams from health system partners, which could be a potential barrier and depends markedly on specific negotiations with health system partners. When considering an increase in residents complement, programs must consider the financial possibility of funded versus unfunded expansion. With a funded expansion, modeling of funding after the funding source is exhausted remains important. Whatever course we take, issues that have financial and relational cost that should be considered include: effect on pass-through dollars, hospital relationships, community relationships, health systems relationships and financial support, productivity of teaching faculty in a teaching role rather than direct patient care role, relationships with consultants, resident and faculty satisfaction. Systems stakeholders include: UW Health, Dean/St. Mary's, other statewide health systems, community networks and organizations, insurance companies, state legislature, Rural Health Cooperative, DHSS, WRWRAP and others. Full financial modeling and further thought about all possible affected parties is beyond the scope of this task force but must be undertaken before a plan is enacted.

According to modeling performed by the current finance committee chair regarding our ability to expand at Belleville without an additional funding source, our task force learned our department currently receives the following:

St Mary's $116k-$120k per resident
UWH $ 11k-$ 15k per resident
Total hospitals $127k-$135k per resident
Block grant $ 54k-$ 66k per resident

Total $182k-$201k per resident

This is conservative – e.g. the block grant allocation is "after upstate PIF adjustment". We use $ 74k as a pre-adjusted block grant $ number per resident.

"How does this compare nationally?" There is no good national data for FM residencies. The WAAMI data is highly variable. The best data is for Medicare GME payments. For 2012

- 25th percentile total GME $ 73k, IME $ 45k, DGME $ 24k
- 50th percentile total GME $118k, IME $ 78k, DGME $ 39k
- 75th percentile total GME $159k, IME $106k, DGME $ 53k
- 95th percentile total GME $214k, IME $153k, DGME $ 82k

So for GME collections we are at the ~ the 60th percentile. Not bad. However consider that many (likely most) FM residencies get no state/university block grant support. Thus our total support is at ~ the 85th percentile for programs that rely just on Medicare GME funding. In addition we get substantial practice/comp support given PIF and technical loss credits. While strictly not "GME" this support greatly enhances our ability to do our jobs, including our jobs as residency faculty.

If we added 6 residents (2-2-2 in Belleville for example) and received no more total money, then our per resident total support would drop to $159k - $176k. This still would put us well above the 75th percentile for programs that only get Medicare GME. We do currently use these funds and would need to gain a clear understanding of how these monies are currently spent. We will also need to model the impact on clinical revenue adding residents would have. Certainly we should seek additional funding, but it appears we can "afford" to expand with current funding streams.

While there are initiatives on both the state and federal level to legislatively expand GME funding (GME Reform, Teaching Health Center Funding, Cap and PRA Adjustments, etc.), the likelihood of new funding in the next several years through these efforts are low. There are however two state funding sources in existence that should be considered.

1) Wisconsin Rural Physician Residency Assistance Program (WRPRAP). This program receives $750,000 per year from the state to promote the development of rural GME in Wisconsin. Typical grants for a new program or expansion of a program are for three years in duration and up to $150,000 in year 1, $125,000 in year 2 and $100,000 in year 3. Smaller planning grants are available. The legislative definition of rural for this program is a community less than 20,000 and more than 15 miles from a community greater than 20,000. Baraboo and Belleville would qualify. Awards are made twice a year.
2) Department of Health Services DHS) funding. DHS has two funding options available to programs in any area in the state except Milwaukee and they make awards annually:
    a. New Programs
        i. $1.75 million available annually
        ii. Three-year awards
        iii. Maximum $250,000 per year; $750,000 total
        iv. Funds must be matched (cash or in-kind)
        v. Funds cannot support more than six months of operation once first cohort of residents begins
    b. Program Expansion
        i. $750,000 Available annually
        ii. Potential Medicaid match
        iii. Funds limited to:
            1. $75,000 per resident; $225,000 per program (annually)
            2. Direct resident expenses (salary, fringe, malpractice insurance, etc.)

In each of this opportunities, funding is limited to development of one resident educational cycle (i.e. 3 years for family medicine). This would provide new support for the development and initial implementation of a residency expansion and allow time for identification of additional support for longer sustainability; “year 4” funding needs to be explored.

If we elect to pursue expansion at a UW Health community clinic, it is this task force’s recommendation that direct funding from UW Health be explored with the approach that training new primary care physicians in this model would ultimately substantially decrease UW Health’s financial output in recruiting physicians to practice in our clinics.

V. Short & Long Term Tactical Plan:

Action plan:

Our next step is to further explore stakeholders, resources, and barriers. The task force has compiled the interests and aspirations of many stakeholders, but others exist. Input from the Executive Team on which direction(s) the department wishes to head in regard to residency expansion and curricular improvement and innovation will allow us to formulate and obtain answer to appropriate questions regarding financial and practical feasibility of the proposed plan.

Our short term plan includes elucidating the financial implications of the agreed upon plan as well as learning more about faculty and staff needs and clinic visit projections with this plan. If we elect to proceed with Belleville expansion in a model that includes partnership with an accessory site, we will have to explore which site(s) may be most interested and advantageous. We also wish to further vet the proposed plan with residents and faculty. Longer term planning will involve modeling resident's schedules, visit numbers, and curricular plans.

Evaluation plan:

As with all aspects of our curriculum, we plan to seek feedback from residents and faculty about how the new model(s) we propagate are performing in meeting our educational goals. In particular, we plan to assess resident engagement and investment in their clinics. We, of course, will continue to monitor resident visit numbers and continuity and assure that residents are meeting ACGME requirements. We will also monitor effects on resident recruitment and faculty engagement. Metrics to track will include: numbers of residents who stay in Wisconsin to practice after residency and numbers of residents who practice in rural and/or underserved areas. We will also continue to review 1 and 5 year post-graduate survey data to track how well graduates feel their residency training has prepared them for their practices. We already track this data and we monitor resident In-training exam performance and board pass rate. From the In-training exam data, we can track curricular areas that are outliers in either over or underperformance by our residents to help gauge efficacy of our curricular changes. Much of this data, we already track. We'd like to add resident burnout, resident and faculty satisfaction, clinic continuity, and patient satisfaction to our tracked measures. Additionally, we will monitor our annual performance in the residency match, however we recognize that many factors contribute to the match success. We recognize that both expansion and curricular change would impact these measures. As we are proposing the changes go hand in hand, we will track the impact of the overall changes as opposed to attempting to (potentially falsely) attribute results to either expansion or a specific change in curriculum.

Responsible parties:

With the number of stakeholders and scale of input needed to investigate implications and feasibility of residency expansion in the proposed manner(s), our task force recommends that a Residency Expansion leadership group be convened to do this work. Members of this group

should include: Drs. Val Gilchrist, Lou Sanner, Bill Schwab, Byron Crouse, Kathy Oriel, Ildi Martonffy, Jensi Carlson as well as Michelle Grosch and Linda Haskins. We'd also encourage frequent input from a member of the Diversity and Inclusion Committee and a resident representative as well as continued discussion at GMEC, ideally with one or more state-wide representatives joining the group. Depending on the course of action selected, input from Dr. Jennifer Lochner and faculty at the selected community clinic (if that model is pursued) will be needed. Input from Baraboo through Dr. Stu Hannah or Angie Womble and financial input from Barb Stransky will also be needed. Our task force envisions that this group will be responsible for deciding on which expansion model(s) our department should enact. We recognize this decision will involve obtaining the appropriate financial modeling to help make the decision as well as senior leadership level input from the previously identified stakeholders. This group would also be responsible for investigating and obtaining grant funding, if applicable, and marketing the expansion however they see fit. Members of the task force not already identified as members of this Residency Expansion Leadership group (excluding those completing their time with the DFMCH) are happy to contribute to this process, as well.

We propose that the residency leadership will be responsible for implementation of curricular changes and innovation, with continued input from the Program Evaluation Committee (formerly known as Education Committee). We will work closely with our scheduling teams to identify how we can implement the desired changes with the fewest possible negative consequences, collaborating, also, with programs who have already made similar changes.

This revision of the initial proposal submitted on May 5, 2016, represents a joint effort of the following task force members:

Ildi Martonffy, MD
Byron Crouse, MD
Jennifer Somers, MD
Chris Danford, MD
Eugene Lee, MD
Kacia Stevenson
Angie Womble
Katy Bixby
Liaison: Melissa Stiles, MD

Additional Relevant Information:

1) **<u>Innovative curricular models</u>:** See attached info from GHC Seattle and Indiana Community Health programs (templates, curriculum outlines)

2) **<u>Postgraduate survey data</u>:** See attached 2009 and 20014 Madison residency graduate data

3) **<u>R1 template for 2016-2017 year (see attached):</u>** due to the larger class size for the 2016-2017 year, we have been able to break up some of the longer inpatient blocks to give residents a reprieve from some of the more intense rotations.

   A modified R1 inpatient schedule was built by creating a matrix with numbers of weeks (y-axis) in the academic year by number of interns (x-axis), as opposed to previous intern schedules being constructed blocks where all interns transitioned between services at the same times. All inpatient services were covered however, insertion of single weeks of an outpatient rotation between challenging rotations introduced the staggering effect. The service transitions of an intern pair are staggered w.r.t. other intern pairs' service transitions; the stability of the intern pair was respected and retained as much as possible. Inpatient service rotations this year are all 3 weeks long, as opposed to the previous mix of 3 and 4 weeks. The resulting schedule allows interns travel from service to service in a manner that resembles a block schedule, with 'outpatient service' blocks interspersed. Staggering the blocks of service for each resident does, at times, place limits on flexibility of coverage when scheduling challenges arise. Other possible non-optimal effects of this new intern schedule are lessened inpatient exposure/learning for residents and possible more frequent team transitions with concomitant effects on relationships with hospital staff and patients. The fracturing of the block schedule model necessitated the fracturing of the temporal integrity of some of the rotations; in many of the interns schedules, Peds Nights, Newborns, Rural Surgery and Community Health schedules are no longer in a contiguous block of weeks. Positive effects of the schedule include the flexibility to provide a more equitable distribution of inpatient service for the interns, as well as the already stated increase of respite and introduction of diversity to the first year curriculum.

4) **<u>Resident Mental Health and Well-being Survey:</u>** Survey conducted spring of 2016, showing high levels of burnout and depression among Madison residents

5) **<u>Stakeholder interview template and notes</u>:**

I'm the chair of the task force on residency education. Our task is to come up with a proposal that details the current status of things in our department, best practices (here and elsewhere), our opinion on direction(s) we should be heading, financial requirements, and short and long term tactical plans for how to "get there."

My sub-group is working on curriculum; the other sub-group is working on residency expansion models to help us train more family docs to better meet the needs of our population.

The final version of our group's mission statement is still being written, but the relevant portion of the one we were given that came from one of the "visioning" meetings as a place to start is:

"Educate these learners directly and intentionally on leadership, advocacy, population and community health, and communication skills in order to better equip them for their future roles as members of an inter-professional health care team; to engage residents with patients and families to improve the experience of care and to improve the health of their communities while delivering care in the place and manner that patients value most."

1) What's your opinion of the goals stated in the "working" (not final) mission statement?

2) What would you add to the statement? Or remove?

3) How should we prioritize the goals? (whichever goals the interviewee sees as important)

4) What should we give up in the current curriculum to make room for XXX?

5) How can these things be taught well as part of a residency curriculum?

6) What else should we focus on?

7) What could/should we change about residency structure to improve the experience of care (continuity, availability, etc.)?

8) How can we balance the needs and time constraints of training with trying to provide care to patients outside of the clinic/hospital setting (if indeed patients value this)?

9) Any other thoughts?

Summary of Interviews:

John Frey:
Merenstein report – same issues, still
Focus on leadership and interprofessional.
Intentional instruction on power dynamics. Leadership = being put into roles that can at first be seen as hard. Power/responsibility balance
Frey, Kirsten, and others are writing a grant for interprofessional education.
Need to talk with Kirsten/Robin about this.
Data literacy training needed (for residents and faculty)
Only thing we left out is technology
Where and how they/we learn informs what we learn
"won't lose what we've already lost" in terms of the "full spectrum" family doc (okay with giving up some inpatient if need be)

Jonas Lee:
1) Community health and communication skills
2) Leadership
3) Advocacy – for patients as well as for our discipline

Quality and value based care, including location that patients value (community center, Boys and Girls club, home visits, etc.); individualization vs. standardization pull.
Palliative model with truly putting the patient's needs first. Start with the patient's goals
Okay with less inpatient
Practice Management stuff. Learned a lot by reading "Family Practice Management" Beef up reading list with more teaching about pragmatic ways to get your office to run.
Importance of continuity, especially important to model for rural folks

Beth Potter:
Agrees with leadership and team, communication as priorities
Okay with less inpatient
May have some more info for us on value based care from a recent conference

Ken Loving:
1) How do you perceive the current level of training our residents have in leadership, advocacy, and team based care? (leaving the pop/comm health out of the equation for now as Kirsten and Robin Lankton are in charge of this aspect of the curriculum and it is already being overhauled).

I MOSTLY WORK WITH THE RESIDENTS WHEN I'M ON CALL. THEY ARE IMPRESSIVE—KNOWLEDGEABLE, COMMITTED AND GREAT WITH PATIENTS. I THINK MANY OF THEM HAVE BEEN LEADERS, BUT I DON'T KNOW IF THEY ARE LEARNING TO BECOME LEADERS WHEN THEY ARE OUT IN PRACTICE; OUTSIDE THE EDUCATIONAL SETTING. THEY ARE GOOD ADVOCATES FOR PATIENTS AND I THINK THEY WANT TO ADVOCATE FOR FAMILY MEDICINE AS A PROFESSION AND UNDERSERVED PATIENTS, BUT THERE ISN'T A LOT OF TIME FOR THEM TO DO ACTIVITIES OTHER THAN PATIENT CARE. I THINK THE INTEGRATED

BEHAVIORAL HEALTH MODEL HELPS THEM LEARN ABOUT TEAM BASED CARE BETTER THAN ANYTHING IN THE OUTPATIENT SETTING.

2) How did you learn what you needed to know in these realms in order to do your job?

AT ACCESS, WE HAVE TO ADVOCATE AND EDUCATE ABOUT WHAT WE DO AND WHAT OUR PATIENTS NEED TO REMAIN VIABLE. WE NEED TO CONVINCE GOVERNMENT OFFICIALS, LARGE HEALTH SYSTEMS AND DONORS OF THE IMPORTANCE OF WHAT WE DO. I'VE LEARNED THE NEED FOR THAT OVER THE YEARS, TRIED TO COLLECT MENTORS AND ADVISORS TO HELP ME, AND FOCUSED ON THE NEEDS OF THE PATIENTS TO EXPAND SERVICES AND GROW.

3) Are these appropriate areas of focus for our curriculum?

YES

4) How can these things be taught well as part of a residency curriculum?

IT CAN'T BE AN ADD ON. THERE NEEDS TO BE A COMMITMENT OF TIME AND RESOURCES, AND YOU HAVE TO FIND MODELS THAT HAVE BEEN SUCCESSFUL AND ADAPT THEM TO THE LOCAL ENVIRONMENT.

5) What else should we focus on?

I THINK YOU HAVE ENOUGH TO FOCUS ON WITH THESE EFFORTS

6) What could/should we change about residency structure to improve the experience of care (continuity, availability, etc.)?

I THINK COVERAGE, WORK HOURS AND COMMITMENT ARE ALL EXCELLENT

7) How can we balance the needs and time constraints of training with trying to provide care to patients outside of the clinic/hospital setting (if indeed patients value this)?

I'M NOT SURE PHYSICIANS ARE THE BEST GROUP TO BE GOING INTO THE HOME OR INTO THE COMMUNITY. IT HELPS WHEN PHYSICIANS ARE PART OF THE COMMUNITY, AND CONNECT WITH THE SOCIAL EVENTS OF THE PATIENTS THEY CARE FOR. COMMUNITY HEALTH WORKERS HAVE BEEN SUCCESSFUL GETTING INTO THE COMMUNITY AND HELPING TO CARE FOR INDIVIDUALS WITH HIGH NEEDS.

8) Any other thoughts?

I'M GLAD YOU ARE WORKING ON THIS.

Danielle Gindlesberger:

1) How do you perceive the current level of training our residents have in leadership, advocacy, and team based care? Team based care they are fine. Leadership and advocacy could use some work. They get better at the team based care with awareness of who to sue as resources. With the "real world" their reliance on these other people can come at a fault as many systems do not have all those resources. They need to be a little stronger at being the "leader" of the team but I think this is a classic resident issue. Some of them get it and others just do not.
2) How did you learn what you needed to know in these realms in order to do your job? A lot of on the job training. I was very involved in National and State committees which taught me more about leadership and advocacy. Exposure to the state medical society, AAFP, WAFP etc is helpful. I also think some people are more natural leaders. Encouraging residents to take lead on smaller projects to help them build the skills for larger ones.
3) Are these appropriate areas of focus for our curriculum? I think they will help build better clinicians in the future world with primary care changing to team based care.
4) How can these things be taught well as part of a residency curriculum? Jim Davis is doing a curriculum redesign for the M1 M2 PDS program at UW and we have chatted about medical education in this realm. How to teach team based care is always tricky. I think more education in A3 thinking and PDSA cycling are helpful. Also lessons in self-reflection and self-awareness to assess one's own strengths and weaknesses help one prepare for the job better as well. We are doing care team redesign again at Dean and I get to lead the charge this time. I am working with my teams on PDSA cycling and understanding that trying something doesn't always mean it will work and "failing" just means you eliminated one more way of doing something. I think that aspect is truly missing from today's curriculum.
5) What else should we focus on? See above and we can chat about it more.
6) What could/should we change about residency structure to improve the experience of care (continuity, availability, etc.)? I guess I need to know if this is more about the patient experience or the resident experience to answer the question.
7) How can we balance the needs and time constraints of training with trying to provide care to patients outside of the clinic/hospital setting (if indeed patients value this)? There is a lot of value in the home visit, but as you know it is done very little anymore. Even health care organizations are using NP and PA to do this work. I think in training it is good to do a few so you get an appreciation of them, but even more important is figuring out how to interpret the information given to you by that team member to help design effective care.

Indiana Program: Tricia Hern, longitudinal curriculum:

Suggested Carl Morris at GHC Seattle and Sam Jones in Virginia if we want to explore this further with slightly different models .
Indiana's model is Module based, a nice hybrid between block system and every day being a free-for-all.
It has improved clinic continuity for their residents and patients. Focus on team time in clinic each Friday on the chronic care modules. Intentional leadership and practice management training.

GHC Program: Carl Morris, longitudinal curriculum:

Clinic First policy
Main goal is to get residents to identify as Family Physicians, first. Getting them in to clinic 4-5 ½ days per week in R1 year with then fewer ½ days R2 and R3 year since this ultimately gives them steady access to cover their panel of about 400 patients (22% of a 1.0 FTE GHC physician). R1s start with 4 patients per ½ day and ramp up to 6 by the end of the year.
They have an exemption so their face to face requirement is 1400 instead of 1650. 3 virtual visits = 1 face to face.
They do not cover the services 24/7. Hospitalist system with good working relationships.
Electives start about ½ way through R1 year.
3 year scheduling endeavor. Lots of lead time and careful tracking.

----------Feedback from Eugene's interviews with people in our department:

Residency Education Task Force: Gathering information

Summary of Meetings with Kathy Oriel, Bill Schwab, and Lou Sanner

1&2) Overall opinion of the goals in the mission statement and things to add or remove?

Overall good goals, nothing to add or remove. Things that they would like to keep in mind when working on the statement:

- Madison is seen as a talent recruiter and retainer from other states, but we should train people to practice anywhere where they might be needed both locally and internationally.
- If we have more trainees, how/where do we train them
- What scope do residencies want to prepare people for? Narrow or broad as this will determine the residency identity and what to articulate in our mission statement.

3&4) How should we prioritize the goals, and what should we give up?

Overall people felt that determining where we felt the residency was heading would determine our goals. There were caveats and things to keep in mind though:

- There are topics/numbers required by the ACGME for family medicine residents to learn and graduate with.
- There are topics and skills that are learned in residency that cannot be taught per se but

need to be experienced that prepare people for the rest of their life, AKA “Meta Skills” or “hidden curriculum”

- Communication and teamwork (being a leader and follower)
- Prioritization (patients, life, work)
- Stress management (acute pt care and self care)
- Emergency patient management (both leading and staying calm and how to treat)
- Improvement skills (self-directed learning)
- Improvisation/comfort with uncertainty
- Using hands (procedures, exam technique/styles, etc)

- Even though graduates feel weak in management of health systems, as residents no one wants to learn it at that time. The trick is having residents learn basic steps so that they know how to find and self teach the knowledge relevant to their specific practice after being in their practice and seeing how it works.

5) What else should we focus on?

- We should focus on having residents have rich experiences and getting rid of those that are not considered rich.
- We should focus on having the residents be a more active and engaged member of a team and truly working with the multiple other members of the care team. In order to model this, we need to have attendings who truly lead an interdisciplinary high functioning team.

6) How can these things be taught?

- For this there is some part of individualization and helping the resident determine their learning style.
- Utilizing other team members who have experience in the topic, MDs, PAs, NPs, RNs, Pharmacists, PTs, etc.
- Cluster didactics allows a uniform distribution of knowledge on key topics that all graduates she know. Can this be substituted for some less rich experiences?

7) What can change about residency structure to improve experience?

- Having more flexibility in the schedule (this can be done by having more residents)
- Having a diverse faculty who have availability to work with residents on shared interests which can count for some of the requirements.
- If faculty and clinics are active in figuring out what their community needs (on school boards, active citizens, home services? etc) then physicians will be affecting the social determinants of health and residents will have models whom they can follow and learn from. So If clinics as a whole are doing this, then the teaching of/learning by residents will naturally follow.
- Maximizing without exhausting those teachers who are effective in teaching
- Include patients in the education. Ex: Patient’s with certain diseases/issues guest lecture, or allows residents to exam, ask questions, etc.
- If getting rid of full time hospital coverage, recognizing that the hospital will adjust for their best interest and therefore resident education may be put on the back burner vs currently with residents being a crucial part to St. Mary’s care they make accommodations for us.
- Finding a way to count our primary care clinic visits for specialty visits without double

dipping if there are some specialties where residents mainly shadow and receive less rich experiences.

8) How can we balance needs and time constraints?

- Having more residents will off load the inpatient services.
- Limiting non residency related things – driving to and from clinic, out of clinic electives that are less rich, less PDS, groups etc which remove residents from clinic and things.
- having more slack with clinic visits.
- Ensure that advisors are getting information from residents and helping with schedules to include that information
- Having residents realize that depending on what they want to do, there might be some compromises of work and after hours.

9) Other thoughts?

- The economics of all these decisions because where is the financial support coming from.
- Can we utilize the community values to align with resident education goals, and therefore maximize a partnership.
- Tracks: Do tracks close doors for the future? Do people really know how/where they want to practice without having experienced it or knowing what's desired in their job market? For those in an opt-out track, are the experiences that are substituted for equally as rich?
- Can residents graduate in 3 years to learn all these skills. Overall Madison graduates do feel prepared to be out in practice, but Madison also has multiple fellowships for those who want more training and this allows for flexibility.
- When talking about changing schedules, keep in mind the scheduling side of things, making sure that residents all have a rich experience without overlapping and knowing availabilities without violating duty hours.

Feedback from GMEC, 1-21-16:

Baraboo: already has more of a longitudinal model. They felt more education on P4P and accountability standards is warranted. Meetings, structure of a practice. Can we be creative about expanding the definition of continuity visits? They do have hospitalist coverage after 5pm there.

Eau Claire: We must be able to sustain whatever we come up with. They agree with Baraboo about getting creative about certain ACGME requirements. We are being asked to do more and more with less and less. Don't dilute what's already there. Balancing act. Realize you will continue to learn in practice. They do not cover MICU and OB 24/7.

Wausau: John Wheat is working on longitudinal curriculum as part of his NIPDD project. Focus on resident ownership of their patient care panel. Change focus to outpatient setting. They do currently cover in patient 24/7 but realize this will likely have to change.

Madison: desire for less time in specialty clinics with more teaching in Fam Med Setting. Focus on "time best spent." Content density needs to be appropriate.
Preserve what is good. More individualization may be needed.
Needs flexibility to accommodate this flux.
We must also refine what is meant by pop health.
Training a specific skill set vs. experience that informs a set of "meta skills" to be used in other settings.
Preserve unique experiences that you'll never get to do again later in your career.
All need to get behind whatever we come up with.
Be mindful of the evolving skill set of staff, so staff can be more programmatically focused; staff ratios.
Structured BHC across all sites.
Having a structured clinic curriculum

Input from Kirsten and Robin regarding community health/population health:
R1 half day on Advocacy + the STFM self-study module
R2/3 advocacy seminar
WAFP: rotating lecture, sometimes on advocacy
Doctor Day – peds does a 90 minute intro session to this
Would like to have more R1's on the rotation at a time. They would greatly be in favor of a longitudinal curriculum. They'd love to have a ½ day per week of practice management/pop health/community health/leadership
Community health learning plan, 8 ½ days during the year
Leadership skills, team based care – PA program has material on this
Private practice, management skills
Individualized track as a way to cover all bases

Madison residency expansion meeting 2/1/16
Attendees-Gilchrist, Schwab, Martonffy, Grosch, Sanner, Crouse
To all
These are my very brief notes from our meeting this morning. Please feel free to add or edit.

1. Future information:
    a. Byron attending a rural policy institute starting today
    b. February 2 ACGME/AA MC call
    c. GME initiative-Kim Marvell office, focused on rural GME
2. Finances
    a. the rural federal grant has not appeared
    b. DHS funding? Available at any time
        i. May be matching federal funds if it is program expansion
        ii. New program funds require matching by the health system
    c. WRWRAP planning grant?
    d. Cost per resident
        i. Margin - in an established program 80,000-100,000 per resident per year

ii. 150,000 per resident per year

e. DFMCH cost allocation
    i. The last time it was reviewed it was approximately 148,000 per resident per year
    ii. Sources of funding include- GME, clinical revenue, block grant

3. Statewide considerations
    a. Hudson-health partners
    b. LaCross-Gunderson and mail programs
    c. Green Bay-apparently MCW is still trying to start a program there
    d. Eau Claire-Mayo and? UW program
    e. New rural training track Aurora
4. Consideration for a Madison
    a. Belleville expansion
    b. Partnerships with
        i. Sauk
        ii. (Dodgeville)
        iii. (Portage)
        iv. Beloit
        v. (Monroe)
        vi. ? GreenBay

Other ideas/needs:

- 10% FTE for a faculty person at each clinic to be in chart of clinic based resident education
- More dedicated, intentional didactic (lecture and clustered didactic) curriculum management with appropriate FTE attached to that

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[i] http://www.aafp.org/news/education-professional-development/20131120rgcfmgrads.html
[ii] Merenstein JH, Schulte JJ. A Residency Curriculum for the Future. *Fam Med* 1990; 22:467-73.
[iii] http://www.aafp.org/news/education-professional-development/20120427acgmepilot.html
[iv] Trumble SC. The evolution of general practice training in Australia. Med J Aust. 2011 Jun 6; 194(11):S59-62.