



PGY-1/2/3 Family Medicine Longitudinal Curriculum

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The Family Medicine Longitudinal experience is required and takes place during all three years of residency. Training takes place at the NWFMR Ambulatory Care Center. This includes a 2 or 4-week rotation each academic year as well as longitudinal clinical experience. The goal of this curriculum is to prepare family physicians to practice family medicine in the ambulatory setting and to develop the skills needed to lead a clinical team in the provision of healthcare for a panel of patients. This experience is the core of the Family Medicine training program and develops residents to practice independently in a multi-professional healthcare team that provides acute and long-term health care, population health management and outpatient procedures in an evidence-based, cost-effective manner.

ACGME Competencies and FM-Specific Milestones Assessed

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
✓ *PC-1, PC-2, PC-3, PC-4, PC-5*
2. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care
✓ *MK-1, MK-2*
3. **Systems-based practice** as manifested by actions that demonstrate an awareness of an responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care
✓ *SBP-1, SBP-2, SBP-3, SBP-4*
4. **Practice-based learning and improvement** that involves the instigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care
✓ *PBLI-1, PBLI-2, PBLI-3*
5. **Professionalism** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds
✓ *PROF-1, PROF-2, PROF-3, PROF-4*
6. **Communication** that result in the effective exchange of information and collaboration with patients, their families, and other health professionals
✓ *C-1, C-2, C-3, C-4*

Family medicine is a primary care specialty which provides high quality care within the context of a personal doctor-patient relationship and with an appreciation for individual, family, and community connections. Continuity of comprehensive care for the diverse patient population family physicians serve is foundational to the specialty. Access, accountability, effectiveness, and efficiency are essential elements of the discipline. The coordination of patient care and leadership of advanced primary care practices and evolving health care systems are additional vital roles for family physicians.

Family Medicine Program Requirements:**IV.A.5.f)** Residents are expected to:

- work effectively in various health care delivery settings and systems relevant to their clinical specialty
- Coordinate patient care within the health care system relevant to their clinical specialty
- Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate
- Advocate for quality patient care and optimal patient care systems
- Work in multi-professional teams to enhance patient safety and improve patient care quality
- Participate in identifying system errors and implementing potential systems solutions

IV.A.6 Each resident must be assigned to a primary Family Medicine Practice (FMP) site.

- Residents must be scheduled to see patients in the FMP site for a minimum of 40 weeks during each year of the program.
 - Continuity of care must not be interrupted for more than eight weeks and at given time or in any one year.
 - Periods between interruptions in continuity must be at least four weeks in length.
- Experiences in the FMP must include acute care, chronic care, and wellness care for patients of all ages.
- Residents must be primarily responsible for a panel of continuity patients, integrating each patient's care across all settings, including the home, long-term care facilities, the FMP site, specialty care facilities, and inpatient care facilities.
 - Long-term care experiences must occur over a minimum of 24 months.
- Residents should participate in and assume progressive leadership of appropriate care teams to coordinate and optimize care for a panel of continuity patients.
- Residents must provide care for a minimum of 1650 in-person patient encounters in the FMP site
 - One hundred sixty-five of the FMP site patient encounters must be with patients younger than 10 years of age
 - One hundred sixty-five of the FMP site patient encounters must be with patients 60 years of age or older.
- Residents' patient encounters should include telephone visits, e-visits, group visits, and patient-peer education sessions.

Competency-Based Objectives and Instructional Methods**A. Patient Care:**

- *Evaluate patients of all ages with undiagnosed and undifferentiated presentations.*
 - Perform complete, concise and accurate histories and physical examinations on all clinic patients.
 - Produce accurate and appropriate documentation for outpatient care--including clinic progress notes and procedure notes when applicable.
 - Demonstrate knowledge of appropriate use and interpretation of outpatient laboratory/imaging studies for assigned patients

- Submit accurate and complete orders for outpatient imaging/laboratory studies at the time of patient visit, including demonstration of medication reconciliation
- Assess community, environmental, and family influences on the health of patients
- *Treat medical conditions commonly managed by family physicians.*
 - Develop expertise at treating the conditions commonly encountered by family physicians.
 - Formulate management plans for patients during clinical encounters.
 - Demonstrate ability to formulate appropriate clinical questions when consultation with a specialist is needed.
 - Coordinate with nursing and clinic management staff to facilitate safe and efficient outpatient follow-up when necessary.
 - Demonstrate ability to reconcile and manage patient medication lists to minimize potential for complications of polypharmacy.
 - Use multiple information sources to develop a patient care plan based on current medical evidence.
 - Actively manage the preventive medicine needs for assigned patient panel.
 - Provide longitudinal maternity care.
 - Perform typical outpatient procedures for common conditions.
- *Counsel and educate patients and their families.*
 - Accurately assess patient's understanding of their disease process (s).
 - Provide patient education with emphasis on health promotion and primary prevention.
 - Provide targeted education for patients, demonstrating sensitivity to cultural and/or religious beliefs held by said patients.
 - Demonstrate skills to comprehensively assess behavioral health concerns and establish a behavioral health plan in collaboration with the patient.

Instructional methods:

Supervised Clinical Management: Application of information to individual patient cases in the Family Medicine clinic.

- Preceptors will be assigned to every clinic sessions at a resident: faculty ratio not to exceed 4:1.
- Residents will be an active member of an assigned clinic team. The clinic team will have "Team Clinic" two half days per block. This will consist of a 1-hour didactic session followed by clinic with the team faculty precepting.

Direct observation:

- A faculty member (ideally the resident's advisor) will directly observe at least four patient encounters each academic year to assess longitudinal growth.

Record review: Faculty team leaders and preceptors will review encounter documentation consistent with program requirements and provide feedback to residents.

Team Huddles: Clinical teams will huddle prior to each clinic session to review roles and responsibilities and to develop diagnostic and management plans. Clinic staff will educate residents on local resources and processes to access them.

Pre-clinic Conference: Residents will arrive timely and prepared for this conference that occurs prior to every half-day clinic session. R3 residents will be transitioned to a full clinic schedule in lieu of this conference in the second part of the academic year; this will enhance their preparations for independent practice.

Didactic Sessions: Applicable topics will be discussed during Thursday afternoon conferences and during the first hour of “Team Clinic” sessions.

Recommended Readings: American Family Physician Journal published twice a month.

Guided Research: Resident presentation of faculty-assigned topics based upon clinical cases.

Written examination: In-service training examination (ITE) will be completed annually to assess progress toward board certification. An individualized Medical Knowledge Enhancement Plan will be implemented based upon ITE performance (see MKEP Policy)

Portfolio review: The Clinical Competency Committee (CCC) will periodically review resident procedure logs/assessment forms and competency evaluations to assess milestone progress toward independent practice.

B. Medical Knowledge

- *Demonstrate proficiency in their knowledge of established and evolving clinical sciences as well as application of this knowledge to patient care.*
 - ✓ Personal study of medicine is an ongoing process and is a behavior pattern necessary for successful completion of training and independent practice in Family Medicine. Demonstrate ongoing personal study by increasing medical knowledge progressively over the course of residency.

- Gain procedural competency according to the Longitudinal Procedural Training Curriculum.

The following list of skills are integral to this curriculum and residents should seek opportunities to train in these procedures during rotations.

<u>A₀ Procedures</u> Procedural competence assumed by graduating from the program	<u>A₁ Procedures</u> Procedural Competence is required for graduation	<u>A₂ Procedures</u> Procedural Competence is optional prior to graduation	<u>B Procedures</u> Procedural Competence requires a focused training plan during residency	<u>C Procedures</u> Procedural competence likely requires additional training beyond residency
<ul style="list-style-type: none"> • Anterior nasal packing for epistaxis • Cerumen disimpaction • Corn/callous removal • CXR interpretation • Digital rectal exam • Drain subungual hematoma • EKG performance and interpretation • Fecal disimpaction • Fetal monitoring • Fluorescein examination (without slit-lamp) • Interpret Spirometry • Intrauterine device removal • KOH prep 	<ul style="list-style-type: none"> • Basic obstetric ultrasound: Amniotic Fluid Index, fetal presentation, placental location (10) • Biopsy: excisional (3) • Biopsies: punch/shave including vulvar (3) • Cardiac Stress Test (10) • Digital Block (1) • Endometrial biopsy (3) • Incision and drainage of abscess, including paronychia (3) • Intrauterine device insertion (3) • Laceration repair with sutures (3) • Newborn circumcision (10) 	<ul style="list-style-type: none"> • Advanced prenatal ultrasound: 1st trimester biometry (10) • Cervical Polypectomy (1) • Colposcopy (10) • I&D of a perianal abscess (1) • Excision of thrombosed external hemorrhoids (2) • Lingual frenotomy (2) • Removal of perianal skin tags (1 or demonstrated competency w/ excision of thrombosed 	<ul style="list-style-type: none"> • Anoscopy • Bartholin’s cyst management with word catheter • Bone marrow biopsy • Cervical cryotherapy • Conscious sedation • Diaphragm fitting • Hematoma block • Intrathecal anesthesia • LEEP • Nasolaryngoscopy • Non-obstetrical, point-of-care diagnostic applications (abdominal, cardiac, musculoskeletal, ocular, pelvic, 	<ul style="list-style-type: none"> • Acupuncture • Allergy skin testing • Bartholin’s cyst management (marsupialization) • Botulinum toxin injection • D&C / MVA • Fine needle aspiration of a cyst, including breast • Flexible sigmoidoscopy • Holter interpretation • Non-surgical cosmetic aesthetics

<ul style="list-style-type: none"> • Laceration repair with tissue glues or staples • Local anesthesia/field block • Pap smear collection • Peripheral venous cannulation • Phlebotomy • Removal of foreign body from ear or nose • Skin lesion destruction • Simple closed reduction of subluxed joint without sedation (e.g. nursemaid elbow or lateral patellar dislocation) • Skin tag removal • Superficial conjunctival foreign body removal (without slit-lamp) • Topical anesthesia • Urinalysis (dipstick, microscopy) • Vulvar biopsy • Wet mount 	<ul style="list-style-type: none"> • Nexplanon insertion and removal (1 each following completion of device manufacturer training) • Toenail removal, partial or full (3) • Upper and lower extremity splints (1 each) • Upper and lower extremity casts (1 each) • Injection/aspiration of joint, bursa, ganglion cyst, tendon sheath or trigger point (5, including 1 knee and 1 subacromial/subdeltoid bursa) 	external hemorrhoid) <ul style="list-style-type: none"> • Removal of a superficial corneal foreign body (2) • Slit lamp exam (3) • Vasectomy (5) 	skin/soft tissue, thoracic, vascular, etc.) <ul style="list-style-type: none"> • Advanced obstetrical applications (nuchal translucency, cervical length, umbilical cord doppler, 2nd/3rd trimester biometry) • Office tympanometry • Peripheral nerve block other than digital 	
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- For A1 and A2 procedures, the minimum number of procedures that must be logged electronically prior to graduation is listed in parentheses.
- Residents should attempt to complete as many Procedural Competency Assessment Tools as possible during rotations.

Instructional methods:

Procedural Training: Residents will actively participate in procedures gaining progressive independence through experience and demonstrated competence. Residents need to utilize the Procedural Training Curriculum throughout their 3 year training to formally document their competence for remote supervision and independent practice.

Recommended Readings: American Family Physician Journal published twice a month.

Supervised Clinical Management: Application of information to individual patient cases in the Family Medicine clinic.

- Preceptors will be assigned to every clinic sessions at a resident: faculty ratio not to exceed 4:1.
- Residents will be an active member of an assigned clinic team. The clinic team will have “Team Clinic” two half days per block. This will consist of a 1-hour didactic session followed by clinic with the team faculty precepting.

Direct observation:

- A faculty member (ideally the resident’s advisor) will directly observe at least four patient encounters each academic year to assess longitudinal growth.

Record review: Faculty team leaders and preceptors will review encounter documentation consistent with program requirements and provide feedback to residents.

Didactic Sessions: During Team Clinic didactic sessions, each resident will present at least once during the academic year:

- R1: patient presentation
- R2/R3: Evidence-based family medicine topic

Guided Research: Resident presentation of faculty-assigned topics based upon clinical cases.

Written examination: In-service training examination (ITE) will be completed annually to assess progress toward board certification. An individualized Medical Knowledge Enhancement Plan will be implemented based upon ITE performance (see MKEP Policy)

Portfolio review: The Clinical Competency Committee (CCC) will periodically review resident procedure logs/assessment forms and competency evaluations to assess milestone progress toward independent practice.

C. Systems-Based Practice

- *Demonstrate an awareness of and responsiveness to the larger context and system of health care.*
 - ✓ Demonstrate understanding of the larger context of outpatient care within healthcare organizations by effectively utilizing referral resources to enhance patient health.
 - ✓ Effect efficient transfers of care and/or consultation with medical services at other healthcare centers when appropriate.
 - ✓ Use appropriate evidence-based clinical care guidelines whenever possible to achieve high quality care.
 - ✓ Through this curriculum and other program curricula, residents will gain in-depth understanding of the local area medical and behavioral resources and will be able to direct/guide patients to the appropriate resources based on patient's needs.

Instructional methods:

Supervised Clinical Management: Application of information to individual patient cases in the Family Medicine clinic.

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- Residents will be an active member of an assigned clinic team. The clinic team will have "Team Clinic" two half days per block. This will consist of a 1-hour didactic session followed by clinic with the team faculty precepting.

Direct observation:

- A faculty member (ideally the resident's advisor) will directly observe at least four patient encounters each academic year to assess longitudinal growth.

Home Visits: Residents will complete four home visits during their training and document them in the Electronic Health Record.

Record review: Faculty team leaders and preceptors will review encounter documentation consistent with program requirements and provide feedback to residents.

Team Huddles: Clinical teams will huddle prior to each clinic session to review roles and responsibilities and to develop diagnostic and management plans. Clinic staff will educate residents on local resources and processes to access them.

Pre-clinic Conference: Residents will arrive timely and prepared for this conference that occurs prior to every half-day clinic session. R3 residents will be transitioned to a full clinic schedule in

lieu of this conference in the second part of the academic year; this will enhance their preparations for independent practice.

Didactic Sessions: Applicable topics will be discussed during Thursday afternoon conferences and during the first hour of “Team Clinic” sessions.

Guided Research: Resident presentation of faculty-assigned topics based upon clinical cases.

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Recommended Readings: Family Practice Management Journal published bi-monthly by the AAFP.

D. Practice-Based Learning and Improvement

- *Continually identify strengths, deficiencies and limits in one’s knowledge to develop personal growth plan.*
 - ✓ Demonstrate improving ability to manage patient panel throughout the three year training program. Each academic year the resident patient panel will increase in size as personal efficiency skills improve.
 - ✓ Apply current evidence to patient practice and document evidence-base care accordingly.
 - ✓ Develop a personal study plan that focuses on self-identified deficiencies to ensure continuous practice improvement.
- *Analyze practice experience and perform practice-based improvement.*
 - ✓ Demonstrate evolution of time management skills evidenced by increased efficiency of patient care and ability to manage more patients effectively.
 - ✓ Residents will learn to analyze and manage patient panels using practice dashboards. Specific areas of analysis will include:
 - Financial performance
 - Progress toward needed minimum in-person encounters (1650)
 - Management of selected health metrics for enrolled panel such as
 - Diabetes management
 - Hypertension management
 - Health maintenance and cancer screening
 - Specific performance measures
 - Continuity of care
 - Access to care
 - Number of urgent care or emergency visits for enrolled patients
 - ✓ Residents will become proficient at clinical coding throughout the three years of training and will receive specific training from coder-auditors as well as faculty physicians.

Instructional methods:

Health System Management experiences: Residents will actively participate in the Health Systems Management Curriculum which includes:

- Coding Training: Periodic coding training will include tri-annual Team Clinic didactics as well as record audit with on-the-spot training. Dashboard review will demonstrate improved coding accuracy over the three year curriculum.

- *Dashboard review:* Clinical performance data will be reviewed quarterly for each resident. This will include data pertinent to the practice to include: access-to-care, panel size and demographics, health outcomes data, etc.

Quality Improvement Projects: residents will actively participate in at least an annual team based quality improvement project.

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Recommended Readings: Family Practice Management journal published bi-monthly.

Guided Research: Resident presentation of faculty-assigned topics based upon clinical cases.

Written examination: In-service training examination (ITE) will be completed annually to assess progress toward board certification. An individualized Medical Knowledge Enhancement Plan will be implemented based upon ITE performance (see MKEP Policy)

Portfolio review: The Clinical Competency Committee (CCC) will periodically review resident procedure logs/assessment forms and competency evaluations to assess milestone progress toward independent practice.

E. Professionalism

- *Demonstrate a commitment to carrying out professional responsibilities and adherence to ethical principles.*
 - ✓ Actively participate in developing a Resident Year Group Professionalism contract and model its application
 - ✓ Arrive timely and active engage in all mandatory work-related and academic events.
 - ✓ Complete all administrative and training requirements on time.
 - ✓ Abide by the CHI-Franciscan, Harrison Medical Center Medical Staff By Laws.
 - ✓ Present at all times an appropriate, professional appearance and demeanor.
 - ✓ Treat others with dignity and respect at all times.
 - ✓ Complete all patient documentation on time according to institutional requirements.

- ✓ Make efforts to manage own patients by working with staff to provide care when needed which might include: walk-in visits, seeing some patients outside of clinic hours.

Instructional methods:

Role Modeling: Physician faculty as well as nursing staff and other clinical staff will role model professionalism at all times.

Professionalism contract: Residents will abide by the residency class written contract.

Portfolio review: The Clinical Competency Committee (CCC) will periodically review resident procedure logs/assessment forms and competency evaluations to assess milestone progress toward independent practice.

F. Interpersonal and Communication Skills

- *Work effectively with others as a member or leader of a health care team or other professional group*
 - ✓ Maintain cordial, professional relationships with clinical team.
 - ✓ Understand each team member's unique skill set and clinical role.
 - ✓ Demonstrate a collaborative relationship with other physicians and health care professionals.
 - ✓ Advocate for the best interest of patients in all interactions.
 - ✓ During third year of training, act as a co-team leader for a patient care team in the FMC.
- *Provide information using effective nonverbal, verbal and writing skills*
 - ✓ Demonstrate skill at complete, concise, and relevant patient presentations to attending and consultant physicians.
 - ✓ Document all patient encounters clearly and completely.
 - ✓ Develop communication skills necessary to create an environment of trust and respect for patients.
 - ✓ Demonstrate skills to comprehensively assess behavioral health concerns and establish a behavioral health plan in collaboration with the patient.
 - ✓ Master interviewing skills with patients to develop accurate diagnoses and to present cohesive plans tailored to the individual needs of the patient.

Instructional methods:

Behavioralist observation and instruction: Behavioral Science faculty will directly observe patient interactions to provide on-the-spot instruction and to assess long-term milestone achievement in this competency.

Presentations: Residents will present annually at Team Clinic and 4 times per year at academic conference.

Role Modeling: Physician faculty as well as nursing staff and other clinical staff will role model professionalism at all times.

Patient feedback: Individual patient feedback will be reviewed with residents to identify strengths and areas for future growth.

Supervised Clinical Management: Application of information to individual patient cases in the Family Medicine clinic.

- Preceptors will be assigned to every clinic sessions at a resident: faculty ratio not to exceed 4:1.
- Residents will be an active member of an assigned clinic team. The clinic team will have "Team Clinic" two half days per block. This will consist of a 1-hour didactic session

followed by clinic with the team faculty precepting.

Direct observation:

- A faculty member (ideally the resident's advisor) will directly observe at least four patient encounters each academic year to assess longitudinal growth.

Record review: Faculty team leaders and preceptors will review encounter documentation consistent with program requirements and provide feedback to residents.

Team Huddles: Clinical teams will huddle prior to each clinic session to review roles and responsibilities and to develop diagnostic and management plans. Clinic staff will educate residents on local resources and processes to access them.

Portfolio review: The Clinical Competency Committee (CCC) will periodically review resident procedure logs/assessment forms and competency evaluations to assess milestone progress toward independent practice.

Specific structure of Family Medicine Longitudinal Curriculum

1. Each resident will be assigned to a FM clinic team consisting of PGY1/PGY2/PGY3 residents and a faculty attending physicians. The team will also include nurses and medical assistants.
 2. The practice team will meet regularly to review performance and to set goals applicable to each specific team and its enrolled patients.
 3. Resident continuity empanelment limits are:
 - a. PGY1 100 patients
 - b. PGY2 200 patients
 - c. PGY3 300 patients
- Empanelment of select patient populations will be guided by the following:
- a. Continuity Obstetric Patients: Residents may be assigned up to 6 continuity obstetric patients in their R1 year and up to 12 continuity obstetric patients in their R2 and R3 year.
 - b. Patients with opioid use disorder on Medication assisted therapy: maximum of 2 patients
 - c. Patients prescribed chronic opioid therapy (refer to GME policy regarding prescribing opioids)
 - d. Patients who work in the Family Medicine Clinic will not be assigned to residents
4. Annual in-person encounter targets per year group
 - a. PGY1 250 encounters
 - b. PGY2 500 encounters
 - c. PGY3 900 encounters
 5. As each resident progresses through training, more leadership of the practice team will be afforded. The PGY3 resident will be acting as a co-team leader for a practice team.
 6. Practice teams will provide cross coverage when appropriate during time when residents are on away rotations.
 7. Practice teams will coordinate personal time off to ensure the team is not understaffed and unable to provide adequate access to care.

PGY1 year: residents will be a member of a clinical practice team in the FMC. He/she will:

- Directly see patients 1-2 half days weekly depending on rotation schedule. Each half day will consist of 2-6 patient visits.
- Manage all empaneled patient healthcare issues using existing clinic workflow.
- Precept 100% of in-person visits prior to patient leaving clinic. The CCC will evaluate each resident at periodic intervals and decide when a change in this supervisory requirement is indicated.
- Document all clinical encounters accurately, comprehensively and timely according to the residency policy.
- Participate in quality improvement projects in FMC.
- Actively engage in procedural training opportunities.

PGY2 year: residents will be an active member of a clinical practice team in the FMC. He/she will:

- Will see 2-3 half days of clinic depending on rotation schedule. Each half day will consist of 4-6 patient visits.
- Provide coverage for other residents as needed in their absence.
- Precept all patients except non-obstetric patients according to the Primary Care Exception Rule.
- Document all clinical encounters accurately, comprehensively and timely according to the residency policy.
- Actively engage in the procedural training curriculum and begin to complete some Procedural Competency Assessments.
- Lead the planning and execution of a quality improvement project for the FMC team.

PGY3 year: residents will act as co-team leader alongside faculty for FMC practice team. He/she will:

- Will see 2-4 half days of clinic depending on rotation schedule. Each half day will consist of 6-8 patient visits.
- Provide coverage for other residents as needed in their absence
- Precept all patients except non-obstetric patients according to the Primary Care Exception Rule.
- Document all clinical encounters accurately, comprehensively and timely according to the residency policy.
- Actively engage in the procedural training curriculum and ensure timely completion of all Procedural Competency Assessments.
- Complete an individualized resident project.

Expectations of Resident:

1. 100% attendance at all meetings and didactic sessions. The faculty team leader must be notified of an unexpected absence prior to the start of the event.
2. Perform routine call responsibilities.
3. Care for continuity and faculty co-assigned Obstetric patients and attend their deliveries whenever possible.
4. Prepare for scheduled Family Medicine Clinics and start them promptly.
5. Complete four home visits and document them in the Electronic Health Record.
6. Follow all policies regarding patient care in the Family Medicine clinic.
7. Actively participation in the annual In-service training examination. An individualized Medical Knowledge Enhancement Plan (MKEP) will be implemented based on ITE performance.

Expectations of Faculty Team Leaders

1. Assume ultimate responsibility for care of patients treated in their clinic.
2. Model appropriate interactions with patients, peers, and hospital staff.
3. Promptly address all resident concerns regarding assigned patients.
4. Appropriately direct and supervise resident's care of patients.
5. Timely and appropriately performance feedback to residents and complete preceptor forms.
6. Timely and appropriately co-sign resident notes.
7. Develop each resident's leadership skill to prepare them to be a successful team leader after graduation.
8. Manage and instruct the didactic portion of the curriculum.

Team Clinic Didactic Topics (26 weeks)

- Tracking healthcare maintenance and outcome-based measures for a panel of patients (Dashboard review) (3)
 - POC: Heather Denis
- Coding training and audit (3) : ICD10 review, Appropriate E&M code selection, Appropriate CPT code selection
 - POC: Jamie Westerhoff
- EPIC pearls and workflow efficiency improvement (2)
 - POC: Deb Foster
- Healthcare management (2)
 - POC: Heather Denis
- Huddles and Triage (1)
 - POC: Heather Denis
- R1 case-based presentations (2-3)
- R2/R3 evidence based topic presentations (4-6)
- Pharmacology instruction with focus on polypharmacy in the outpatient setting
- Strategies to provide care for patients with chronic pain conditions
- Behavioral Health metrics, care utilization and case management

Evaluation Process

The resident will be given an incomplete for the rotation and will not be eligible for graduation until the following items are completed.

1. Resident Evaluation: *(the resident is evaluated by several department members)*

- Daily evaluation:
 - ✓ Verbal feedback regularly by attendings regarding their on-the-spot performance.
 - ✓ Preceptors will complete regular electronic feedback forms for each half-day clinic session (these are mandatory on Team Clinic days).
 - ✓ All members of the resident's healthcare team will also provide informal feedback regarding their performance as a team member.

- Periodic scheduled feedback:
 - ✓ At least 4 observed visits must be completed in New Innovations each academic year.
 - ✓ The faculty members assigned as the advisor will complete electronic evaluations at the completion of each Family Medicine block rotation and at the completion of the academic year.
 - ✓ The CCC team will comprehensively review each resident's progress in milestone achievement, procedural competence, supervision requirements and preparation toward independent practice as a family physician.

- Final Evaluation:
 - ✓ The final evaluation of a resident will occur at the end of the three year training program and will be conducted personally by the Program Director who will have reviewed the entire portfolio to include CCC recommendations. This evaluation will culminate in the creation of a formal letter of recommendation that the resident be awarded privileges to practice independently.

2. Staff Evaluation: **(evaluation of faculty/clinic/curriculum by residents)**

- Residents evaluate staff using the current processes prior to every CCC milestone review.

3. Curriculum Evaluation: **(residents evaluate the training experience)**

- Residents assess quality of training via current feedback process prior to every CCC milestone review. The CCC will forward resident feedback to the Associate Program Director for evaluation and action as determined by residency leadership.



M. Watson, MD

5/3/18

Date