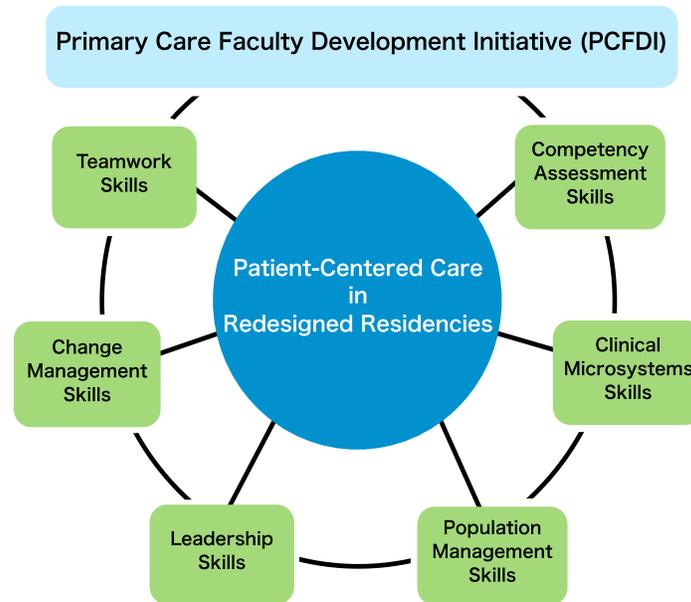


Primary Care Faculty Development Initiative (PCFDI)



PROGRAM GOALS & FACULTY COMPETENCIES

Leadership Skills

Goal: Develop the leadership skills necessary to create a new culture of primary care practice within the local residency and its GME environment.

Faculty Competencies:

- Demonstrate the ability to actively engage in and provide clinical and educational leadership for the practice's change and improvement process.
- Identify personal leadership characteristics that impact on one's effectiveness as a leader, manager and teacher.
- Apply leadership practices that support collaboration and team effectiveness
- Develop a shared leadership model by involving faculty, residents, providers and staff from every level to be engaged in the change process.

Change Management Skills

Goal: Manage the inherent resistance to change within one's residency.

Faculty Competencies:

- Create an agenda for change and align leadership to the effort's goals and means.
- Communicate strategically, effectively and consistently throughout the change efforts.
- Use information systems and measurement to help initiate, manage and sustain the change process.
- Apply evidence-based change management methods and approaches in both clinical care and education.

Teamwork Skills

Goal: Introduce teamwork models and practices necessary for optimizing patient safety and quality within the practice environment.

Faculty Competencies:

- Establish team processes that support diverse professionals to work together in support of common change goals.
- Participate as a team member and leader in practice improvement, including evaluation of the practice and performance of PDSA cycles.
- Engage in team training at the local level that optimizes patient safety and quality of care.

Population Management Skills

Goal: Improve panel management in our training practices.

Faculty Competencies:

- Utilize registries and/or other IT tools to identify and manage populations of patients within the practice.
- Interpret data as a measure of patient outcomes and design strategies to target those patients whose outcomes are not improving.
- Identify community resources available to the patient populations served by your residency training program and demonstrate the integration of these resources into the management of patients.

Clinical Microsystems Skills

Goal: Use insights from an understanding of clinical microsystems to transform the practice to embrace patient centeredness, effectiveness and efficiency.

Faculty Competencies:

- Appreciate the roles of the various members of the healthcare team and demonstrate how these roles can be integrated for optimal patient care.
- Demonstrate comprehensive, coordinated care using an evidence-based personal care plan, with goals prioritized by the patient and decision-making shared with the patient.
- Manage patients and families with sensitivity to patients' health literacy, beliefs, customs, culture, and community.

Competency Assessment Skills

Goal: Insure comprehensive assessment of required competencies of trainees.

Faculty Competencies:

- Design assessment systems that utilize multifaceted methods of assessment and interdisciplinary assessors for each required competency as well as the ability to assess the integration of competencies in care delivery.
- Use appropriate assessment tools based on their “utility” for purpose, based on validity, reliability, educational effect, feasibility and acceptability.
- Train and calibrate assessors to use direct observation to enhance the utility and value of assessment.
- Devise assessment methods that connect educational outcomes with clinical outcomes.

Train-the-Trainer Meeting Draft Agenda- April or May 2013

Note: This should be considered a draft agenda that will be revised by the core faculty group as they refine the program content more fully.

Day 1: Basics in “Change”

A. Introduction

Content

1. Brief overview of the scope of the problem in primary care along with data about the current state of affairs in primary care training
2. Sharing of local challenges/why they are here as a team with a particular focus on areas of overlap. Teams will share their current hopes and challenges and their goals for the project. Specific concerns and questions of each group will be captured and tabulated. This preliminary list will be re-visited on day 3 as part of the next steps conversations and change management plans.

B. Change Management & Leadership Skills

Content

1. Introduce the concepts and techniques to manage change and the importance of leadership.
2. Introduce planning instruments that participants will revisit and complete on day 3 to help them anticipate challenges and prepare for their action plan.

C. Overview of Patient-Centeredness and PCMH Principles

Content

1. Explore the basics of what it takes to transform a residency clinic into a patient centered clinic based on PCMH principles.
2. Set the stage for Day 2 and ensure folks have a reasonable grasp of core concepts and principles.

Day 2: The Team Caring for the Individual Patients and Populations

A. Clinic Systems Management

Content

1. Building on the lessons learned in change management on day 1, the morning session of day 2 now focuses on clinic systems necessary to care for a population and subpopulations of patients (e.g. diabetes, obesity).
2. Skills focus would be basic systems science and Microsystems, basic QI tools such as PDSA and flowcharts, and panel management.
3. Interdisciplinary teamwork and understanding the appropriate roles of the clinic staff
4. Use of clinical decision support, performance data, registries and patient safety
5. Effective integration of residents into clinic systems management

Methods Notes

1. Focus at the principle level (more akin to “theory bursts”) with small group exercises and large group debriefs.

2. Develop exercises that include topics such as flowcharting, team huddles, shared mental model building about what these skills look like in behavioral terms and in the context of graduate medical education.
3. Include basic approaches to assessment of teamwork, PBLI and SBP as part of training
4. Use Performance Improvement Modules used as part of Maintenance of Certification from the respective Boards for each discipline as a learning exercise to be accomplished back in their programs. This is one practical way to learn how to do quality improvement work, can be accomplished in a year and could provide patient outcome data for program evaluation.

B. Teaching and Evaluating Competencies

Content

1. While the “newer” competencies (e.g. PBLI, SBP, teamwork) are critically important (and the primary focus of day one), the “traditional” competencies of patient care, communication and clinical reasoning have received short shrift yet represent one of the potential great strengths of primary care. These are traditional competencies but the expectations to achieving them are different in a PCMH. Specifically care must be patient-centered, and the important skills of motivational interviewing, shared decision-making, application of evidence-based treatment based and clinical decision-making, and communication that must focus on listening skills and assessment of health literacy.
2. This workshop would build on the morning session with a stronger focus on the “traditional” competencies of patient care (clinical skills), interpersonal skills and communication and professionalism, but will use these competencies as the framework to focus more explicitly on competency assessment.

Methods Notes

1. Use specific interactive techniques such as performance dimension and frame of reference training and new findings from direct observation research using videotape and small group exercises that also includes training in feedback skills.
2. Discuss the contributions of milestones and EPAs to overall learner assessment.
3. Engage in guided reflection on how milestones and EPAs can be used to improve learner assessment in the PCMH

Day 3: Putting It All Together

A. Managing Longitudinally through Patient-Centered Care Coordination

Content

1. Focus on the visit or other encounter (e.g. phone) closure and how the care plan will be coordinated with other care providers inside and outside the clinic. This will emphasize the importance of the inter-professional team and their specific roles in care coordination.
2. Discussion of community linkages and services to assist the patient with chronic disease or the patient recovering from acute illness.
3. Concepts covered may include: asynchronous care, navigating the system for patients and families, transitions of care, identifying and addressing system problems, point of care information seeking, and cost conscious care.

B. Application of Learning back in your Program

Content

1. Review and suggestions for creating integrated clinical, educational and assessment systems in the ambulatory setting and specifically, how residents will be incorporated into the transformation
2. Teams will finalize their innovation plans and anticipate challenges. They will share with the large group.

“BOOSTER” PROGRAM

9-12 months post kick-off session

Rationale: This 1-day session will focus on each team’s progress and provide protected time to reflect with a learning community on the first year of their transformation. This session will also be used to help each group prepare and plan for the subsequent trajectory of their training program, especially around issues of sustainment.

A. Innovation Project Summary Reports (4 hours)

Content

1. Each team of programs will share what they have accomplished and where they plan to go next. Hopefully evaluation data will be available at the trainee and practice level.

B. Assessment System Check-in (2 hours)

Content

1. This session will focus on progress made regarding changes to the assessment system to date.

C. Content TBD based on Needs Identified thru Site Visits and Coaching Calls

D. PCFDI Program Sustainability

Content

1. Discussion on sustaining a national faculty development initiative.

LONGITUDINAL COACHING

at intervals throughout the 12 months

Following the initial meeting, members of the core faculty will be assigned to each team of programs of the three disciplines to assist faculty in the application of new skills gained in the program. The core faculty will visit each team of residencies selected for this program and will provide ongoing coaching through use of conference calls. These calls will allow teams to bring challenges to the group, fill gaps in knowledge and skills identified after the initial workshop, and problem solve as barriers are encountered.

The coaches will try to proactively identify issues that could be covered as mini web-based workshops (“just in time” faculty development). Educational webinars, which will offer the opportunity for training broader groups of faculty, residents and clinical staff are anticipated.

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