Population Health Longitudinal Curriculum **PGY: 1-3**
NGMC- Family Medicine Residency Program
Gainesville, Ga

Description of Rotation:

The Behavioral Health curriculum is a longitudinal experience during the PGY 2-3 years. Training will take place in the Family Medicine practice setting, community based behavioral health service, simulation/role play and didactics with supervision by FM Faculty. Supplemental longitudinal learning in the FMP supervised by Family Physician Faculty is also expected. This activity is embedding into the ongoing care of your panel of patients and needs to take place in the context of your clinic with an interdisciplinary approach. For this reason, this activity must take place in the FMP.

Overall Goal of the Population Health Curriculum:
Residents will learn to provide evidence-based, compassionate, comprehensive population health management skills and resources for incorporation into the practice of family medicine. This rotation will facilitate a broader view of Population health through encounters with families and patients. The longitudinal population health curriculum aims to equip medical learners with the knowledge, skills, and attitudes necessary to address population health needs while fulfilling the six ACGME core competencies. By integrating medical knowledge, patient care, system-based practice, practice-based learning and improvement, professionalism, interpersonal communication skills, and patient panel management, this curriculum emphasizes a comprehensive approach to population health.

Rotation Location: Family Medicine Practice - NGPG – Family Medicine
1439 Jesse Jewell Pkwy, Suite 102
Gainesville, GA 30501

Preceptor(s):

Monica Newton, DO	Leslie David, MD	Abhishek Singh, MD
Sajiv Alias, MD	Amy Bailey, MD	William Bostock, DO
Linu Joseph, MD	Nhi-Kieu Ngueyn, DO	Tembele Yangandawele, MD

Sample Schedule: PGY2: One half day a month
PGY3: Two half days a month (unless on nights)

Key Activities
1) Panel Management
a) Ensure that all patients in a population are included in a panel to regularly observe evidence-based preventive and chronic care tasks and recognize health disparities
b) Develop a system to identify care gaps
c) Develop a process to close care gaps and inequities with “in-reach”
d) Develop a process to close care gaps and inequities with “outreach”
2) Patient Risk Stratification
a) Risk-stratify by population subgroup (race, ethnicity, neighborhood, insurance, languages spoken, citizenship, etc.) R
b) Risk-stratify by disease burden
c) Risk-stratify by co-morbidity
d) Risk-stratify by frequency of visits to emergency room or hospital admissions

3) Care Management and Self-Management Support
a) Designate staff to create individual care plans for patients with chronic conditions
b) Develop a system for patients to obtain self-management support
c) Educate residents on this pathway and create a seamless referral system
4) Complex Care Management
a) Develop a process to accurately identify complex care patients
b) Develop a small Complex Care Management (CCM) team for high-needs, high-cost patients
c) Create the technology infrastructure to support the CCM team (telehealth, mobile application, etc.) Include nonclinical team members to provide wrap-around services (social worker, community health worker)
5) Addressing Social Determinants of Health (SDOH)
a) Create a pathway within the EHR to collect information about SDOH
b) Identify a member of the care team who can address SDOH
c) Provide a list of social services/resources that can be used to meet the identified patient needs
d) Develop a referral system for clinical team members to refer to the appropriate staff member to have these needs met
6) Ensuring Health Equity
a) Collect data on a variety of demographic factors such as race, ethnicity, gender identity, sexual orientation, languages spoken, and citizenship
b) Ensure PHM and quality improvement initiatives have an equity analysis
c) Provide data to residents and faculty on health inequities found within the patient population
d) Once an inequity is identified, create a plan of action and accountability within the team to address the problem
e) Incorporate lectures and case discussions that address inequities found in the clinic's patient population

Tentative schedule of Ongoing Pop Health activities with your panel
First quarter of Academic Year
1) Ensure graduating seniors panel is absorbed in your team
2) Outreach to patient for soft hand off
3) Engage panel re: closing preventative care gaps and annual wellness (particularly Medicare patients)
Second quarter of Academic Year
1) Focus on BP control and to a lesser degree diabetes
2) Manage your Cardiovascular registries and provide support throughout the holiday season
3) Work on ambulatory blood pressure monitoring
4) Engage with any diabetic that has not had AIC this year (run report)
Third quarter of Academic Year
1) Focus on Diabetes control and weight loss
2) Cohort patients with Obesity and prospectively outreach to them regarding your help with weight during the upcoming year
3) Assist Diabetes patients with CGM is appropriate and prior authorizations at beginning of year

Fourth quarter of Academic Year
1) Focus on CHF, Afib, and COPD
2) Run registries and compare for standard of care (guidelines management)
3) Work on team development within your clinic and POD to enhance workflows with these chronic disease states
4) Lipid management and anticoagulation should be discussed with those not on appropriate therapy.

Patient Care:	
PGY level	By the end of the residency the resident will be able to:
2-3	Demonstrate how to access primary care provider-specific population health data collected by NGMC. (PC-1, PC-3)
2-3	Use these quality markers to evaluate the care of their patients. (PC-2)
2-3	Display an understanding of the role that registries play in managing patient and population health. (PC-1, PC-2, PC-3)
2-3	Achieve base target scores for all routine NGPG quality initiatives. (PC-3.4)

Medical Knowledge Objectives and Competencies	
PGY level	By the end of the residency the resident will be able to:
1-3	Demonstrate improvement in quality measures over the course of the longitudinal experience. (MK-1,2)
1-3	Develop knowledge of the following aspects commonly seen in Family Medicine (MK-1, MK-2) • Immunizations • Screening guidelines • Preventative counseling • Motivational interviewing • Screening for SDOH
1-3	Appraise pharmaceutical and non-pharmaceutical therapies for the most common chronic illness diagnosed in Family Medicine. (MK-1, MK-2)

Interpersonal and Communication Skills	
PGY level	By the end of the residency the resident will be able to:
2-3	Demonstrate how to accurately capture quality data within EHR and communicate collaboratively with the Clinic Lead MA (Medical Assistant), Social Worker, Case Manager, and other support staff. (IPC-3)
1-3	Adapt communication that supports interdisciplinary team and interagency collaboration while using repeating back, verification, clarifying questions, numerical clarification, and the SBAR model (IPC-3)
1-3	Communicate in verbal and non-verbal ways which build therapeutic rapport, supports patient/family comprehension, convey respect, empathy, and cultural sensitivity to all persons (IPC-1, IPC-2)
1-3	Utilize Motivational Interviewing skills when building the physician-patient relationship and health promotion (IPC-1, IPC-2)
1-3	Communicate effectively with all physician and non-physician members of the health care team to ensure comprehensive and timely care of patients. (IPC-3)
1-3	Present information, on patients, concisely and clearly both verbally and in writing. (IPC-3)

Systems Based Practice Objectives and Competencies	
PGY level	By the end of the residency the resident will be able to:
2-3	Demonstrate responsibility for the coordination of a care team to optimize the health of a continuity panel. (SBP-1,2,3)
2-3	Describe how Medicare/Medicaid, commercial insurers, and health systems use quality measures regarding population health and physician payment. (SBP-1)
1-3	Understand and utilize the multidisciplinary resources necessary to care optimally for patients. (SBP-2)
1-3	Apply evidence based, cost-effective diagnostic and treatment strategies in the care of ambulatory patients. (SBP-2)
1-3	Collaborate with other members of the health care team, including residents at all levels, medical students, nurses, clinical pharmacists, occupational therapists, physical therapists, nutrition specialists, patient educators, behavioral health specialists, case managers, and providers of home health services to advocate for patient care. (SBP-3)
1-3	Know when and how to refer patients to specialists, and how best to utilize the assistance provided. (SBP-4)

Practice Based Learning and Improvement Objectives and Competencies	
PGY level	By the end of the residency the resident will be able to:
2-3	Effectively use patient registries to assess and manage population health. (PBLI-1)
1-3	Commitment to professional scholarship, including systematic, critical examination of relevant print and electronic literature, with emphases on integration of basic science with clinical medicine, and evaluation of information considering principles of evidence-based medicine (PBLI-1)
1-3	Identify and acknowledge gaps in personal knowledge/skills in the care of ambulatory patients and independently create and implement a learning plan. (PBLI-2)
1-3	Incorporate faculty feedback into clinical/academic performance and participate in system change (PBLI-2)
1-3	Recognize inefficiencies, variation, and quality gaps in healthcare delivery in Family medicine (PBLI-2)

Professionalism Objectives and Competencies	
PGY level	By the end of the residency the resident will be able to:
1-3	Accept professional responsibility as the primary care physician for patients under his/her care (PROF-1)
1-3	Recognize and respond appropriately to signs of stress or impairment in self and team members (PROF-1)
1-3	Complete assigned curricular readings, assignments, and self-assessments promptly and participate in semi-annual feedback sessions. (PROF-2)
1-3	Acknowledge errors when committed and perform self-analysis to avoid future similar mistakes while performing tasks in a timely manner with an attention to detail. (PROF-2)
1-3	Behave with humanistic qualities of respect, compassion, integrity, and honesty in all patient/staff interactions with similar and differing cultures (PROF-1);
1-3	Understand ethical concepts of confidentiality, consent, autonomy and justice. (PROF-1)
1-3	Display professionalism through integrity, altruism and resolving conflict of interest. (PROF-1)

Teaching Methods	
Clinical Teaching	Faculty Role Modeling
Case Based Teaching	Supervised Clinical Management
Didactic	Guided Research, Multimedia & Readings
Supplemental readings	

Research Scholarly requirement	
Patient Oriented Point of Care Research	Quality Improvement projects

Procedures/Skills Taught (PC5)	
Clinical Interview skills	Patient Centered Communication
Diagnostic and treatment planning	Referral and collaboration
Assessment and Interpret data	Pharmaceutical and non-pharmaceutical therapies
Motivational Interviewing	

Supervision/Evaluation:
Residents will work one-on-one and be supervised by Family Medicine core faculty. While the resident will interact with several health care providers, the overall supervision of patient care, behavior and diagnostic interpretations will be provided by the preceptor. The faculty preceptor will indirectly observe patient care. Any direct patient care performed during your pop health time will be precepted by clinic preceptor.

Assessment Methods	
Direct and Indirect Observation	Quality metrics of your panel
360 Assessment from patients/staff	Quality metrics of your team

EPA's
18. Advocate for patients, families, and communities to optimize health care equity and minimize health outcome disparities.

Residency Outcomes
Practice as personal physicians, providing first contact, comprehensive and continuity care, to include *excellent doctor-patient relationships*, *excellent care of chronic disease, routine preventive care* and *effective practice management*
Effectively *lead, manage, and participate in teams* that provide care and improve outcomes for the diverse populations and communities they serve
Provide *preventive care* that improves wellness, modifies risk factors for illness and injury, and detects illness in early, treatable, stages for people of all ages while supporting patients' values and preferences

Required Reading	
AAFP Population Health Curriculum	AAFP Population Health Curriculum
Population health Webinar	Population Health Webinar