So Your Rural Clinic is GME naïve?

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Disclosures

- Glenn Gookin has no actual or potential conflict of interest in relation to this program/presentation
- Matt Personius has no actual or potential conflict of interest in relation to this program/presentation
- This presentation represents our opinions and experience only and does not represent the formal opinion of Adventist Health, Dignity Health or Chapa-De Indian Health

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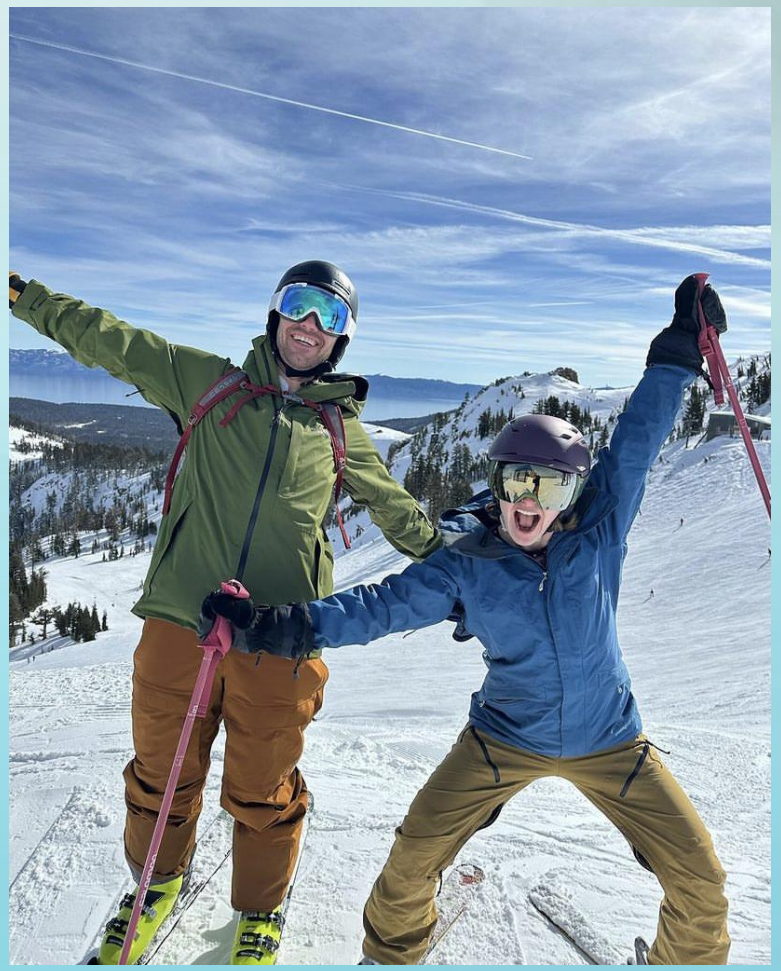
Objectives

- Develop your vision for a clinic of excellence then maximize your existing clinic strengths as you establish your residency continuity clinic
- Review and synthesize ACGME rules for a family medicine continuity clinic including tracking empanelment of patients
- Identify creative opportunities for engaging clinic staff and patients in embracing resident physicians
- Be confident in billing for resident visits

Family Medicine Residency Program - Grass Valley

- Dignity Health Methodist Hospital of Sacramento/Sierra Nevada Memorial Hospital Program
- 2/2/2 Program
- ACGME preliminary accreditation received October 25th, 2021.
- Matched first class 2023, second 2024
- Maintenance of Accreditation Site Visit 3-19-24
- Residents full time at rural clinic, Grass Valley July 2024



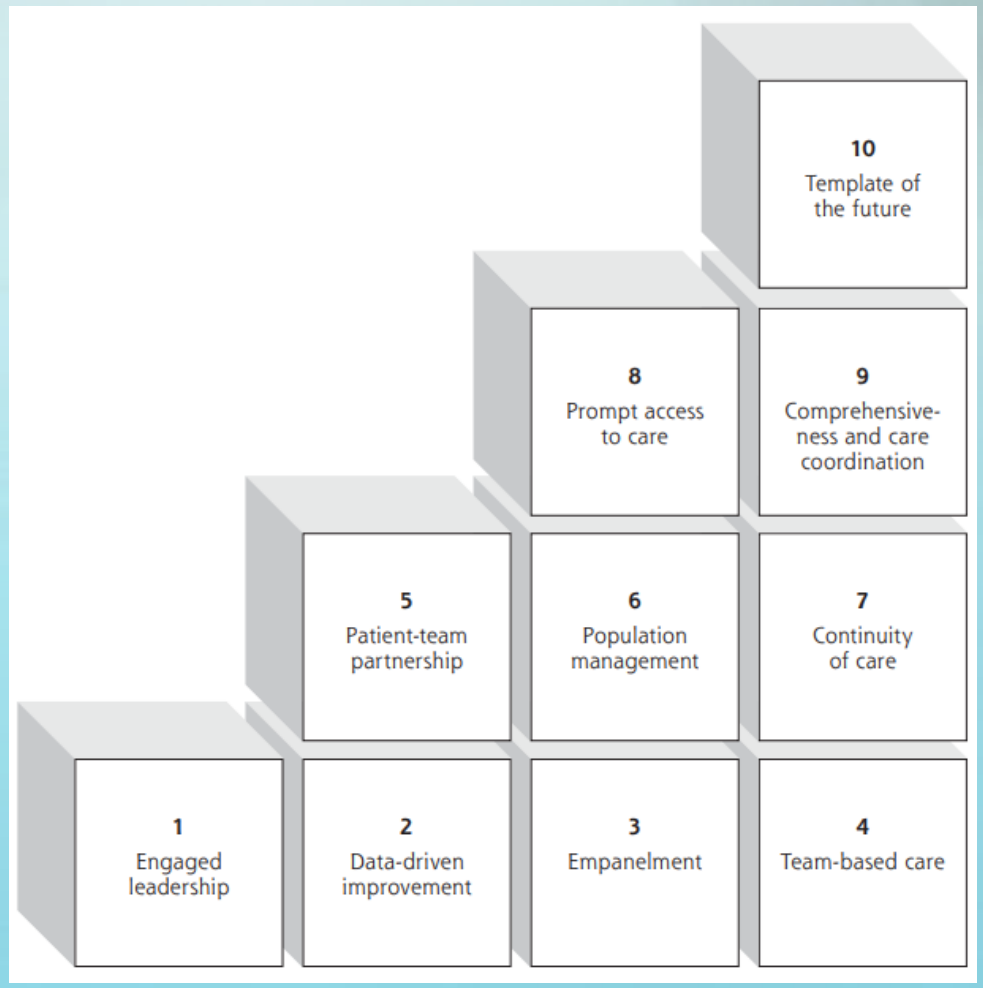
Family Medicine Residency Program - Sonora

- 4/4/4 Program
- ACGME preliminary accreditation received October, 2022.
- Matched first class 2023, second 2024
- Residents full time at rural clinic, Sonora July 2024

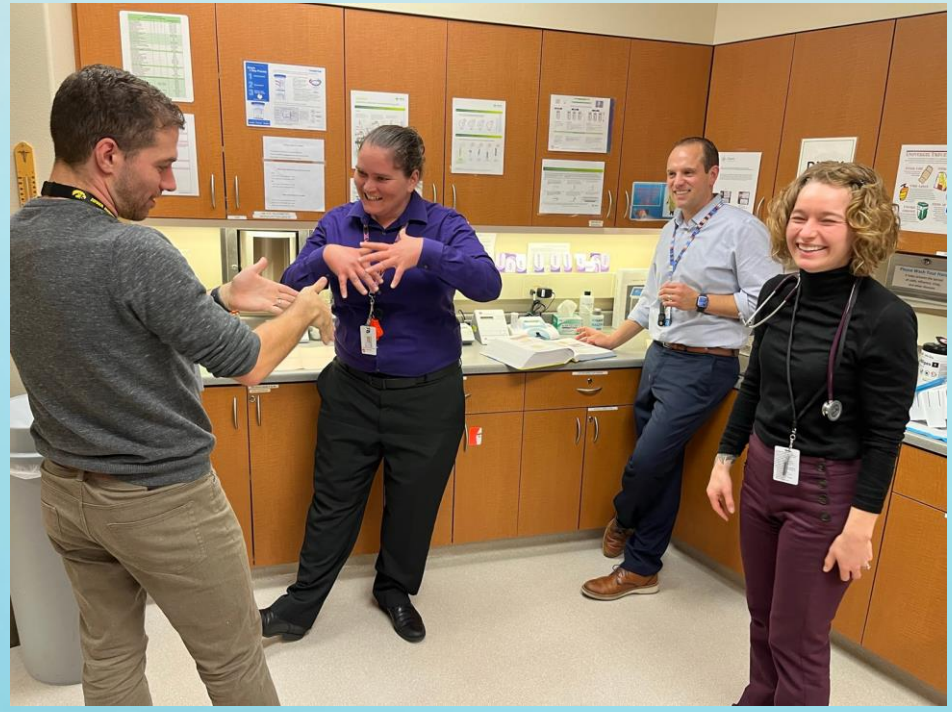



Demonstrate your Clinics Strengths

- Bodenheimer et. al described a conceptual model that guides practice improvement.
- “10 building blocks of high-performing primary care.”
- Synthesis of a team at UCSF and their thinking from a decade of observing and experiencing improvement work in primary care.



Staff Engagement



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Glenn Gookin, MD PhD
Residency Program Director

Julie Garchow, MD
Residency Program Assoc Director

Introducing Resident Physicians at Chapa-De

Chapa-De is excited to have resident physicians at our health center. A resident is someone who has completed college and medical school. They have received their Doctor of Medicine degree (MD or DO). They are now completing direct training in their chosen specialty. The residents at Chapa-De will become family medicine doctors.

Family medicine residents must complete three years of firsthand training. Then they can become licensed board-certified doctors. An experienced doctor supervises residents. This doctor is certified by the American Board of Family Medicine. There are great benefits to receiving care from a resident. Residents have the most up to date medical knowledge. Patients also benefit from the experience of the supervising doctor.

During your visit, a resident will do a detailed exam. They will also ask questions about symptoms and your medical history. The resident will then talk to their supervising doctor. The supervisor will ask questions and offer guidance. Then the resident will decide on a diagnosis and care plan. This process is called precepting. Precepting makes sure patients are getting the best possible care. It also ensures the resident is prepared to work on their own in the future.

Our residents work extremely hard to give you the best care possible. They are proud to be serving Chapa-De patients. We hope you will welcome them as your future doctor.

What is a Resident Physician?

Program Director: Dr. Glenn Gookin, MD, PhD, FAAFP

Associate Program Director: Dr. Julie Garchow, MD

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Patient Engagement and Preparation

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Frequently Asked Questions – Residency Program

Is a Resident a doctor?

A resident has completed college and medical school. They have received their Doctor of Medicine degree (MD or DO). Now they are completing firsthand training in their chosen specialty. This will allow them to become a board-certified family medicine doctor.

Do Residents give good quality care?

Yes. Patients often like having visits with residents because they see fewer patients per day. This way they can spend more time with each patient. They also just completed medical school and have the most up to date medical knowledge. Residents also work closely with an experienced Supervising Physician. Patients will receive exceptional care.

Will my visit be with the Resident and the Supervising Physician?

Your visit will be with our Resident. They will do a detailed exam and ask questions about symptoms and your medical history. The resident will then talk to their supervising doctor. The supervisor will ask questions and offer guidance. Then the resident will talk with you about a diagnosis and care plan.

Is the Resident my new doctor?

They may be. Some Chapa-De patients in Grass Valley will be assigned to our Residents for their ongoing care. Others may see a Resident if their usual provider is not available.

Who can answer further questions?

- Our Residents
- Glenn Gookin, MD PhD - Residency Program Director
- Julie Garchow, MD - Residency Program Assoc Director

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Meet Our Residents

Nick Sparr, MD

Nick Sparr graduated from the University of Iowa Roy J. and Lucille A. Carver College of Medicine. He has worked as a nursing assistant in an adult inpatient psychiatry unit and spent twelve years working in phlebotomy. He also spent time working as a manager at a lab. He is passionate about community health and helping with local organizations.

Dr. Sparr is from Beaverton, Oregon. His personal interests include downhill skiing in places like Mt. Hood, Crested Butte, and Arapahoe Basin. He also enjoys woodworking and shade tree mechanics.

Kelty White, MD

Kelty White graduated from the University of Nevada, Reno School of Medicine. Prior to medical school, she earned her bachelor's degree in biology with Magna Cum Laude honors. She has focused on women's health, rural medicine, and "gut" health. She spent ten years working in the service industry before and during medical school. She also worked for two years as a certified nursing assistant.

Dr. White is from Truckee. Her personal hobbies are skiing, mountain biking, climbing, partner acrobatics, construction/trade work, gardening, and spending time with her dogs.

Learning Environment

- I.D.1.k) Each FMP site must participate in ongoing performance improvement, and demonstrate use of outcome data by assessing the following: clinical quality for preventive care and chronic disease; demographics; health inequities; patient satisfaction; patient safety; continuity with a patient panel; referral and diagnostic utilization rates; and financial performance. (Core)

- I.D.1.k).(1) Each FMP should measure and report this data to the FMP care teams and appropriate preceptors at least semi-annually. (Detail)

FMP

- IV.C.1.d) Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team that works together longitudinally with shared goals of patient safety and quality improvement. (Detail)

- IV.C.1.d).(1) This should include integration of multiple non-physician professionals (e.g., behavioral health specialists, certified nurse midwives, clinical nurse specialists, lab technicians, nurse practitioners, pharmacists, physician assistants) to augment education, as well as interprofessional team clinical services. (Detail)

Empanelment

"Empanelment is the act of assigning each patient to a primary care provider who, with support from a care team, assumes responsibility for coordinating comprehensive services for his/her panel of patients."

~Safety Net Medical Home Initiative. Brownlee B, Van Borkulo N.

Empanelment: Establishing Patient-Provider Relationships

Empanelment vs 1650, what has changed?

- IV.C.3.c).(5).(b) Each resident's panel of continuity patients must be of sufficient size and diversity to ensure adequate education, as well as patient access and continuity of care. (Core)

- IV.C.3.c).(5).(b).(i) Programs must ensure that each graduate has completed a minimum of 1,000 hours dedicated to caring for FMP patients. (Core)

Empanelment

- I.D.1.c).(1) Each FMP must organize patients into panels that link each patient to an identifiable resident and team. (Core)

- IV.C.3.c).(5) 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. (Core)

Empanelment

- IV.C.3.c).(5).(b).(ii) Annual patient-sided continuity should be at least **30 percent** at the end of the **PGY-2** and **40 percent** at the end of the **PGY-3**. (Detail)

- IV.C.3.c).(5).(b).(iii) Annual resident-sided continuity should be at least 3**0 percent** at the end of the **PGY-2** and **40 percent** at the end of the PGY-3. (Detail)

Empanelment

- Have a clear plan when you approach your clinic manager/nursing lead. Address any obstacles to residents being assigned as PCP.
- Determine panel size by PGY.
- Are residents clearly identified for as PCPs in the chart?
- Is it easy for staff/schedulers to tell who the patient is assigned to?
- How are resident teams associated with the panel assignment? How are these identified?
- Who is allowed to change panel assignments?
- Do schedulers have directives for scheduling follow-ups to preserve empanelment? Are resident schedules built out ahead of time?
- Does your EMR contain prebuilt identifiers that can be used to track patient empanelment?

Empanelment

- IV.C.3.c).(5).(b).(iv) Panels must include a minimum of 10 percent pediatric patients (younger than 18 years of age). (Core)
- IV.C.3.c).(5).(b).(v) Panels must include a minimum of 10 percent older adult patients (older than 65 years of age). (Core)
- IV.C.3.c).(5).(b).(vi) Panel size and composition for each resident must be regularly assessed and rebalanced as needed. (Core)

Medical Director, PD, QI Manager review Quarterly?
I.D.1.k).(1)

Meetings

- Make sure you clearly understand your clinics org chart
- Set regular meetings with:
  - Nursing/ medical assistant lead
  - Call center leads
  - Medical Director
  - IT/Facilities
  - Others (?)

Patient Advisory Council

- I.D.1.h) Each FMP must have members of the community, in addition to clinical leaders, serve on an advisory committee to assess and address health needs of the community.(Core)
- I.D.1.h).(1) The advisory committee should have demographic diversity and lived experiences representative of the community. (Detail)

Breakout

How are you tracking patient sided and resident sided continuity?

Any tips for how you built the resident panels?

- _____
- _____
- _____
- _____
- _____
- _____

Billing

- GC modifier for Medicare/private carriers (unless primary care exception in which case GE modifier used).
- Bill under preceptor's NPI.
- When billing based on time, only time spent by supervising physician may be included.
- Preceptor must document presence and level of involvement in care, reference resident documentation. Resident should also document preceptor involvement.
- Useful to have method for tracking resident-seen patients to ensure proper coding (many EMRs have this built in).
- No additional billing/coding adjustments for FQHCs.
- Missing attestations and delayed preceptor sign-offs are most prevalent issues when all other requirements are met.

Capital Improvement

- 2 patient rooms per resident physician
- Procedure room
- Precepting space
- Meeting room
- Telehealth facilities
- Lactation room
- Access to food
- ADA accessible

Conclusion

- Your Community recognizes the value of embracing graduate medical education, but your clinic must as well, help them get there!
- Early preparation is key. Have regular meetings with lots of face time.
- Accept that no clinic will be perfect or perfectly capable of satisfying every ACGME requirement from day 1. Plan for the future while focusing on success every day.
- Maintain ongoing communication with clinic management.
- Don’t forget the ideal clinic that you set out to be – aim high!