# Essentials of Ambulatory Care

## *A Postgraduate-Level, Interdisciplinary, Interprofessional Curriculum at the University of Minnesota*

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Team-based care is a cornerstone of primary care. However, in medical school and residency, trainees get little formal education on this as a concept and how it works in an outpatient setting. Faculty members from the University of Minnesota created a one-day workshop, "Essentials of Ambulatory Care," to help residents in primary care specialties as well as pharmacy and nursing students pursuing advanced degrees better understand the roles and responsibilities of members of the primary care team. The workshop also helped them develop new skills for doing patient-centered visits. This article describes the workshop and what we learned from those who participated in the first session.

We are entering a period in health care when day-to-day practice is changing more rapidly than the training of doctors, nurses, physician assistants, pharmacists and other providers. Although team-based care is now a cornerstone of outpatient primary care practice, there still is little formal education about teamwork or team-based care in medical school. The same is true in residency programs for the primary care specialties and midlevel provider programs, both of which require trainees to master such competencies.[1,2] Also, many of the clinical faculty who teach in these programs have not been trained in the concepts of systems, outcomes measurement, population management and the patient-centered health care home.

As health care organizations are beginning to recognize the benefits of robust primary care,[3,4] demand for primary care is growing. Increased access to health care as a result of more people having insurance because of the Affordable Care Act and the aging of the population also have increased the need for primary care at a time when many physicians are retiring and graduating medical students are choosing more lucrative specialties.

In an effort to address deficiencies in medical education, the three primary care boards (American Board of Pediatrics, American Board of Internal Medicine and American Board of Family Medicine) together with the federal Health Resources and Services Administration and the Josiah Macy Jr. Foundation launched the Primary Care Faculty Development Initiative.[5] The goal of this initiative is to train faculty so they can transform their primary care training programs and better prepare residents for practice. A secondary goal is to improve trainees' experiences in continuity clinics in order to attract more of them to primary care careers. In 2013, the University of Minnesota was one of four institutions that received a grant from the Macy Foundation to institute such changes.

That year, nine faculty physicians from the university's pediatrics, internal medicine and family medicine residency programs as well as educators from the College of Pharmacy and School of Nursing formed the Minnesota Primary Care Transformation Collaborative. Members participated in national train-the-trainer sessions offered by the Primary Care Faculty Development Initiative in April of 2013 and May of 2014. Those sessions covered topics such as the Triple Aim, the patient-centered medical home, population management, systems thinking, leadership and change management. The intent was that participants would incorporate those concepts into their training programs.

Upon returning to Minnesota, members of the Minnesota collaborative developed "Essentials of Ambulatory Care," a workshop to help residents in primary care specialties (family medicine, pediatrics and internal medicine), first-year ambulatory care pharmacy residents, and registered nurses earning their nurse practitioner

credentials or clinical doctorate better understand the roles and responsibilities of various members of the health care team and develop new techniques for efficient, patient-centered visits. The plan was to offer the one-day workshop three times during the academic year. In this article, we describe our experience with the first one.

## About the Workshop

In designing the workshop, we decided to include a combination of didactic and interactive experiences that would provide participants with a better understanding of key principles such as patient-centeredness and team-based care delivery, introduce them to the components of the patient-centered medical home and teach them useful skills they could apply in practice. The goals and objectives are further articulated in the Table.

The first session was held in October 2014 at Smiley's Family Medicine Clinic in Minneapolis. Forty-six trainees attended. Twenty-four of the participants were pharmacy residents, seven were internal medicine residents, four were pediatrics residents, three were family medicine residents and eight were nurse practitioner students. Eight faculty members presented on various topics and/or facilitated small-group activities.

The morning was divided into two sessions. The first was devoted to team-based care and included a general discussion of the need for teamwork in primary care, the roles and responsibilities of various team members, and the background, training and scope of practice of each of those team members. The second was devoted to the patient-centered medical home and included discussions about what patient-centeredness means, how the medical home helps meet the Triple Aim's goals, and the components of a patient-centered medical home. The morning ended with a session on systems theory, in which we introduced concepts and then had the attendees apply systems thinking to the design of a medical office exam room.

TABLE

### Workshop Goals and Objectives

- Articulate the value of working in interprofessional and interdisciplinary teams.
- Reflect on own values, personal and professional, and respect those of other team members, patients and families.
- Be able to describe the roles, training and responsibilities of other team members.
- Place the interest of patients and populations at the center of care.
- Respect the unique cultures, values, roles/responsibilities and expertise of other health professions.
- Develop a trusting relationship with patients, families and other team members.
- Choose effective communication tools and techniques, including information systems and communication technologies, to facilitate discussions and interactions that enhance team function.
- Engage diverse health care professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific patient care needs.
- Define the Triple Aim as a guiding principle behind health care improvement.
- Describe the working components of the patient-centered health care home.
- Learn about the role of systems in the context of health care delivery.
- Utilizing the exam room as a model, apply systems thinking to health care delivery and improvement.
- Describe agenda-setting as a technique to improve the patient experience during the office visit.
- Become familiar with the Patient-Centered Observation Form as a tool for observation and feedback regarding patient centeredness during the office visit.
- Learn about transitions of care and important factors for successful transitions.

The afternoon began with a session on patient-centered interviewing. We introduced participants to the Patient-Centered Observation Form, a tool that outlines discrete behaviors that will enhance a clinic encounter.[6,7] It emphasizes the importance of establishing rapport, agenda-setting, discussing behavior change and co-creating care plans with patients. Participants reviewed recorded interactions between providers and patients and used the form to rate each encounter. Then in small groups they discussed how the providers could have improved on the interaction. The remainder of the afternoon was devoted to care transitions—defining when they occur, describing the different components of a transition, reviewing evidence for effective transitions and discussing how teams can facilitate care transitions.

## Lessons Learned

Overall, the workshop was deemed a successful first effort by both teaching faculty and trainees alike. We also learned a number of things through the experience. Logistics proved to be a challenge; it was difficult to find a date that would work for residents and students in multiple training programs and to find a space that was large enough to accommodate the group. We originally had called the workshop "Primary Care Essentials" but changed the name to "Essentials of Ambulatory Care" when we recognized that not every internal medicine or pediatrics resident would pursue a primary care career. We believe the workshop is applicable to those going into subspecialties as well as primary care, and we eventually hope to engage more learners heading toward more professions.

We used pre- and post-workshop surveys as well as a debriefing with faculty presenters to identify what worked well and what needed improvement. Participants said one of the highlights of the workshop was an exercise in which each of them was asked to play a specific role during a team huddle. The learners were given certain personality traits and responses to questions. The exercise proved to be both entertaining and educational and drew many positive comments. Learn-

ers reflected on the frustration of being ignored or interrupted by team members, and on how the team did not effectively develop a care plan because of poor communication.

Participants were mostly positive about the afternoon session, which involved viewing videotaped patient encounters and working through the Patient-Centered Observation Form. One noted that it was a "very useful strategy for learning about agenda setting," as the providers and the patients in the videotaped visits had multiple questions and concerns. However, a few thought the session was redundant ("We've already been taught how to take a history in medical school," one said). With such feedback in mind, we plan to build on content presented in other portions of the training and introduce new ideas for structuring a patient visit.

Throughout the workshop, we incorporated training on specific content as well as skills that trainees could readily put into use in a primary care setting. In doing so, we also hope to influence attitudes regarding primary care. One result that surprised us on our post-workshop survey was that there was a slight decrease in interest in primary care (80% post-workshop versus 85% pre-workshop). Although the numbers are small, it led us to speculate that we may have presented primary care in too negative a light. Videos showing "difficult" patient interactions, slides outlining the time pressures in primary care and discussion about the challenges in care coordination, particularly around transitions of care, may have negatively influenced some participants.

In the future, we will strive to emphasize the positives—the fact that primary care physicians have continuity with their patients, work in high-functioning teams and know that their patients are getting the best care at the lowest cost possible. We plan to introduce narratives from patients, families, physicians and other team members that illustrate these positives. The concept of provider satisfaction has been recently dubbed the "fourth arm of the quadruple aim"[8] and has direct relation to the ability to provide care that advances the Triple Aim.

Ultimately, the goal of the workshop is not only to teach residents and other health care students about being members of a primary care team but also to attract more trainees to this career path. Given the changes in our health care system and the pressing need for more primary care providers, we hope the next iteration of our workshop will enable us to do just that. **MM**

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## REFERENCES

**1.** Chen F, Delnat CC, Gardner D. The current state of academic centers for Interprofessional Education. J Interprof Care. 2015;14:1-2.

**2.** Gilman SC, Chokshi DA, Bowen JL, Rugen KW, Cox M. Connecting the dots: interprofessional health education and delivery system redesign at the Veterans Health Administration. Acad Med. 2014;89(8):1113-6.

**3.** Nyweide DJ, Anthony DL, Bynum JP, et al. Continuity of care and the risk of preventable hospitalization in older adults. JAMA. 2013; 173(20): 1879-85.

**4.** Beasley JW, Starfield B, van Weel C, Rosser WW, Haq CL. Global health and primary care research. J Am Board Fam Med. 2007;20(6):518–26.

**5.** Josiah Macy Jr. Foundation. Primary Care Faculty Development. Available at: http://macyfoundation.org/grantees/profile/primary-care-faculty-development-initiative. Accessed March 13, 2015.

**6.** Chesser A, Reyes J, Woods N, Williams K, Kraft R. Reliability in patient-centered observations of family physicians. Fam Med. 2013; 45(6):428-32.

**7.** Mauksch L, Safford B. Engaging patients in collaborative care plans. Fam Pract Manag. 2013;20(3): 35-9.

**8.** Bodenheimer T, Sinsky C. From triple aim to quadruple aim: care of the patient requires care of the provider. Ann Fam Med. 2014;12(6):573-6.