Does The Family Practice Residency Program At Genesys Regional Medical Center Prepare Their Residents For An Office Based Primary Care practice?

By

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ABSTRACT

Increasingly, physicians are being more scrutinized and held accountable for their medical decisions by governmental regulatory agencies, third party insurance carriers, non-professional groups and the general public. Given this scrutiny, graduate medical education programs, or residency training programs as they are called, must ensure that they are adequately preparing their residents for prevention, recognition, and management of a broad spectrum of disease problems in the ambulatory care setting. The family practice residency program at Genesys Regional Medical Center in Grand Blanc, Michigan, formerly St. Joseph Hospital (SJH) of Flint, had as its primary ambulatory care training site the Family Health Center at the SJH campus. A questionnaire was mailed to 123 family practice graduates asking them to rate how well they felt they were trained at the SJH/Family Health Center to manage 24 of the most commonly seen patient problems in the ambulatory care setting. They were also asked to rate and comment on how well the Research Practice Management (RPM) rotation prepared them to manage the business side of their office practice. Forty-three percent of the SJH graduates responded to the questionnaire, rating their overall experience with the top 20 most commonly seen ambulatory problems as very good. The areas of training that dealt with patient counseling and behavioral problems, along with the RPM rotation were rated less than expected by this author, but the graduates who completed the questionnaire offered possible remedies for improving the ambulatory curriculum.

INTRODUCTION

Over the past 30 years residency programs for primary care physicians have shifted the focus of clinical training from the hospital side of acute patient care to include an increased emphasis in ambulatory care. This shift is part of a changing medical environment with outside pressures pushing for reform in the academic medical community. Pressures include a demand from the general public for more preventive health measures, for physicians to become more accountable for their decisions, changes in doctor-patient relationships, and a rapidly changing world of innovation and medical knowledge. Hospitalized patients now have a shorter length of stay, while ambulatory patients with urgent medical needs are being told to stay away from costly emergency room care. Thus, the added time for reflective study in a hospital setting, once afforded a resident to learn from their patients, has shifted to a fast pace ambulatory care setting. The family practice residents at St. Joseph Hospital (SJH) in Flint, MI, rotated at various ambulatory care sites during the course of their three years of training. The Family Health Center (FHC) at the SJH Campus served as their primary ambulatory training site for over 30 years. This paper is intended to assist the current Family Practice Residency Director and his teaching faculty in evaluating the overall effectiveness of the SJH/FHC, and aid in the planning and implementation of changes, if any, to that experience. To that end, this paper will look at the reasons why physicians are more accountable today then in years past for their medical decisions; why a major part of training for family practice residents has moved to the ambulatory care setting; how SJH graduates from 1984 to 1999 rated their FHC clinical experience, and what suggestions the graduates have for improving the existing curriculum.

PHYSICIAN ACCOUNTABILITY

Fredric Wolinsky (1980) wrote that the image of the physician medical profession over the years has been viewed by the general public as one of "trustworthiness, prestige and responsibility – a profession that is responsible for our national healthcare delivery system." From a historical perspective the physician has been autonomous and the profession self-regulating with little or no interference from governmental agencies. The autonomy came as a result of the 1910 Flexner Report, a serious and comprehensive study that demonstrated there was a major gap in the level of medical knowledge and the ability of physicians to apply that knowledge. In the late 1800's, physician trainees served as apprentices under an office-based physician as part of their clinical training, yet there was no agreed upon standard in how academic or clinical medicine should be taught. In fact, there was no accrediting body to govern the quality of education during or after medical school, no central licensing authority, and in some cases individuals were able to buy their medical degree without having gone through any formal training. After the Flexner Report, over 45 percent of the 155 US medical schools closed their doors because they were unable to improve their medical school curriculum, teaching faculty, and educational facilities, a demand from private foundations who funded these schools. But the Flexner Report also served as a turning point for the medical profession in that physicians were given the authority from the government to regulate themselves; in essence, they were allowed to function autonomously with little to no interference. In return, Wolinsky wrote, "the physician medical community promised it would deliver the best and most efficient medical care that money could buy."

Prior to the Flexner Report, the federal government had little to limited involvement and

control with public health activities according to *Congress and the Nation* (1945 - 1964). Records show that one of the earliest 'public health activities' occurred in 1798 when the Marine Hospital Service (MHS) had been established to provide much needed medical care to the merchant seaman with problems such as yellow fever and dysentery. The program later included the U.S. Coast Guardsmen and federal prisoners, and by 1878 began working with local and state government to quarantine and stop epidemics. The federal government also established the *Hygienic Laboratory* in the 1800's to aid in the understanding and control of communicable diseases such as cholera. The name later changed in 1930 to the *National Institute of Health*, and then the *Public Health Service* designed to monitor foods used for human consumption, as well vaccines, blood plasma, toxins, and serums. By the mid 1940's numerous laws were consolidated under the *Public Health Service Act*, making it accountable to the *Federal Security Agency*. By 1956 a *Health Amendments Act* was passed and several governmental agencies were linked even closer to the health care provider. The Act funded: "scholarships for physicians, nurses and allied health personnel; training of educators to teach medical students; improvements in state mental institutions; and continued support of the *Hill-Burton Act* for hospital construction." Then in 1961, President John F. Kennedy stated: "that the health of our nation is key to its future...to its economic vitality, to the morale, and the efficiency of its citizens, to our success in achieving our own goals and demonstrating to others the benefits of a free society." According to *Congress and the Nation* (1945-1964) President Kennedy's speech is credited for triggering a series of key health care proposals made over the next 30-years, that called for funding: (1) a loan forgiveness program for physicians willing to move to areas of the United States that were medically under-served; (2) construction

of additional college classrooms and building renovations; and (3) medical school curriculum development. But it was also at this point in history that governmental agencies moved even closer to the health care provider and a movement away from physician autonomy and to physician accountability. President Kennedy believed that certain areas in the health care system were deficient and proposed that "more federal involvement was needed with increased accountability".

Charles Boelen (1995) wrote that public groups are demanding that the health care industry improve upon its delivery of medical services and goods, and ensure the efficient use of its resources to prepare future doctors to meet the healthcare needs of all communities. Boelen stressed the importance of accountability stating "what is good for society can no longer be determined solely by professionals, or the institutions that deliver the goods, that arguments being voiced by both non-professional groups and consumers reflect a general democratization of society that aims at given every citizen a chance to be heard." Similarly, Arthur Gomez (1997) stressed that resident teaching hospitals must be willing to meet the needs of the general public stating: "physician graduates should by the time they complete their training be able to prescribe with formularies and adherence to pre-authorization processes for referrals, procedures, and hospital admissions, able to negotiate for their patient needs within such systems." Bruce Vladeck (1999) wrote that health care reform is needed, making physicians more accountable for their actions, noting that there are areas of the health care delivery system where the "focus should be placed on preventive and chronic care, home health care, and on geriatrics." John Morrissey (1994) believed that physicians should not only promote prevention but should be prepared to justify their clinical

decisions when prescribing a less intensive course of medical treatment for their patients. Barbara Gastel et. al. (1995) added that physician accountability should begin in medical school, emphasizing that the medical schools should think in global terms as they prepare their students for a future in medicine, able to function anywhere as a physician generalist.

Jordan J. Cohen, MD President of the Association of American Medical Colleges, wrote in 1995 that Graduate Medical Education (GME) should "expect an increase in scrutiny from the general public, that the current system for GME reimbursement from the federal government has been waning and that the cost to educate physicians is a responsibility that should be shared by the physician and the general public". He also stated "there is no other profession with such immense costs associated with the resources it needs to train physicians", noting that institutions involved in GME must be prepared to: (1) "thoroughly re-examine the process of training and doing what it can to reduce costs; (2) open its books to justify the costs to an understandably skeptical general public; and (3) accept requirements from lawmakers that are certain to place on any additional public funding for medical education."

From another perspective, Spencer Forman (1990) expressed concern about a lack of focus by the academic medical community on health care related issues that affect the general public. He cited issues such financing Graduate Medical Education (GME), the quality of foreign medical graduates who come into this country, the poor minority representation in medicine, and the availability or lack of primary care physicians. Forman warned that the lack of focus on critical health care issues has invited the government into the affairs of the medical community. An example is that of the Libby

Zion case, whereby a teaching hospital was accused of 'failing to provide a level of medical care that was appropriate' to a patient named Libby Zion, eventually prompting an intervention by the New York State Government. A grand jury believed and concluded that that a resident physician, fatigued from working long hours on the job, had mismanaged the young woman's medical care that resulted in her death. While the hospital was exonerated of all charges, according to Lucette Lagnado (Wall Street Journal 1998), key revisions were made in the New York State Hospital Code calling for "limits on the hours a resident could work, as well as improved supervision of junior residents, and sufficient ancillary support services to offer relief to fatigued residents". These changes have since been endorsed and implemented by the Accreditation Council for Graduate Medical Education, an organization that accredits all allopathic residency programs. Forman believed that government has been left to "grapple with the macro aspects" of certain health care issues and that the "government will reach even closer to the patient bedside in its drive to assure quality of care; intruding into the residency (training programs) whenever it gets in the way." To that end, Christine Cassel (1985) stated that "Physicians are caught in a transition between the ethos of over-treatment, formerly encouraged by financial incentives from open-ended reimbursement, and a new ethos of under-treatment, derived from government attempts to contain the health care costs which it pays." The author noted that physicians must be careful from the ethical side of patient care, or else the private sector will become more involved in the decision making process. Cassel stressed that physicians must be prepared to defend their clinical decisions stating they should use "scientific knowledge, clinical experience, and a thoughtful approach to value choices."

MEDICAL EDUCATION IN THE AMBULATORY SETTING

As we enter a new millennium, Alan Bernstein (1998) stated that the practice of medicine will continue to live under a managed care system; loosely defined a "delivery system that attempts to manage the cost of, quality of, and access to health care." Typically, access to care in the managed care system begins with a primary care physician in the ambulatory care setting. Bernstein writes that health care trends will see a rise in medical consumerism, fewer solo practitioners, an emphasis on outcome-based quality management, an increasing elderly population, newer drugs, improved technology, and a managed care system that rewards the physicians who demonstrate improved patient care outcomes.

To prepare physicians, the first experience according to Richard Goss (1996) begins in that ambulatory care setting, normally seen in the third year of medical school as part of a clinical clerkship where the students receive instruction on data gathering, care coordination and diagnostic reasoning. Gerald Perkoff (1986) wrote in 1986 that training in the ambulatory setting is more commonplace now than in previous years and that there is an "increase expectation by patients that their medical care will be personal, changes in the types of patients seen, a progressive limitation imposed on the education of medical students by shorter lengths of (hospital) stay for patients relative to a DRG (diagnosis related groups) system of payment, and a need for well-trained primary care physicians resulting from an increase in managed care organization." Perkoff noted that there are educational benefits in this setting, particularly for medical students, with an opportunity to observe and manage patient-care problems of an urgent nature with

physician faculty who can offer students one-on-one teaching. Randol Barker (1990) also stressed the value of ambulatory education noting, "The learner in the ambulatory environment has an opportunity to see the hard-to-recognize manifestations of a disease as it revels itself, particularly in the early stages of development". The learner will see diseases that can go unrecognized until they present in an advanced stage that requires hospitalization. Barker stressed that the ambulatory model has quantitative data on a variety of patient related medical problems that residency program directors should use to design, or improve upon the resident's curriculum.

RESIDENCY GUIDELINES AND REQUIREMENTS

The Accreditation Council for Graduate Medical Education (ACGME) reviews and approves all allopathic residency-training programs (Directory 2000 - 2001), with each residency assigned a Residency Review Committee (RRC). In addition, each residency program has its own set of specific requirements called the ***Essentials***. For the Family Practice Programs, the Essentials focused on such elements as: ***Hospital and Ambulatory Facilities***, ***Program Personnel and Qualified Teaching Faculty***, ***Program Evaluation***, ***Curriculum Rotations***, and ***Patient Population.***

However, this author noted that in terms of the ***Patient Population*** there was no mention in the *essentials* as to the types of diseases and/or disease patterns that a family practice resident must see in the Family Health Center (FHC), only that each resident must be assigned to a minimum number of half days sessions in the FHC to see patients, and with at least three hours per session to gain an adequate clinical experience for RRC approval (see Table I ACGME Requirements):

Table I
ACGME Requirements for the FHC

Resident Year	Number of Half-Days Per Week	Hours/Session	Patient Visits/Session
Level I	1	3	**3 Patients/Session**
Level II	2	3	**6 Patients/Session**
Level III	3	3	**8 Patients/Session**

Requirements stipulate that the ambulatory center "must maintain a stable population of sufficient number and variety necessary to ensure comprehensiveness and continuity of experience for the residents." In terms of patient mix, the requirements state that the ambulatory centers should have a "broad-spectrum of problems that represent varied income levels, ages and sexes." To enhance the ACGME Family Practice Requirements, there also exist criteria from the Residency Assistance Program (RAP) (1989), designed and developed in cooperation with the American Academy of Family Physicians, to serve as a resource for program directors and teaching faculty as a means for achieving 'excellence' in family practice training. With respect to the ambulatory centers and patient populations, the RAP Criteria only states: "There should be evidence of patient assignments of more complex families and patients to the residents commensurate with their level of training and experience; there should be regular statistical reports that document office visits, patient demographics, diagnostic studies and pertinent information for each resident to assure a broad patient care experience; there should be a stable population of families, households and assigned patients per resident; and there should be a minimum number of half-day sessions worked per week and patient visits per year per resident" (see Tables II & III).

Table II
RAP Criteria for the FHC

Minimum # of Families/Households and Patients per Resident

Resident Year	Families/Households	Assigned Patients
Level I	50	150 – 200
Level II	100	300 – 400
Level III	150 – 200	450 – 600

Table III
RAP Criteria for the FHC

Office Sessions and Patients per Year per Resident

Resident Year	Half-Days/Week	Hours/Session	Office Visits/Year
Level I	1 – 2	3 – 4	198 – 528
Level II	2 – 3	3 – 4	528 – 1188
Level III	3 – 5	3 – 4	1188 – 2640

In terms of patient visits, the RAP Criteria states that the resident should have at minimum, 44 weeks per year of patient visits. If however the number of patient visits were less than the range of patient visits identified in Table III, the resident would be at risk of an inadequate exposure of clinical problems. If the average patient visits per resident per year is greater than range of patient identified in Table III, the residents risk sacrificing education for service. Again, there is no mention of patient types.

Residency programs must also provide an appropriate ambulatory practice center or Family Health Center for patient care and faculty teaching. According to both the

ACGME and **RAP** guidelines, the following facility elements are needed for an adequate clinical setting, they are:

1. Functional Status

Operation of the FHC should be controlled by the program director; when seeing patients the priority must go to the family practice residents; and the FHC should be utilized as an educational enhancement of the family practice program.

2. Design

Signage to identify the FHC should be visible/clear to all patients; in a multi-office building, the FHC sign should be the same as that of the other medical practices; signage within the FHC should be easy to read to assure staff/patient efficiency; treatment/counseling areas should ensure comfort, privacy and confidentiality; a relaxing room should be available for individual, family & group counseling; as well a room for monitoring of physician patient visits with videotaping, audio-taping and/or a one-way mirrored window for viewing capabilities.

3. Size

The FHC should be of sufficient size for teaching, administration and patient care; a program of four residents in each of the three years requires in excess of 5,000 sq. ft. of patient care area to meet requirements; there should be an adequate waiting room with seating for all patients; examination/treatment rooms should be adequate in size to accommodate the patient, family, resident and teaching faculty; and there should be adequate office and examination space for the ancillary support staff.

4. Equipment

There should be immediate access to supplies/equipment for office emergencies such as cardiopulmonary arrests; and there should be equipment available in the center to train residents in the full scope of family practice diagnostics.

5. Diagnostic Laboratory, Imaging & Ancillary Testing Services

Plain film x-ray and ultrasound capability should be available; laboratory capabilities; quality assurance protocols consistent with the level of laboratory service as defined by regulations; and other supportive ancillary testing within the FHC such as audiometry or pulmonary function studies.

6. Record System

Automated patient records should be maintained within the center documenting the patient's primary physician; a problems lists with past hospitalizations and surgical procedures; allergies, current medications and health care maintenance should all be prominent in the chart; family member charts should be accessible for reference; and any after-hours patient care should be documented.

7. Scheduling

There should be training programs for the support staff responsible for patient scheduling on promotion of continuity of care, physician times, and sensitivity to patient needs.

8. Sources of Income

There should be evidence of solid financial support for the family practice center; and that the budget should be under the direction/control of the program director.

9. Hours of Operation

The FHC should operate during hours consistent with those practiced by other family practice groups in the community; the hours should meet the needs of the patients as well as training needs for the residents; it should be open at least two 3 - 4 hour sessions each weekday; patient access to care from residents should be available 24 hours/day, seven days per week; staff policies should be monitored for compliance; and office hours should be advertised to all patients.

10. Pharmaceutical Representatives

Written policies should be developed and utilized for visits by pharmaceutical representatives, and for the acquisition and distribution of drug samples.

The **ACGME** Practice Management curriculum requirements are as follows:

"There must be 60 hours of instruction in practice management taught in both didactic and practical settings. Emphasis should be on providing the resident with the tools to be successful in practice while optimizing patient care. The Family Practice Center should be considered one of the primary sites for teaching practice management."

The **RAP** Practice Management curriculum is more specific:

1. Residents should be taught the principles/practices of office financial viability.

2. Training should occur in structured, didactic educational experiences.

3. Specific curricular elements should include the following:

- Professional Goals
- Selecting a Community and Type of Practice
- Practice Configuration
- Practice Facilities and Support
- Personnel Policies and Procedures
- Practice Operations
- Medical Records and Quality Assurance
- Marketing
- Health Care Risk Contracting
- Practice Finance/Economics, Patient Billing/Physician Reimbursement
- Medical-Legal Issues

- Contract Negotiation
- Personal Financial Management

4. Family physicians with practice management expertise in a variety of practice settings should be used as faculty.

5. Residents should experience managing patients enrolled in managed care systems. In particular, the residents should be taught the principles of cost-effective, quality patient management for patients enrolled in pre-paid managed care delivery care systems.

6. Residents should participate in quality assurance and utilization review committees in the family practice center and in the hospital(s).

In addition to the ACGME and RAP guidelines, residency programs should stress the value of a full-time office manager according to Robert Rakel, MD (1984). He writes that office managers should: "possess the credentials as a health care practitioner and manager of people, scheduling their work assignments and daily routines; maintaining employment records, benefits, vacations, sick leave, inventory control, and assume the responsibility for ordering supplies; conduct employee meetings; coordinate physician schedules with the paramedical staff; prepare both the daily administrative and financial reports of productivity; review the budget and expense statements; conduct individual performance appraisal sessions; develop liaisons with medical, business, and community groups; and be able to design patient flow and paper flow systems." Again, there is no mention as to the types of diseases and/or disease patterns that a family practice resident must see in the Family Health Center (FHC),

LITERATURE REVIEW

Joel Cantor, et al., (1993) conducted telephone interviews with over 6,053 physician graduates on the appropriateness of their residency training in regard to how well they were prepared for their current medical practice. The authors reported that over 80% of the graduates had rated their inpatient training experiences to be good. However, 45 percent were *critical about their lack of preparation* for recognition and management of medical conditions in the *ambulatory setting* stating "too much focus concentrated in the tertiary care settings." The authors noted that the programs had not kept up with the demands that face today's physician, stating that the "changes in predominant patterns of disease that have shifted from acute to chronic conditions, rendering conventional education and practice weak instruments for improving health."

In a study conducted by David Smith and Barbara Haupt (1983), residency programs in Pediatrics, Internal Medicine, and OB/GYN were evaluated as to their ability to manage the diseases most commonly seen outside of their respective areas of residency training. Using data from a 1978 National Discharge Survey, the authors identified 20 of the most commonly seen diagnoses in a hospital setting, accounting for roughly 78% of all patient discharges in the 413 hospitals studied. The study focused on competency levels that the authors viewed as necessary in residency programs for prevention, early recognition, and management of certain diagnostic categories. Results from this study raised concerns as to the length of training that is needed by residents to become proficient in the medical management of certain conditions that were outside of each respective discipline. For example, the pediatric resident is normally exposed to inpatient

problems that present in a manner that is usually congenital, gastrointestinal, respiratory, or of infectious disease nature, whereas, patients with trauma related injuries that are seen in an office setting are considered to be outside of the pediatric discipline. According to the authors, *pediatric residents would benefit if more of their curriculum shifted to the office or the ambulatory setting* with increased emphasis placed on a wider variety of cases with severe morbidity.

Michael Stone (1994) surveyed 2,267 family practice graduates from various residency programs on how well they were trained in the area of practice management; graduates had to be active in a clinical practice for at least a two-year period. They were asked to rank the relevance of selected practice management topics and how well their residency programs prepared them for the practice management side of their current office practice. Stone compared the information he collected to a previous study conducted in 1987 by the American Association for Family Practitioners. With a 25 percent response rate, he found that there were minor differences between the two results. However, the graduates in Stones study recommended that curriculum changes were needed and that *residents should be more involved in the business affairs of their family practice* health centers to improve both the understanding of financial matters and their work efficiency.

Lawrence Linn et al (1986) conducted a survey of 234 graduates from 15 Internal Medicine Residency Programs who had completed their training at least two years prior to the study. Graduates were asked to use a four point Likert Scale and rate 27 activities associated with clinical content and skills training. Eight activities were identified by the graduates as needing additional attention, they were: "nutritional counseling, dermatology, office management, management of depression, office orthopedics,

sexual dysfunction, career counseling, and developing exercise programs." As for the inpatient setting, over 80 percent of the graduates had rated the time devoted to patient care activities to be more than appropriate. However, they recommended that their respective training programs eliminate the time a resident spends on problem-oriented medical records, family and/or behavior therapy, and communication skills. When asked to comment on a set of proposed educational innovations, the majority stated that they would like to see an increase in the contact hours the residents spend with sub-specialty physicians and physician peers who work in the ambulatory settings. As to the second part of the survey, graduates were asked to rate job satisfaction and stress levels using a five point Likert Scale. Though the majority of respondents stated that they were satisfied with their jobs and did not feel overly stressed, job satisfaction measured slightly below the 3.0 mid-point range. Significant is the fact that the authors stated that "as the practice of internal medicine becomes less and less hospital-based and if the program directors are going to try to meet the needs of practicing internists, *dramatic changes in time allocation from the inpatient to outpatient training must take place*".

HYPOTHESES

A review of the literature has shown that the ambulatory setting has become an important part of residency education, especially for residents in the primary care specialties. Further, the literature has shown that physician graduates, as well as teaching institutions must be prepared to demonstrate accountability for their decisions and patient treatment outcomes, and they should be prepared to justify their clinical decisions and skill levels. But missing from the literature and from the ACGME Essentials is the type of patients and the disease patterns a resident must see to be properly prepared for an ambulatory based practice.

My hypotheses are directed at (1) the St. Joseph Hospital (SJH) FHC in Flint, and the level of training the residents had received to 20 of the most commonly seen disease problems in an ambulatory setting, and (2) the training the residents received from the business side of office management; my hypotheses are as follows:

Hypothesis #1: The types of patients seen in the SJH/FHC mirror that of the top 20 most commonly seen patients as reported by the Department of Health and Human Services in 1995.

Hypothesis #2: Family practice graduates feel that the SJH/FHC has prepared them for the types of disease patterns that they are currently seeing /managing in their current office practice.

Hypothesis #3: Family practice graduates feel that they were well prepared for the business side of their office practice.

METHODOLOGY

A four-part questionnaire was designed to assess two areas of residency training in the SJH/FHC. In the first section (Parts I and II) of the questionnaire, graduates were asked ***to compare disease specific patterns as seen in their current clinical practice*** to the ***disease specific patterns that they saw in training in the FHC***. For the second section of the survey (Parts III and IV) of the questionnaire, the graduates were asked to ***evaluate how well they were trained for the business aspects of their office practice*** and ***what changes they would recommend***, if any, to the FHC curriculum. This author developed the first section of the questionnaire with recommendations coming from Mark Vogel, PhD, Director - Post Doctoral Behavioral Science Program at Genesys. The second section of the questionnaire was developed with Kenneth Yokosawa, MD, Director for the Family Practice Residency at Genesys, and Richard Rankl, MD, Associate Program Director. Final approval of this study came from my *First Reader,* Ellis Perlman, PhD, (Retired) Professor, Political Science Department, at the University of Michigan - Flint, and from my *Second Reader,* Robert P. Sutton, PhD, Vice President for Academic Affairs at Genesys, and Past President for the Association for Hospital Medical Education, an organization representing the teaching institutions and/or hospitals in the United States. An overview of the questionnaire is as follows:

COVER LETTER (See Appendix 1a):

A cover letter from Dr. Yokosawa was addressed to the physician graduates lending his support to the questionnaire and stressing the importance of its completion.

PART I (See Appendix 1 b):

Dealt with background information specific to the graduate resident, such as their age, gender, graduating class, population of the city of current practice, type of practice, and whether they were a US or International Medical Graduate, etc.

PART II (See Appendix 1c & 1d):

Graduates were asked to rate how well the FHC prepared them to manage the top 20 most commonly seen diseases in an office setting, as reported by DHHS (1985), using a five point Likert Scale.

PART III (See Appendix 1e):

Five open-ended questions were asked as to what the residents believed to be the most important issues for a (new) graduate to know when managing a new practice.

PART IV (See Appendix 1f):

Six open-ended questions were asked of only those residents from 1994 through 1999 who participated on the Research/Practice Management (RPM) rotation as to the value of the rotation.

Patient data for a five year period was also gathered from the FHC in regards to: the number of patient visits; the types of patients; the number of new patients; the number of obstetrical deliveries coming from the FHC; and the number of patient cancellations or no shows. A five-year period was chosen to allow this author the opportunity to compare changes, if any, in patient volumes, and in the types of diagnoses seen in the FHC at the SJH Campus.

SUBJECTS

Residents who had successfully completed their residency training at SJH during the period July 1, 1984 through August 31, 1999 were mailed a questionnaire. The selection of the graduates was based on the assumption that these individuals had been in private practice for at least one year and would have had time to build up an adequate patient base for this study. This author arbitrarily excluded residents from this study who had graduated before July 1, 1984, assuming that this group had been away from the residency program for too long a period of time to remember important details about their FHC training. The Medical Education office at Genesys Regional Medical Center provided a list of FP graduates, along with their last known address and graduation date from the residency program.

SETTING

SJH was owned by the Sisters of St. Joseph of Nazareth, Michigan, and had served as the primary sponsor for the ACGME approved Family Practice Program since 1971. As a 421-bed full service acute care hospital, the family practice residency program was the sole residency at the hospital, providing medical care to a population base of more than 450,000. By 1994, SJH legally merged with three local hospitals: Wheelock Memorial Hospital (WMH) in Goodrich, Flint Osteopathic Hospital (FOH) in Flint, and Genesee Memorial Hospital (GMH) in Flint to form Genesys Health System. This merger brought together FOH, the largest *osteopathic* teaching hospital in the state with multiple specialty and sub-specialty training programs, SJH with one of the largest family

practice *allopathic* training programs in state, and GMH a sponsor of a one-year *podiatric* residency program.

In February of 1997 the four hospitals relocated their training programs, medical staff, ancillary staff, and in-patient medical services to a newly built 410-bed hospital called Genesys Regional Medical Center in Grand Blanc, MI. However the FHC did not move, and remained behind at the old SJH site with residents driving roughly 25 minutes between the FHC site and the new hospital. Located on the third floor of the administration building just north of the old hospital, the FHC was designed to mirror a group practice. It occupied a little over 15,000 square feet; there were 26 exam rooms, two of the rooms were equipped as special procedure rooms for sigmoidoscopies, colposcopies, and casting. Three more rooms were equipped with videotaping and monitoring capabilities for resident evaluation and education. There were four resident team offices designed for 10 residents each, and two nursing stations, one each to support two team offices. Each team office represented a partnership of sorts with each resident assigned to one team during his/her three years of training where residents could collaborate with each other on patient related or office issues. An effort was made to balance the makeup of the teams from the perspective of gender, post-graduate level and nationality. A preceptor office for teaching faculty was located between the four team offices with licensed supervising physician faculty available to comment on resident-patient interactions, lab results, diagnoses, treatment plans, and patient concerns. Equipped with reference materials and eventually a computer for access to medical literature, the preceptor office also housed sub-specialty faculty on certain days, available to provide support on obstetrical, dermatological, pediatric, and surgical cases.

The FHC also housed a Post Doctoral Behavioral Science Program with Fellows available to the residents for patient referrals, allowing residents sit in on the patient consultations.

A medical laboratory was available over the 15-year period for teaching a variety of lab tests that were commonly found in the physician's private office. However, changes in the regulation of ambulatory labs had forced the FHC to contract with an outside firm to provide a secondary comprehensive laboratory with a full-time phlebotomist for those patients needing specialized testing. Diagnostic imaging such as x-rays and ultrasounds were available at the primary hospital with patients accessing the hospital by using the connecting tunnels. After the hospital move, the x-ray capabilities remained behind for the FHC and an urgent care facility located on the same campus. A business office was also centrally located to the team offices with all of the patient medical records available to the residents 24 hours per day along with computer access to a patient billing system.

PRACTICE MANAGEMENT CURRICULUM

From 1985 to 1999 the Research Practice Management (RPM) curriculum had taken on several forms but for the most part had followed the overall goal as written in the SJH Rotational Manual for that period; the goal was as follows:

"To provide an understanding of practice management to the residents so they have the knowledge to make the appropriate personal choices and to fulfill their ethical responsibility to advocate for the highest standards in delivering patient care." Guest speakers also served as an integral component to the RPM curriculum addressing a variety of topics such as: time management, capitation, referrals, marketing, staffing,

and managed care. The curriculum included an ambulatory rotation with the residents exposed to a variety of management styles by a group of physicians who have shown efficiencies both in office management and in their clinical practice. Residents were then required to complete the American Academy of Family Physicians (AAFP) Home Study Self-Assessment (Monograph) series on Practice Management. The material is reviewed while they were rotating on the RPM service and at the end of the rotation they were tested on what they had learned. Residents were provided with over 27 different Monographs on a variety of family practice topics as a means to compliment their three-year curriculum with testing of the material occurring at the end of each rotational cycle.

RESULTS

In September of 2000, a questionnaire was mailed to 169 family practice graduates from the GRMC/SJH Family Practice Residency Program. Included with the questionnaire was a cover letter from Dr. Yokosawa encouraging the graduates to answer and return the questionnaire to this author using an enclosed self-addressed prepaid envelope. Of the 169 graduates who were initially mailed a questionnaire, 46 were returned with the envelope stamped as undeliverable. This author attempted to update the mailing addresses for the returned questionnaires by referring to the *American Academy of Family Practice Directory* and *Alta Vista People Search* an Internet Search Engine. This author mailed the same questionnaire and cover letter out again to 123 confirmed addresses, knowing that potentially the majority of these graduates might have already received the initial mailing. After six months passed the second mailing produced an additional 28 responses from our family practice graduates (see Appendix 1a for a copy of the ***Cover Letter*** and the ***Questionnaire)***.

RESPONSES TO (PART I) OF THE QUESTIONARE

Fifty-one questionnaires out of 123 were returned for a 43 percent return rate. Two or more responses came from each of the graduating classes, except for the class of 1993; there were no responses from this group. See Table IV of those who responded.

Table IV
Survey Respondents

	POTENTIAL # of RESPONDENTS					ACTUAL # of RESPONDENTS				
Class	Female	Male	IMG	US		Female	Male	IMG	US	Response
1985	2	7	3	6		2	5	1	6	78%
1986	1	6	1	6		0	2	1	1	28%
1987	3	8	5	6		1	4	3	2	45%
1988	2	8	5	5		0	4	3	1	40%
1989	2	7	2	7		1	2	0	3	33%
1990	2	6	6	2		0	2	1	1	25%
1991	2	4	4	2		1	3	3	1	67%
1992	0	3	3	0		0	3	3	0	100%
1993	6	6	8	4		0	0	0	0	-0-
1994	3	3	5	1		1	1	1	1	33%
1995	5	6	3	8		0	3	2	3	36%
1996	3	6	3	6		0	3	1	2	33%
1997	3	5	5	3		1	1	2	0	25%
1998	4	5	4	5		3	3	2	4	67%
1999	2	3	2	3		2	1	0	3	60%
Total	40	83	59	64		14	37	23	28	42%

The potential respondents from each graduating class are broken down into four variables: Female, Male, U.S. Medical School Graduate, and International Medical School Graduate. The graduating class of 1992 demonstrated the highest return rate at a 100 percent and there were no responses from the class of 1993. Overall there were 37 male graduates and 14 were female graduates (see Table V).

Table V
Male and Female Responses

	Survey Responses	Confirmed Addresses	Percent Responded
Females	14	40	35%
Males	37	83	45%
Total	**51**	**123**	**42%**

There were 48 out of 51 graduates who were board certified by the American Board of Family Practice (see Table VI); the 3 outliers were female but one indicated that her board certification had lapsed but that she planning to retake the certification exam.

Table VI
Graduates with F.P. Board Certification

	Board Certified		Not Board Certified	
	IMG's	U.S. Grads	IMG's	U.S. Grads
Females	2	9	2	1
Males	19	18	0	0
Total	**21**	**21**	**2**	**1**

Forty-four respondents reported that they were actively involved in the practice of Family Medicine (see Table VII). Seven reported involvement in the other areas: one went on to become a Dermatologist, one serves as a Hospitalist, one is a Medical Administrator of a Health Care Insurance Plan, one is in the Military practicing Aerospace Medicine, one works in the Emergency Room, and two are working in Urgent Care Centers.

Table VII
Respondents Still Active In Family Medicine

	Active in Family Medicine		Not Active in Family Medicine	
	IMG's	U.S. Grads	IMG's	U.S. Grads
Females	3	9	1	1
Males	16	16	2	3
Total	**19**	**25**	**3**	**4**

On a whole graduates reported averaging over 5,000 patient visits per year in their respective practices, with 20 percent of that population or 1,000 patients less than 17 years of age. Twenty-three graduates reported they offer prenatal care services, with 22 of 23 offering to perform the obstetrical delivery and averaging from 12 to 75 deliveries per year. Thirty-six reported they were part of a group practice with one or more partners. Of this group, three stated they serve as full-time teaching faculty with family practice programs. As to *group practices*: 11 work in communities with a population base of 20,000 or less; six work in a population base of 50,000 or less; four are in a population base of 100,000 or less; and 11 work in a population base that is greater than 100,000. Of the *solo practitioners*, five work in a population base of 20,000 or less;

two are in a population base of 50,000 or less; and one is currently in a community of less than 100,000 as a population base (See Table VIII).

Table VIII
Type of Practice and Size of Community

	NUMBER OF PRACTICE TYPES PER POPULATION			
PRACTICE TYPES	POPULATION < 20,000	POPULATION < 50,000	POPULATION < 100,000	POPULATION > 100,000
Solo Practice	5	2	1	0
Group Practice	11	6	4	12
FP Residency Faculty	0	0	1	2
Hospitalist Physician	0	0	1	0
HMO Administrator	0	0	0	1
Military Physician	0	0	1	0
Emergency Room	0	0	0	1
Urgent Care Physician	0	0	1	1
Dermatology Practice	1	0	0	0

The majority of graduates stated that they have an office coordinator. Better than half of the graduates are taking an active role in both staff evaluations and regular staff meetings but less than half staying involved in employee scheduling (see Table IX).

Table IX
Office Management

FP Graduate	Have a Manager or Office Coordinator	Graduates Involved With Scheduling Of the Support Staff	Graduates Involved With the Staff Evaluations	Graduates Hold Regular Staff Meetings
Yes	39	18	34	26
No	5	26	10	18

The FHC statistics in Table X are for a five-year period from 7/1/1994 to 6/30/1999.

Table X
SJH/FHC Patient Statistics for the Fiscal Years Ending (FYE) June 30th

	1995	1996	1997	1998	1999
Physician Office Visits	32, 051	32, 060	26, 949	24, 048	22, 992
Non-Physician Visits	868	1, 574	1, 714	1, 732	1, 016
Total Outpatient Visits	32, 919	33, 634	29, 482	25, 780	24, 008
Total Inpatient (Hospital) Care Days	6, 435	5, 609	5, 188	4, 272	4, 470
New Patients	2, 218	2, 637	1, 868	1, 713	1, 618
Admissions to Hospital	1, 307	1, 603	1,424	1, 217	1, 207
FHC Patients Sent to the Emergency Room	3, 568	3, 462	2, 813	3, 404	3, 612
New OB Patients	519	451	373	344	342
Number of Obstetrical Deliveries	404	392	299	242	269
Average Daily Outpatient Visits	132	134	117	102	95
No-Shows (Scheduled Appointments)	9, 472	8, 526	8, 370	7, 364	6, 858
Percent No-Shows per Office Visits	**30%**	**27%**	**31%**	**31%**	**30%**

Billing data for the above five-year period is reflected on the next page in Table XI and sorted by fiscal year, diagnostic billing codes, patient problems, and the types of patient volumes seen during that period of time. Each patient problem was placed in one of 24 diagnostic categories as defined in the questionnaire. However, some variation existed in billed diagnoses as compared to the diagnostic categories, so a "clustering" method was used, as described by Robert Rakel, MD (1986), whereby billed diagnoses were placed into one of the 24 diagnostic groupings based on its patho-physiologic condition.

Table XI
Billing Data by Diagnosis for the SJC/FHC

	Description of Diagnosis	1995	1996	1997	1998	1999
1	Hypertension	894	559	1,030	989	714
2	URI / Pharyngitis	3,188	2,522	2,335	1,941	1,963
3	Well Child Examinations	3,672	3,573	2,178	2,370	2,137
4	Diabetes Mellitus	652	580	679	974	669
5	Prenatal Care	4,641	3,521	2,886	3,063	3,261
6	General Medical	2,104	1,888	1,672	2,618	2,268
7	Otitis Media	1,451	1,123	1,158	1,113	886
8	Bronchitis	1,733	1,518	1,585	1,652	1,136
9	GYN Examinations	1,579	1,429	1,166	1,387	1,291
10	Sinusitis	1,072	818	959	1,172	923
11	Depression	510	329	362	264	293
12	Vaginitis	255	306	315	243	250
13	Urinary Tract Infection/Cystitis	742	352	411	309	365
14	Back Pain	631	255	425	476	560
15	Immunizations	0	58	159	203	266
16	Abdominal Pain	1,152	1,089	1,366	1,135	748
17	Congestive Heart Failure	667	337	731	702	470
18	Diagnosing Pregnancy	330	541	364	220	554
19	Contraception	25	0	0	0	0
20	Arthritis	224	352	228	552	617
21	Marriage / Family Counseling	206	460	492	525	589
22	Alcoholism / Substance	49	73	78	64	53
23	General Counseling	430	308	251	370	175
24	Behavioral Problems (ages 2-	304	178	234	300	311
25	Dermatological Problems	1,337	831	1,045	1,132	1,133
26	Sprains & Strains	737	941	987	599	673
27	Conjunctivitis	345	218	154	171	164
28	Medical/Surgical Aftercare	324	214	340	194	209
29	Neurological Issues	216	224	194	193	134
30	Normal Hospital Deliveries	597	224	916	937	628

RESPONSES TO PART II OF THE QUESTIONNAIRE

Graduates were asked to rate how well the FHC experience prepared them to manage the top 20 most commonly seen diseases in the U.S. (DHHS 1995) using a five point Likert Scale with a score of 1 equaling a poor clinical experience and a 5 equaling an excellent. Graduate responses are tallied per each category and averaged to reflect a Mean Score and overall Mean Score (see Table XII).

Table XII
Results from Residents Rating Their Clinical Experience

	PATIENT PROBLEMS	1	2	3	4	5	MEAN SCORE	MEAN SCORE
1	Hypertension			4	28	19	4.28	
2	URI/Pharyngitis				17	34	4.66	
3	Well Child Examinations		1	3	16	31	4.50	
4	Diabetes Mellitus		1	7	26	17	4.14	
5	Prenatal Care			1	16	34	4.64	
6	General Medical Exam			2	22	27	4.48	
7	Otitis Media			1	18	32	4.60	
8	Bronchitis			3	20	28	4.48	
9	GYN Examinations		1	3	20	27	4.44	
10	Sinusitis			4	19	28	4.46	
11	Depression		5	13	18	15	3.82	
12	Vaginitis		1	1	21	28	4.48	
13	Urinary Tract Infection/Cystitis				19	32	4.62	
14	Back Pain		2	18	18	13	3.84	
15	Immunizations		1	4	19	27	4.40	
16	Abdominal Pain			8	26	17	4.18	
17	Congestive Heart Failure		1	7	31	12	4.06	
18	Diagnosing Pregnancy			1	14	36	4.70	
19	Contraception			6	24	21	4.30	
20	Arthritis			16	21	14	3.98	
21	Marriage/Family Counseling	1	11	15	16	8		3.40
22	Alcoholism/Substance Abuse		14	16	19	2		3.18
23	General Counseling		9	19	19	4		3.36
24	Behavioral Problems (ages 2-7)		15	20	12	4		3.12
							4.36	**3.27**

Overall Mean Score = 4.17

With respect to the top 20 diagnostic categories, the average score was 4.36, with the four remaining patient problem areas (Marriage and Family Counseling, General Counseling, Alcoholism and Substance Abuse, and Behavioral Problems) having an average score of 3.27. Respondents had an opportunity to offer comments if they either strongly agreed, or strongly disagreed when rating their experiences. Of the 51 graduates who responded, 15 offered comments; this author has segmented those comments into four general themes:

Behavioral Science Training Insufficient

- Counseling skills were learned in short exposures relative to actual patient contact in the psychiatry rotation.
- I am not comfortable in counseling my patients but had excellent experiences in the FHC and feel comfortable managing these problems.
- My overall training in the FHC was excellent but the patient counseling was poor.
- The Behavioral Science rotation had the potential to provide us with the inherent knowledge in managing mental health problems but the (behavioral) fellows did not "process" the residents as they thought they did instead, the rotation created animosity between the residents and fellows.

Not Enough Behavioral Training/Too Much Prenatal Management, And Obstetrical, & Well Child Training

I was well trained to do *well child exams* including developmental assessments but there was not enough exposure to the psychological or behavioral problems.

Despite the access to Behavioral Science faculty there was little supervision. There was didactics but no practice. Too much emphasis was placed on prenatal care and obstetrical delivery but little on gynecology, pathology and management.

- My psychiatry experience was weak. OB training, which was a lot, proved pretty useless for my current private practice.

Too Much Obstetrical Training

- Received good exposure to colposcopy skills as well as very good obstetrical training; unfortunately, I'm not doing obstetrics. The orthopedic experiences could have been better since I now see a significant number of patients with back pain. The Infectious Disease training was excellent.
- I feel that we as graduates could provide Prenatal Care in our sleep, particularly with Dr. Goetz and the additional exposures at the (City of Flint) McCree Clinic and the SJH Outpatient Specialty Clinic.
- I received outstanding OB training at the McCree Clinic and the Outpatient Specialty Clinics; at these clinics the outpatient nurses were very good when assisting with the gynecology exams. In addition my FHC exposure to the outpatient lab procedures was very good and the Infectious Disease experience was well grounded with Dr. Bodem as our teacher.

Well Prepared To Manage the Most Common Ambulatory Patient Problems

- I strongly agree that we were prepared to manage all of the patient problems as noted in the questionnaire. However my typical patients seen in the FHC were young adults and children not older patients with chronic problems like arthritis, congestive heart failure, or diabetes mellitus.
- Currently, I see acute illnesses daily in my current private practice as well as in my urgent care center. I strongly agree that my FHC training prepared me well.
- My experiences being called to the SJH Emergency Room to evaluate patients was good. In my current rural practice I see acute problems in the ER and in my office where I have to decide who I can manage safely and who is in need of hospitalization. I believe I was better prepared then my present colleagues.
- My residency training and my current *ongoing* Continuing Medical Education (CME) activities have prepared me to handle all diagnoses.

Final Comment

- This author was unable to interpret the handwriting of the last respondent.

RESPONSES TO PART III & IV OF THE QUESTIONAIRE

There were five open-ended questions in Part III of the questionnaire relative to what they believed a resident should know before beginning a new clinical practice. Responses to the questions can be found in **Appendix II** of this paper. However, four primary themes, or recommendations as to what a resident should know before venturing out into a clinical practice are as follows: financial, personnel, legal, and the computerization of an office.

1. Financial Issues

Billing, procedural coding, collections, insurance forms, and cost of services.

2. Personnel Issues

Job descriptions, hiring employees, delegation of assignments, staff evaluations, employee dismissals, encouraging employees to perform their assignments well, and training the employees to address patient scheduling problems.

3. Legal Skills

Understand Medicare fraud laws, regulatory issues, proper patient documentation, liability issues, and the legal and business aspects of a clinical practice.

4. Computerization Skills

Be competent in computer technology, electronic medical records, etc.

A second set of open-ended questions were asked relative to the Research/Practice Management (RPM) rotation were asked in Part IV of the questionnaire and directed to the graduating classes of 1995 through 1999. Responses to these questions can be found in Appendix III of this paper. The majority of respondents identified their rotations as being a positive experience, especially with exposure to the operational flow of activities in those offices. There were some offices that were not as helpful as they

could have been, and the residents noted that there was not enough time to fully appreciate the experience. The graduates stated that there could have been more structured time spent with the staffing and billing aspects of the office experiences, and recommended that the RPM rotations continue with the residents visiting the various physician offices within the Genesys Health System but focus should be on the physicians who have an efficient office practice. It was also recommended that the RPM rotation be moved to the second half of the residents third year of training when possible, increasing the amount of time from three half days to five days in primary care physician offices. Overall, the graduates found the RPM rotation to be a positive experience but more structure is needed and an increase emphasis should be given to group practices, as well as billing procedures and encounter forms.

DISCUSSION

Results from Part II of the questionnaire support the first two hypotheses with the following conclusions:

Hypothesis # 1: The type of patients seen in the FHC from 1985 to 1999 mirrors that of the top 20 most commonly seen patients (DHHS 1985) in an ambulatory setting. As seen in Table XI, support for this hypothesis was based on the patient volumes per each respective diagnosis seen in the FHC over the sample five-year period.

Hypothesis #2: The Family Practice graduates agreed that their experiences in the FHC prepared them for the type of disease patterns they now see in their medical practice. As seen in Table XII, support for this hypothesis is based on the responses using a Likert Scale to rate their experience with disease problems. A rating of [**one**] is equated to a poor experience, while a rating of [**five**] equated to a positive experience. Graduates on average rated all of their experiences at a 3.17.

However, results from Part III and IV of the questionnaire do not appear to fully support the third hypothesis and so the conclusion would be as follows:

Hypothesis #3: The Family Practice graduates were not in total agreement that they were well prepared for the business side of their office practice. Responses to Part III and IV of the questionnaire while positive in some areas suggest that improvement is needed in the curriculum being taught both in the FHC and during the RPM rotation as reflected in Appendix II.

In regard to the overall respondents, there were no graduates from the class of 1993 who responded to this survey. However the cross-section of graduates who did respond appears to be representative of the potential mix of graduates with at least two or more responses coming from each of the graduating classes (see Table I). The male graduates were more likely to return the survey with a 45 percent response rate, versus the female graduates with a 35 percent response rate. Graduates from the U.S. medical schools were more likely to return the survey with a 43 percent response rate, versus international medical graduates with a 39 percent response rate. Response rates between the male and female graduates, and the response rates between the U.S. and International Medical School graduates were negligible.

In regard to response rates, Jeffrey Sobal and Kevin Ferentz (1989) had conducted a study on response rates with three groups of family physicians; they were: physician graduates, resident physicians, and program directors. The authors received a 63 percent response rate from their initial mailing, and a 17 percent response rate to their second mailing. As for physician response rates, the two authors stated, "physicians are often busy, difficult to contact, protected from researchers, and resistant to surveys". Important though is the fact that the information returned from the second mailing was similar to the information received from the initial mailing, yet the authors still believed that conducting follow-up mailings not only serve to improve the maximum return rate but the increase in the response rates help to ensure the validity of the study. In contrast this author reported a 26 percent return rate after the initial mailing, or 32 responses out of a potential of 123 responses. The second mailing yielded a 21 percent return rate with data that was similar to the information received from the first mailing.

Walter Gunn and Isabelle Rhodes (1981) examined the effects of physician response rates focusing their study on three key factors: an endorsement of a highly respected national organization, monetary incentives, and an emphasis in a cover letter that their questionnaire was time sensitive. The authors reported that they saw an increase in response rates from 58 to 70 percent when the incentives were increased from $25 to $50 respectively. However, there was no monetary incentive offered by this author due to a lack of funding for this study. But with respect to an endorsement, as stressed by Gunn and Rhodes, Dr. Yokosawa was kind enough to write a letter of support to encourage the SJH graduates to respond to this author's questionnaire, stressing the fact that their input was needed as part of an Internal Review Process and that the information would help in the design of a resident curriculum (see Appendix 1a).

Heberlein and Baumgartner (1978) stated that monetary incentives are but one factor affecting higher response rates, and that the larger the monetary incentive, particularly if prepaid then the greater the response. However, the two authors noted that there are certain individuals who are more likely than others to respond to questionnaires when they have been conditioned to cognitive testing such as college students. The authors also cautioned against the invasion of ones privacy as it may discourage a respondent from returning the questionnaire; instead they stressed that anonymous procedures be adopted so as not to identify respondents. They also cautioned against any repeated mailings that could cause a sense of guilt for the respondent for not having returned the questionnaire after the first mailing. Depending on the length of the questionnaire, the authors recommended that the questions be spread out over two or more pages to allow the respondents time to progress more easily through a set of questions. As for this

author's study, the questionnaire was developed knowing that the SJH physician graduates had been routinely tested on empirical factual knowledge during their undergraduate, medical school and residency training years and were conditioned to cognitive testing. The questionnaire used by this author was five pages long. Graduates could respond anonymously or they could identify themselves if they wanted a copy of the final paper. Twelve respondents have requested a copy of the results.

With respect to board certification, there were 48 out of 51 graduates who have maintained their board certification with the American Board of Family Practice (ABFP). Of interest is the fact that seven out of the 48 respondents, who were not active in family practice, reported that they have maintained their ABFP Certification. As for the three respondents who were not board certified, all were female, two were international medical graduates, and one had reported that her board certification had lapsed but that she was preparing to re-take the exam. For the graduates who remained active in the field of family practice, the majority reported that they had joined a group practice, a trend Bernstein (1998) had reported as preferred by the majority of graduates in this country. The respondents in this study who had chosen a solo practice life-style were few in number and were primarily located in communities with populations of less than 50,000. The graduates were evenly divided for the most part relative to their practice location with 26 of the 51 respondents working in populations of greater than 50,000, while the remaining 25 respondents were located in populations of less than 50,000.

In regard to the FHC statistics, there was information obtained as to the age of the patients seen for the five-year period identified in Table X. Of concern to this author are the comments made by two of the graduates. One graduate stated that he had been

well trained to conduct well child exams including developmental assessment but noted that not enough exposure had been given to psychological and/or behavioral problems. The second graduate expressed concern that the majority of patients he saw in the FHC were young adults and children and not older patients. This author questions if there is a proper balance of patients, adults versus children, given that less than 20 percent of the graduates reported that their current population is made up of patients less then 17 years of age. With respect to patient visits, there was a decline of 10,000 patient visits between the academic years 7/1/1997 to 6/30/1999. Given the decline in patient volume, this author would have expected the graduates to have rated their experiences as poor with fewer diagnostic cases to see and manage, especially when patient visits averaged around 30,000 or more per year prior to 1996. Even though the patient volumes were lower then normal, Dr. Yokosawa stated that there were just enough cases to meet the criteria set forth by the ACGME for the size of the SJH program. Of interest, this author found no difference in how the graduates viewed their training when comparing the periods 1985 to 1989, 1990 to 1994, and 1995 to 1999 (see Appendix III). While the downturn of patient visits from 1997 to 1999 placed the residency program at risk of being cited by the ACGME for accreditation violations, the low volume appeared to have no effect on the resident responses. The minimum number of patient visits needed to by SJH to remain accredited is based on a 44 week per year schedule with 39 residents; 13 residents at each of the three levels, or 22,310 patient visits per year. As noted above, when comparing the ACGME Requirements to the actual FHC Patient Visit Statistics, the program just barely met the ACGME requirements with patient volumes of 24,048 in 1998 and 22,992 in 1999. However, according to the RAP Criteria the FHC patient volumes fell below the minimum number of patient visits needed to be a *program of*

excellence. A follow-up study should be done to see if the volumes have returned to the pre 1997 levels.

The FHC patient volume loss has been attributed to the announcement and subsequent relocation of St. Joseph Hospital to its new site in Grand Blanc. Dr. Yokosawa reported that the FHC patients might have assumed that the FHC was moving with the hospital, a site roughly 25 minutes away from the current location. In response to public perception, a public awareness campaign was initiated with an announcement that the FHC would remain open at the old site. Improvements were also made to both the exterior of the FHC building and surrounding campus grounds as a means to reverse the decline in patient visits. As a result, Dr. Yokosawa stated that patient visits stabilized and remained above the ACGME requirements needed to maintain program accreditation.

The proposed methodology for this study had originally called for a review of the FHC statistics that would have included the period 07/1/1993 to 06/30/1995. However the information received from the 'billing company' was deemed incomplete for these periods given that some months were missing key diagnoses from the report, that prevented this author from performing a thorough analysis. As for the diagnoses that were analyzed, a clustering method based on its patho-physiologic condition was used to determine the placement of the diagnoses into one of 24 diagnostic groupings. To ensure proper placement, this author referred to the 25th Edition of Stedman's Illustrated Medical Dictionary (1990) for the diagnoses deemed questionable in terms of definition. This author also met with Richard Rankl, MD, Associate Program Director for Family Practice to discuss the diagnoses that this author was unable to define. As for the

diagnoses that did not fit in one of the 24 diagnostic groupings, six additional categories were created for a total of 30 diagnostic groups (see Table XI).

In terms of patient volumes there appeared to be a sufficient patient base in all but two of the top 20 diagnostic categories: patients with Contraception needs and those in need of Immunizations. In fact there were no patients seen with *contraceptive needs* in the FHC in four of the five years sampled, yet the graduates rated their experiences as very good with an above average mean score. For patients with *immunization visits* the SJH graduates again rated their experience as positive even with patient volumes initially low during the same five-year period. Two possible explanations exist for the above average ratings; the *first explanation* could be that the residents saw a sufficient patient volume of both types in rotations occurring outside of the FHC, which met their needs. A *second explanation* could be the fact that there were a variety of lectures offered to the graduates on a daily and weekly basis that also may have exposed them to the two diagnoses; or perhaps it was both explanations combined (see Appendix III a – d).

In the areas of counseling and behavioral management (categories 21 to 24) as identified in Part II of the questionnaire, five graduates stated in their comments that their training was insufficient, and that it did not prepare them for the patients that they are seeing in their current clinical practice. Though the patient volumes in these areas were lower than the volumes found in the first 20 diagnostic categories, graduates did have access to a full time Post Doctoral Behaviorist and FHC physician faculty for advice and assistance. The residents also had two rotations during the course of their three years of training at two-week intervals, along with lectures provided by the behavioral science team to compliment their training. In addition there were a variety of

physician lectures that focused directly and indirectly on topics revolving around the areas of counseling and behavior management. One such series of lectures was the weekly *Visiting Professor Series* that was offered to the residents and physician medical staff, and coordinated by this author, whereby guest faculty were invited to speak on a wide range of topics to meet the needs of the medical community.

With regard to the four office management questions in Part I of the questionnaire, 44 graduates stated that they were actively involved in the field of family practice. Of the 44, there were 39 who stated that they had employed an office manager (or coordinator) to serve as the contact person for their operational issues. For those in a *group practice*, there were 33 of 39 who stated that they employed an office manager and that they and their partner(s) took an active role in scheduling, evaluating, and meeting with their office staff. There were also six *solo-practitioners* who employed an office manager, stating that they were directly involved in the operational side of the office practice. Of the five practitioners who stated that they did not have an office manager, three were in a group practice and two were solo-practitioners. For those in the group practice, one did not employ a manager and noted that neither he nor his partner(s) had any involvement in the daily operations of their office. The remaining two graduates reported that they took responsibility for staff scheduling but did not conduct staff evaluations or meetings. As for the two solo-practitioners, one stated that he alone was responsible for scheduling staff assignments and both graduates noted that they conducted regular staff meetings and evaluations.

In Part III of the questionnaire, the graduates recommended that residents should know four primary areas of office management before venturing out into a clinical practice,

those areas were defined as follows: financial, personnel, legal, and computerization. With respect to Part IV of the questionnaire, the majority of graduates stated that the office-based rotations with the physician medical community for the most part were positive. However, the graduates commented there was not enough time to fully appreciate the rotation and that there could have been more structured time spent with the business side of the physician practices. The graduates recommended that the RPM rotations continue to utilize the physician offices within the Genesys Health System but focus should be on those physicians who manage an efficient and productive office practice. It was recommended that the RPM rotation be moved to the second half of the residents third year of training when possible, increasing the amount of time from three half days to five half days per week in those offices. Given the recommendations, dedicated teaching time should be increased in certain areas of the RPM curriculum that focus on the financial aspects of the clinical practice. Consideration should also be given to inviting back the SJH alumni who would be willing to share their office experiences and views on how to manage a successful clinical practice.

When educating residents, it is important for program directors and teaching faculty to be reminded of the fact that the ability to remain autonomous in their clinical decisions has been waning over the last 50 years. Residents should be taught how to defend their clinical decisions and the importance of judicious administration of medical resources. Boelen (1995) noted this fact stating that increasingly the general public has demanded that physicians be accountable for how they administer medical services to patients and reconcile the resources needed to support the services to ensure efficiency in their clinical practice. Boelen's beliefs can be supported with the Libby Zion case whereby the

general public and the New York state government challenged the clinical decisions made by a resident physician, accusing both the resident and hospital of medical mismanagement that caused her death. Though the hospital was exonerated from any malpractice liability, recommendations were made to change key residency guidelines, changes that have been adopted by the ACGME. From this perspective, residency programs must include in their curriculum an emphasis on physician accountability for as Boelen wrote: "what is good for society can no longer be determined soley by professionals and the institutions that deliver the goods, that the arguments being voiced by the non-professional groups and consumers reflect a general democratization of society that aims at given every citizen a chance to be heard."

CONCLUSION

The ambulatory setting is a key component for the family practice residency curriculum. The emphasis on ambulatory training is driven by a number of factors, one of which is the demand from the general public for more competent physicians who can use "scientific knowledge, clinical experience, and a thoughtful approach to value choices." To that end family practice residency programs should routinely assess the effectiveness of its ambulatory curriculum, making changes as needed to meet the healthcare demands of society and the general public. From an ambulatory perspective, the type of patients and volume seen in the FHC on an annual basis is important and should be compared to the top 20 or 30 most commonly seen ambulatory patient problems as reported by the Department of Health and Human Services. When patient volumes are less then adequate in the FHC for teaching purposes, the program director should find an alternative activity to compliment the ambulatory curriculum. With respect to the RPM rotation, dedicated teaching time should be increased when residents are rotating through the physician offices, as per the comments from the graduates who responded to the questionnaire. However this author also believes that residents must assume some responsibility for how they choose to learn. For the SJH residents, a number of educational opportunities were made available to them from within the hospital setting, the ambulatory physician offices, ambulatory sites such as the Family Health Center, daily and weekly lectures, and of course reading/self study. Consideration should also be given to inviting back the SJH alumni who could share their experiences and views on how physicians might succeed in managing a successful clinical practice. Important is the fact that program directors must be prepared to defend

their residency curriculum to accreditation agencies, the general public, and governmental groups. This author recommends that another alumni survey be conducted with the same set of questions to compare how well the family practice program is doing as compared to the current study in preparing its residents for a successful clinical practice. The new study may want to include the same group of graduates from this authors study but with one difference, the repeated survey should also inquire as to what if any changes have been made by the graduates to improve their clinical practice since the last survey. Also, the family practice program should examine the patient mix or balance of patients seen in the FHC and/or the ambulatory rotations in general. Comments from the graduates in this authors study suggest there may be to much emphasis placed on obstetrical training and pediatric training, and not enough on patients 18 years of age and older, and on problems involving counseling, substance abuse, and behavioral issues. The information obtained from the survey would be used, as part of the internal review process for the GRMC and recommendations made by the graduates will be considered when updating the residency curriculum.

Appendix 1 a

GENESYS REGIONAL MEDICAL CENTER
One Genesys Parkway
Grand Blanc, MI 48439-8066

September 7, 2000

Dear Graduate:

A few months ago you received a survey relative to a study that is being conducted about your ambulatory care experience at the Genesys: St. Joseph Hospital Family Practice Program. As part of an Internal Review Process, the information collected will be used, if necessary, to make adjustments to the current ambulatory curriculum. If you have not completed and returned the survey to us would you please take the ten (10) minutes to answer the questions and return it using the self-addressed prepaid envelope.

The survey itself is broken down into four parts. Part I is background information... you are not required to give us your name unless you would like a copy of the survey results – all responses will be kept confidential. Parts II and III should be answered by all graduates, while Part IV should be answered by those of you who completed a rotation in Research Practice Management (RPM) within the last five years.

Your help in completing this survey in a timely manner will be most appreciated. As the new Program Director for the Family Practice Residency, I feel privileged to be part of a great tradition that is coming up on its 30Year anniversary. With your help, we can better prepare our future graduates for the challenges that face them in this next millennium.

Should you have any questions, please contact Tom Drabek at 810-605-5128 or email him at tdrabek@genesys.org.

Sincerely,

Kenneth E. Yokosawa, MD

Kenneth E. Yokosawa, M.D.
Director, Family Practice Residency Program
Genesys Regional Medical Center

Appendix 1 b

St. Joseph/Genesys Family Practice Survey - 2000

PART 1: BACKGROUND INFORMATION

For the questions below please fill in the blank, circle or check your answer.

What is your Age? _____ What is your Gender? Male_____ Female_____

Are you an International Medical Graduate? Yes___ No___

In what Year did you graduate from the Family Practice Program? _____

Are you Board Certified in Family Practice? Yes___ No___

Are you currently practicing Family Medicine? Yes___ No___ If no, what are you currently doing? _____

What is the population of the community where your practice is located?

(<20,000) _____ (<50,000) _____ (<100,000) _____ (>100,000) _____

What is your *type of practice*? Solo Group Military Other = _____

Do you have a *manager or coordinator* run your office? Yes ___ No ___

Do you assist your manager/coordinator in *staff scheduling*? Yes ___ No ___

Are you involved in *Evaluating your office staff*? Yes ___ No ___

Do you meet with *your office staff* at least once per month? Yes ___ No ___

On average, what is the number of patient's visits per year? _____ Of those, how many of these patients are under the age of 17 years? _____

Are you providing prenatal care to your patients? Yes ___ No ___ If yes, do you perform the delivery? Yes ___ No ___ Average # per year? _____

If you would like a copy of the results, please complete the info below:

Name: _____

Address: _____

_____

_____

Appendix 1 c

PART II:

In looking back at the context of your ambulatory care experience at the Genesys – St. Joseph Hospital Family Practice Health Center, please respond to the patient problems and activities below as to how adequately the Family Health Center prepared you to manage the various types of patient problems and practice activities?

I Was Adequately Prepared To Manage the Following Patient Problems & Activities	(PLEASE CIRCLE YOUR RESPONSE) Strongly Disagree				Strongly Agree
1. Hypertension.....	1	2	3	4	5
3. Well Child Examinations.....	1	2	3	4	5
4. Diabetes Mellitus.....	1	2	3	4	5
5. Prenatal Care.....	1	2	3	4	5
6. General Medical examination.....	1	2	3	4	5
7. Otitis Media.....	1	2	3	4	5
8. Bronchitis.....	1	2	3	4	5
9. GYN Examinations.....	1	2	3	4	5
10. Sinusitis.....	1	2	3	4	5
11. Depression.....	1	2	3	4	5
12. Vaginitis.....	1	2	3	4	5
13. Urinary Tract Infections/Cystitis.....	1	2	3	4	5
14. Back Pain.....	1	2	3	4	5
15. Immunizations.....	1	2	3	4	5
16. Abdominal Pain.....	1	2	3	4	5
17. Congestive Heart Failure.....	1	2	3	4	5
18. Diagnosing Pregnancy.....	1	2	3	4	5
19. Contraception.....	1	2	3	4	5
20. Arthritis.....	1	2	3	4	5
21. Marriage/Family Counseling.....	1	2	3	4	5
22. Alcoholism/Substance Abuse.....	1	2	3	4	5
23. General Counseling.....	1	2	3	4	5
24. Behavioral Problems (Ages 2 to 17)...	1	2	3	4	5

OPTIONAL RESPONSE:

If you strongly agree or strongly disagree with any of the above areas, we encourage you to please turn to the next page, identify the patient problem or activity by the number and provide us with a brief explanation.

Appendix 1 d

(I strongly agree or strongly disagree because...)

ITEM #BRIEF EXPLANATION

Appendix 1 e

PART III:

Currently, our family practice residents are required to do a Research and Practice Management (RPM) rotation. Please answer the following questions:

1. **What are the three most important things for our family practice residents to know when running and managing a clinical practice?**

   (1) _____

   (2) _____

   (3) _____

2. **What is your biggest challenge today when it comes to practice management?**

   _____

   _____

   _____

   _____

3. **What practice management challenges will face are future family practice residents?**

   _____

   _____

   _____

   _____

4. **In retrospect, when you first organized and began managing your new office practice, what preparation and/or key information, if any, would you recommend that we teach our residents?**

   _____

   _____

   _____

   _____

5. **Have you come in contact with any of our family practice graduates? If yes, have you observed any gaps in knowledge, skills, or attitudes relative to practice management?**

   _____

   _____

   _____

   _____

PART IV:

If you who graduated in 1995, 1996, 1997, 1998, or 1999, please answer the questions about your Research Practice Management (RPM) Rotation:

1. **What was the best element of the RPM Rotation?**

   _____

   _____

2. **What was the worst element of the RPM Rotation?**

   _____

   _____

3. **What should we change about the RPM Rotation?**

   _____

   _____

4. **What should we make sure remains the same on the RPM Rotation?**

   _____

   _____

5. **What is your reaction to the following proposals:**
   (1) Move the RPM Rotation to the second half of the 3rd year (January to June).

   _____

   _____

   (2) Increase the amount of time from 3 to 5 half days per week that residents are in the various office practices to observe practices to observe the office flow.

   _____

   _____

   (3) Increase the number of office sites residents see during their RPM Rotation, for example: residents would go to a different office setting each week.

   _____

   _____

6. **What is your overall opinion of the RPM Rotation?**

   _____

   _____

   _____

   _____

Appendix II

Responses to Part III of the Questionnaire

The comments below are in response to what the graduates should know when beginning a new clinical practice with duplicative responses grouped together:

Question 1: ***What are the 3 most important things for our family practice residents to know when running and managing a clinical practice?***

- 17 Responses: Understand billing, coding, collections, and insurance forms.
- 14 Responses: Personnel issues: hiring, delegation, evaluation, and dismissal.
- 7 Responses: Understand HMO's and reimbursement mechanisms.
- 7 Responses: Management training, scheduling, and managing large numbers of patients.
- 3 Responses: Medicare fraud laws, regulatory issues and proper patient documentation.
- 3 Responses: Development of sound business skills (e.g.: choosing a group practice).
- 3 Responses: Developing good time management skills.
- 3 Responses: Establish good practice management skills; maintain good doctor/patient relations as well as patient satisfaction.
- 2 Responses: Ability to delegate responsibility to staff and make them feel part of the practice.
- 2 Responses: Know ones limitations and when to refer to a sub-specialist.
- 2 Responses: When managing capitated patients, understand how to assess the viability.
- 2 Responses: Stay focused on caring for patients; make sure to follow lab results.
- 1 Response: Should be aggressive about medical resource utilization.
- 1 Response: Don't overwhelm your practice with managed care patients.
- 1 Response: Avoid total dependence on others.
- 1 Response: Establish and maintain a good rapport with ones peers.

- 1 Response: Pay your good employees a good wage.
- 1 Response: Focus on community/preventive care, and early diagnosis and treatment.
- 1 Response: Computerize your practice.

Question 2: ***What is your biggest challenge today when it comes to practice management?***

- 17 Responses: Coding, billing, referrals, & dealing with insurance companies.
- 11 Responses: Practicing cost-effective medicine while limiting overhead and maintaining a reasonable flow of patients.
- 9 Responses: Knowing the expectations of HMO's, PPO's, and 3rd party payer groups.
- 8 Responses: Getting employees to do their job well and be happy.
- 5 Responses: Employee recruitment, selection, management, delegation and termination.
- 4 Responses: Time management as it relates to scheduling and seeing patients.
- 3 Responses: Understanding budgets, finances, non-billable accounts, and accounts receivable.
- 2 Responses: Changes in reimbursement mechanisms.
- 2 Responses: Need to know formularies.
- 1 Response: Electronic medical records.
- 1 Response: Patient outcomes.
- 1 Response: Where patients can go and where they can't go.
- 1 Response: Physicians unwillingness to accept a role in fiduciary accountability with patients.

Question 3: ***What practice management challenges will face future family practice residents?***

- 7 Responses: Computer technology: charting, Internet, & web-advertisement.
- 5 Responses: Managed care, proving cost-effectiveness and being accountable.

- 5 Responses: No room for sloppy patient management must be business savvy with time constraints pushing you to be effective.
- 5 Responses: Time management for balancing both personal and business activities; avoid doing more than able to realistically able to do.
- 2 Responses: Business management skills; program should partner with colleges.
- 1 Response: Management of overhead costs.
- 1 Response: Liability issues.
- 1 Response: Practice management issues will not get any better.
- 1 Response: Employed physicians will have no control of their practices.
- 1 Response: Training the office staff to deal with patient scheduling issues.
- 1 Response: Becoming lazy and unwilling to sacrifice.
- 1 Response: Physicians will be more accountable; need to know more.
- 1 Response: Be willing to change patient perception.
- 1 Response: DRG's and Medicare issues.
- 1 Response: Discern hospital administration techniques in control of your practice.
- 1 Response: Employee – Employer relationship.

Question 4: ***In retrospect, when first organizing your office practice, what key information, would you recommend that we teach our residents?***

- 8 Responses: Understanding finances and running an office.
- 7 Responses: Understanding coding, billing, and capitation.
- 5 Responses: Personnel management: hiring, firing and staff evaluations.
- 4 Responses: Be prepared to run a practice well.
- 3 Responses: Make sure your credentials are in order before signing up for insurance groups.
- 3 Responses: Have a business plan.
- 3 Responses: Understand the legal and business side of running a practice.
- 2 Responses: Knowing about formularies, documentation and billing.
- 2 Responses: Hire a good account and patient and insurance biller.

- 2 Responses: Understanding contracts.
- 2 Responses: Maintain a positive attitude through good communication skills.
- 2 Responses: Exploring model practice situations.
- 2 Responses: Managing a Medicare practice.
- 1 Response: The ability to conduct a self-audit relative to quality indicators.
- 1 Response: Hire an office manager.
- 1 Response: Don't purchase unnecessary items at the start of your practice.
- 1 Response: Time management.
- 1 Response: Understanding the conditions of joining a group practice.
- 1 Response: Know how to schedule patients.

Question 5: ***Have you come in contact with any of our family practice grads? If yes, have you observed any gaps in knowledge, skills or attitudes relative to practice management?***

- There were 16 Yes Responses:

  A few respondents reported that they observed difficulty with some the graduates working in large group practices, otherwise they did not see any gaps in their knowledge but noted learning is ongoing.

- There were 22 No Responses:

  There has been no contact with previous graduates.

Responses to Part IV of the Questionnaire

The questions below were directed at the physicians who had graduated either from 1995 through 1999 relative to their Research/Practice Management (RPM) rotation. Their comments were grouped due to duplicative responses to these questions.

Question 1: ***What was the best element of the RPM rotation?***

- 5 Responses: Exposure to a variety of good practice management offices.
- 3 Responses: Seeing how a real medical practice flows and operates.
- 3 Responses: There was an opportunity to better understand research.
- 1 Response: Exposure to computer skills.
- 1 Response: Thought the competition for the research awards was a good.

Question 2: ***What was the worst element of the RPM rotation?***

- 2 Responses: Physician offices not always helpful; some offices were slow.
- 2 Responses: There was not enough time.
- 1 Response: A bad experience if it was in the wrong practice.
- 1 Response: Billing and learning about PHO's.
- 1 Response: Value to long term set goals was not established.
- 1 Response: There was not enough time to work on Research Projects.
- 1 Response: Exposure to the Dort Highway Faculty Practice.
- 1 Response: Performing routine stuff (Blood Pressures, Temps) in FHC.
- 1 Response: Dissatisfied with the entire rotation.
- 1 Response: Not enough managed care exposure.
- 1 Response: Conducting statistical analysis.

Question 3: ***What should be changed about the RPM rotation?***

- 4 Responses: More experiences with staffing and billing.
- 3 Responses: There is a need for more structure to the rotation.
- 2 Responses: Have speakers from outside of the system speak on billing.

- 1 Response: Have the ability to sit down with the support staff/personnel.
- 1 Response: List tasks residents should know when starting a practice.
- 1 Response: Separate the rotation into two-week blocks with no vacation.
- 1 Response: Move the rotation out of the FHC.
- 1 Response: Should be spending time with a chart reviewer.
- 1 Response: Should spend more time on research aspects of the rotation.

Question 4: ***What should remain the same on the RPM rotation?***

- 4 Responses: Continue to visit the various physician offices within the Genesys Health System.
- 2 Response: Spend more time with the good physician practices.
- 1 Response: More exposure to successful office practices.
- 1 Response: Continue with the research projects.
- 1 Response: Overhaul the entire system.

Question 5: ***What is your reaction to the following 3 proposals?***

(1) Moving the RPM rotation to the second half of the 3rd year?

- 10 Responses: A good idea.
- 3 Responses: No difference either way.
- 1 Response: If you move the rotation a lot less will get done.

(2) Increase the amount of time from 3 to 5 half days per week that residents are in the various physician offices to observe the office flow?

- 7 Responses: Would agree with the statement as long as it is not in the FHC or specialist's office but that in a family practice office.
- 6 Responses: It is unnecessary to adjust the amount of time.
- 2 Responses: Agree to increase providing it's not in the current format. Recommend one half day of lectures from the preceptors.

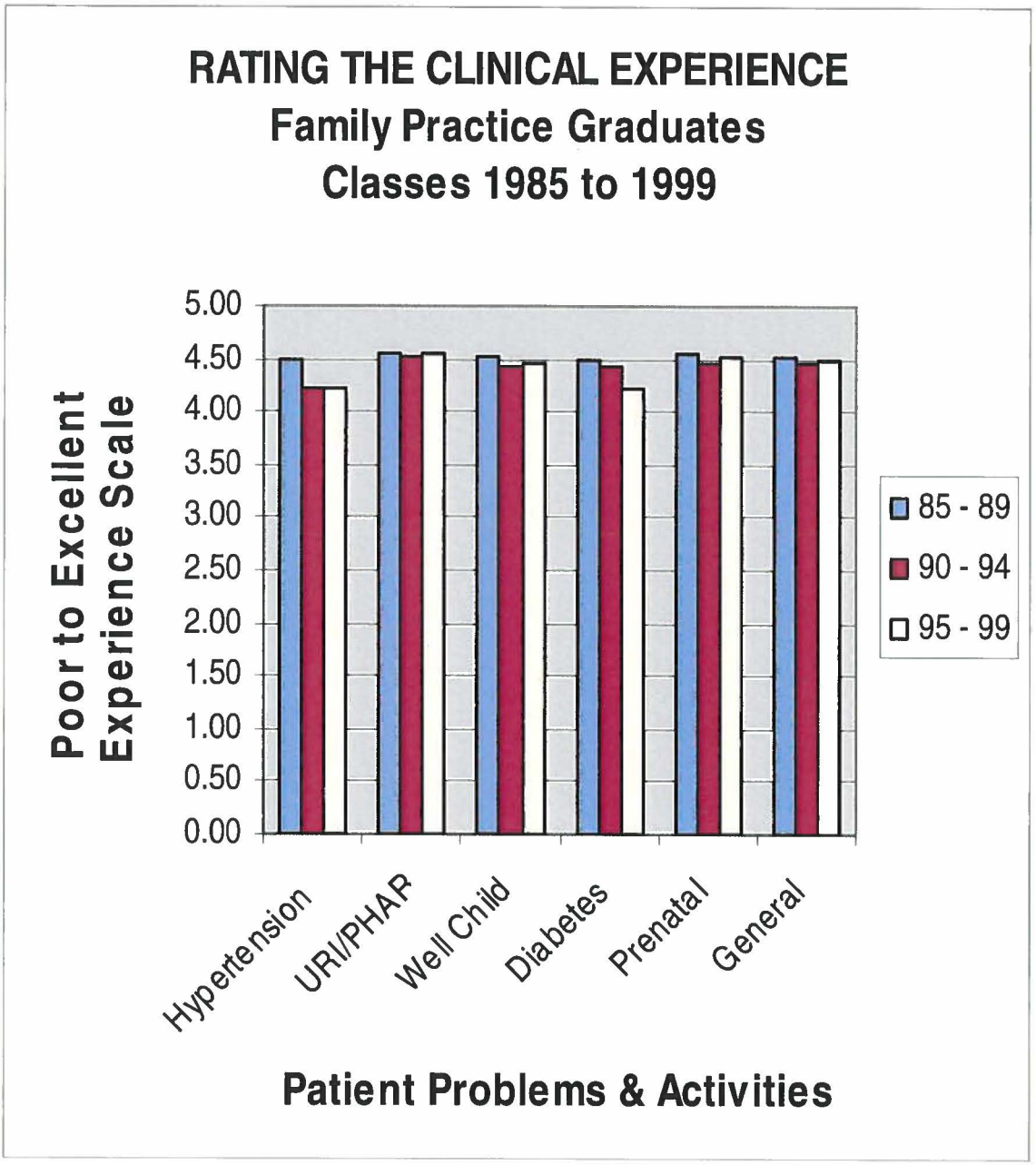
(3) Increase the number of office sites residents sees during the RPM rotation, for example: residents would go to a different office setting each week.

- 9 Responses: Good idea, it would allow for more practice styles.
- 3 Responses: Would agree but it should require structured visits.
- 1 Response: Maybe two more office rotations however you would want to avoid diluting experience.
- 1 Response: Leave it optional if the resident wants more exposure.

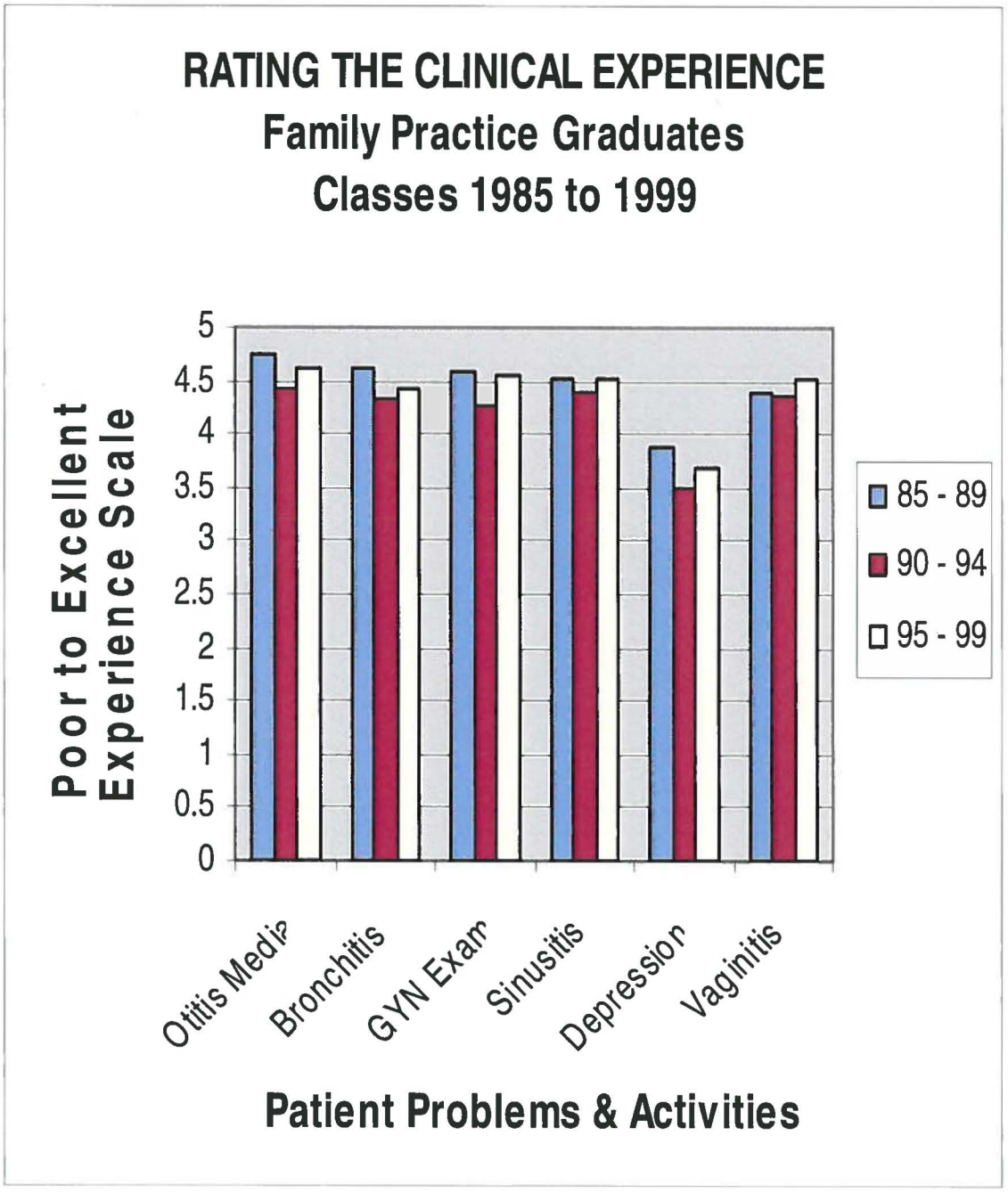
Question 6: ***What is your overall opinion of the RPM rotation?***

- 9 Responses: The rotation has been a good tool, very useful.
- 1 Response: Residents need to experience a variety of group practices.
- 1 Response: Need to see a variety in billing procedures and encounter forms.
- 1 Response: The rotation was weak due to a lack of focus.
- 1 Response: Some faculty could spend more time helping with resident projects.
- 1 Response: Need to stress implementation issues.
- 1 Response: Rotation had good intentions but inadequate in terms of usefulness.
- 1 Response: Not bad.

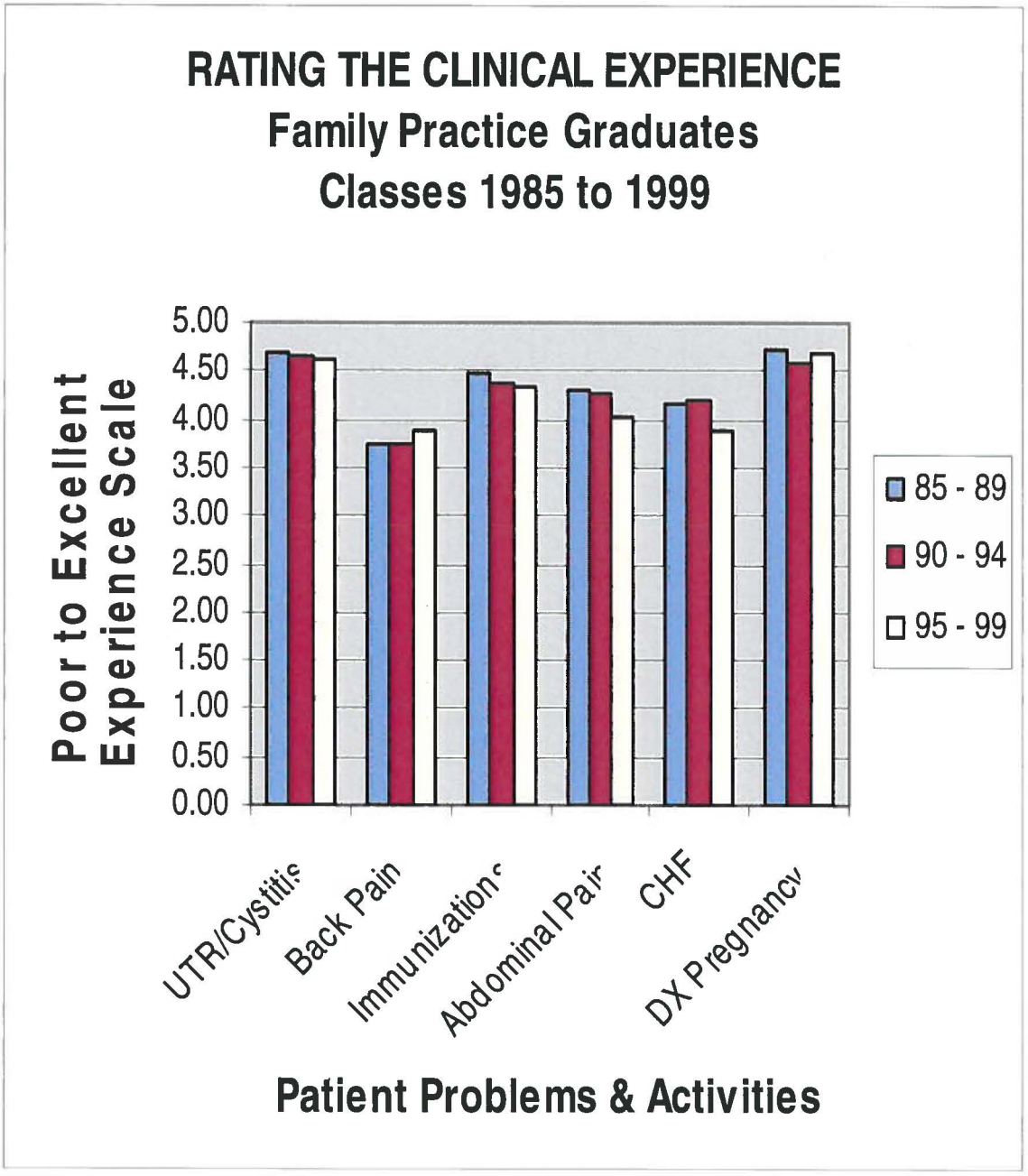
Appendix III-a



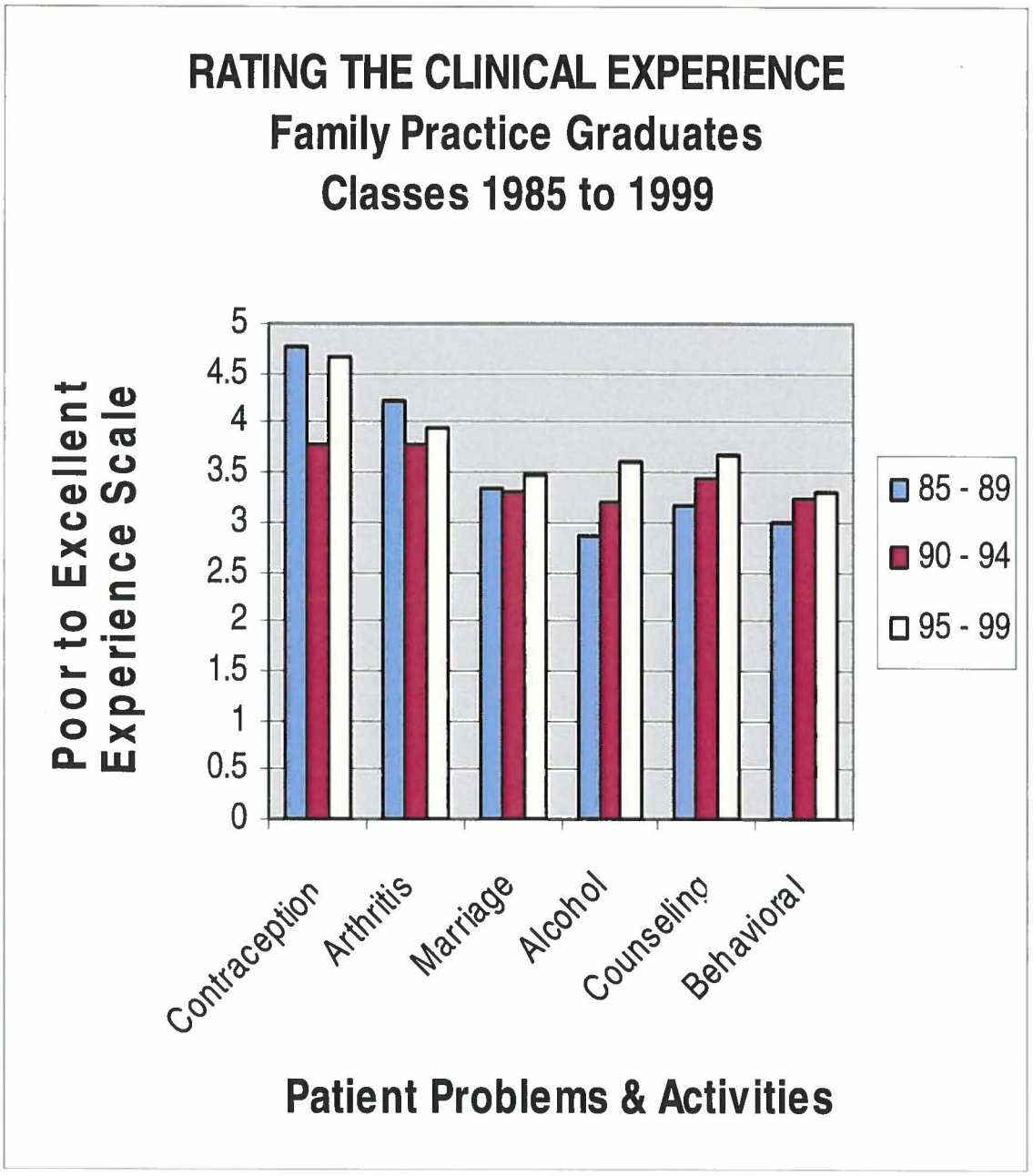
Appendix III-b



Appendix III-c



Appendix III-d



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