UNIVERSITY OF MINNESOTA

Pursuant to 1992 Laws, Chapter 549,
Art 6, Sec tion 4, subd 5 and coded
Mn Stat 137.38

EDUCATION AND TRAINING OF PRIMARY CARE PHYSICIANS

February 1993

University of Minnesota Medical School Partnership with MinnesotaCare
Revised Progress Report

Executive Summary

MinnesotaCare legislation passed in 1992 asked the University of Minnesota Medical School campuses in Minneapolis and Duluth to increase the supply of primary care physicians. Specifically, the Medical School was asked to develop programs that will increase the number of residency program graduates who practice primary care (family practice, pediatrics, medicine) in Minnesota by 20 per cent by the year 2000, and encourage graduates to establish practices in areas of rural Minnesota that are medically underserved.

The Medical School has responded by initiating curriculum reform at the medical student and primary care residency levels. A Dean's Committee was established to oversee the new primary care training activities, and a Task Force on Primary Care Education has been formed. A demographic study is in progress to measure student characteristics associated with choice of a primary care career. Modifications of curriculum design and clinical experiences emphasizing primary care are being studied with prompt implementation planned at the third and fourth year levels.

Primary care residency initiatives are being implemented in all three primary care departments. The Department of Family Practice developed a new rural residency program in which 12 residents spend their first year training in the Twin Cities, and their second and third years training in a rural community and regional medical center. Rural and regional training sites are currently being selected with the first class entering the new program in July 1993.

The Department of Pediatrics initiated profound curriculum changes during 1992 emphasizing primary care including a 400 per cent increase in outpatient clinic training time, a new community-based primary care clinic network, new rural and urban community-based primary care training electives, a new general pediatric post-residency fellowship in academic general pediatrics, and faculty development in primary care teaching. Ten residents have elected the rural training experience in the past seven months, and five have elected the urban community-clinic experience.

The Department of Medicine new primary care initiatives include expansion of ambulatory care training, expansion of the general medicine fellowship, and general medicine faculty development.

Continuing medical education developed by the Medical School in 1992 continues to emphasize primary care with 26 primary care courses taught in the Twin Cities, 66 lectures in non-metropolitan communities, and 20 audio teleconferences. In total, about 50,000 Minnesota physicians participated in these educational activities.

Significant progress has been made in the first seven months of the Medical School's partnership with MinnesotaCare. Medical School emphasis on new primary care programs and course development will continue into the 21st century.

The UMD School of Medicine has developed short-term and long-range initiatives to enhance its national leadership in training rural family physicians. A department of Family Medicine will further strengthen the rural, family practice emphasis of the school. Preventive health focus will be added to the medical students' training. The new department will work closely with the Minneapolis Medical School to develop new rural educational and research programs.

Duluth's Family Practice Center, recognized for its excellence in placing family physicians into rural Minnesota, will expand its residency over the next several years, working toward the goal of increasing by one-third (nine students).

Research methods for improving rural health care are being developed. Several Health Sciences units are working with selected rural communities throughout the State. Each community is to serve as a demonstration site, creating a "partnership" with Health Sciences to assist in developing newer approaches to health care delivery. These sites will also be used for interdisciplinary education for students and residents from multiple health professions. They will train together in these small communities, preparing for the future delivery of rural health care.

University of Minnesota Medical School
Partnership with MinnesotaCare

Revised Progress Report
February 22, 1993

Summary of Health Professional Education in the HealthRight Act
(Chapter 549, Article 6, Sections 4 - 6)

Sec. 4. [137.38] EDUCATION AND TRAINING OF PRIMARY CARE PHYSICIANS.

Subd. 1. CONDITION of funding acceptance by the Board of Regents.

Subd. 2. PRIMARY CARE definition: A type of medical care delivery that assumes ongoing responsibility for the patient in both health maintenance and illness treatment. It is personal care involving a unique interaction and communication between the patient and provider. It is comprehensive in scope, and includes the overall coordination for care of the patient's health care problems including biological, behavioral, and social problems. The appropriate use of consultants and community resources is an important aspect of effective primary care.

Subd. 3. GOALS. Increase the number of graduates of residency programs of the medical school who practice primary care by 20% over an 8-year period; and encourage graduates to establish practices in areas of rural Minnesota that are medically underserved.

Subd. 4. GRANTS. Seek private and nonstate grants for medical school primary care training initiatives.

Subd. 5. REPORTS. Report progress annually on January 15 to the legislature.

Sec. 5. [137.39] MEDICAL SCHOOL INITIATIVES.

Subd. 1. MODIFIED SCHOOL INITIATIVES. Study demographic characteristics of students who select primary care careers, and modify the selection process accordingly.

Subd. 2. DESIGN OF CURRICULUM. Ensure that the curriculum provides students with early exposure to primary care, and support premedical school educational initiatives that provide students with greater exposure to primary care physicians and practices.

Subd. 3. CLINICAL EXPERIENCES IN PRIMARY CARE. Provide students at both medical school campuses with internal medicine and pediatric primary care experiences, including rural practices, community clinics, and Twin Cities HMO's.

Sec. 6. [137.40] RESIDENCY AND OTHER INITIATIVES.

Subd. 1. PRIMARY CARE AND RURAL ROTATIONS. Increase general medicine, pediatrics, and family practice primary care training experiences, including rural practices, community clinics, and HMO's.

Subd. 2. RURAL RESIDENCY TRAINING PROGRAM IN FAMILY PRACTICE. Establish a rural family practice residency program in which the second and third training years are based in rural communities utilizing local clinics and community hospitals with specialty rotations in nearby regional medical centers.

Subd. 3. CONTINUING MEDICAL EDUCATION. Develop continuing medical education programs for primary care physicians that are community-based and accessible in all areas of the state.

Medical School Responses to the HealthRight Act

I. EDUCATION AND TRAINING OF PRIMARY CARE PHYSICIANS (Sec. 4)

A. **Central Coordination** (Sec. 4, Subd. 3)

In July 1992, Dean David Brown appointed the HealthRight Oversight Committee to coordinate primary care training initiatives in the three primary care departments (Family Practice, Pediatrics, Medicine) and in the medical school, and to prepare the annual legislative report. The Committee is charged with increasing the number of graduates of residency programs of the Medical School who practice primary care (family practice, general pediatrics, general medicine) by 20% by the year 2000. This means an increase in family practice graduates from 73 to 77 per year, in general pediatrics from 11 to 14 per year, and in general medicine from 15 to 20 per year. Since each residency is three years in length, the overall number of primary care trainees will increase in family practice from 219 to 231, in general pediatrics from 33 to 42, and in general medicine from 45 to 60.

The School has committed to central coordination of primary care experiences and curricula with regard to undergraduate medical education. The Educational Policy Committee has requested the formation of a **Task Force for Primary Care Education,** which will be responsible for this central coordination. Dr. Nicole Lurie will chair this task force.

Initial activities will include both a series of action steps and the creation of a plan and timeline for change. Immediate action steps will include:

- Conduct of a study of matriculants to determine predictors of choosing primary care careers.
- Expansion of early clinical exposure to appropriate primary care role models (years 1 and 2).
- Providing student opportunities to take the required ambulatory care course in year 3 rather than year 4.

B. **Grants (Sec. 4, Subd. 4)**

The new focus on primary care training in pediatrics led to the Pediatric Department's recent submission of a federal Primary Care Training Grant proposal to expand the activities recently implemented under HealthRight.

II. MEDICAL SCHOOL INITIATIVES (Sec. 5)

A. **Student Demographic Characteristics Associated With A Primary Care Career Choice (Sec. 5, Subd. 1)**

Studies of two groups of graduates from the University of Minnesota Medical School

are in progress. The first group consists of graduates from the classes of 1991 and 1992. The second set includes graduates of 1985 and 1987, who are in practice or completing specialty training beyond the period required to enter primary care practice. Each of these groups will be divided between those who entered primary care specialties (Family Practice, Medicine, and Pediatrics) and those who selected all other specialties.

For the 1991-92 group, we are analyzing demographic data derived from the Association of American Medical Colleges (AAMC) Matriculation and Graduation Questionnaires. The Matriculation Questionnaire is administered to all entering students on the first day of medical school. The Graduation Questionnaire is administered to seniors at the time they are completing their residency selection process in the Spring of their fourth year. Students entering the University of Minnesota Medical School in Minneapolis, as well as the School of Medicine in Duluth, have been included in the study. The results of the questionnaires are tabulated by the AAMC, which derives national statistics as well as individual school results from this data. The AAMC has provided us with the responses to the two questionnaires of those 1991 and 1992 graduates who agreed to release their information. These questionnaires are the source of the demographic data that will be analyzed initially. Some of the items that will be analyzed include:

- Age
- Sex
- Year of the completion of the first degree
- Early specialty choice information
- Desired size of the future practice community
- Type of practice setting
- Educational level and income of the parents
- Financial aid and indebtedness information
- Information about marital status
- Education and indebtedness levels of the spouse
- Factors involved in the specialty choice decision,
- Plans for primary care practice.

Primary care and non-primary care groups as a whole will be compared. In addition, we will divide the two groups between the students who matriculated in Minneapolis and those who attended the Duluth school.

The second study will involve 1985 and 1987 graduates. These two classes were selected because we already have data about which of these individuals are in practice in the three primary care specialties. We will analyze their Graduation Questionnaire data to determine if there are differences between the two groups of practitioners with regard to the demographic data available from the questionnaire. We will also compare the Duluth and Minneapolis students within the groups.

Data has been received from the AAMC, and computer programs are being used to obtain descriptive and inferential statistical analyses to study the issues described

above. The computer analysis will provide the responses to each relevant question, statistically computed for the different groups. Initial data from the 1991 and 1992 groups indicates differences in attitudes and values between those graduates selecting the three primary care specialties and those choosing other specialties.

Should it be necessary, we are prepared to investigate whether additional information about these groups of students, such as size of hometown, and academic performance data prior to and in medical school might be predictive of a decision to enter primary care. Since this information is not readily available, we have decided to focus our initial efforts on the information that can be obtained from the AAMC questionnaires.

A complete report will be available in June 1993. Results of this study will be presented to the Admissions Committees of both medical school campuses.

B. Curriculum Design and Clinical Experiences in Primary Care (Sec. 5, Subd. 2-3)

The University's Department of Family Practice has pioneered studies of primary care medical education, resulting in one of the premier primary care training experiences in the United States. As the primary care focus expands to rural access and includes the specialties of general pediatrics and general medicine, new training methods must be developed. The new Task Force for Primary Care Education will spearhead these efforts.

The Task Force will conduct an in depth review of goals and desired primary care skills of medical school graduates, as well as those of graduating residents and practicing physicians. Methods will include interviews, focus groups, surveys, site visits and a primary care conference. Existing primary care curricula will be reviewed with the aim of coordinating primary care education and developing a curriculum within which primary care is integrated into all four years, in a skill building fashion.

The Task Force will suggest modifications to the years 3 and 4 medical student curriculum seeking a rapid impact on medical student career choices. Simultaneous work will begin with year 1 and 2 students to identify meaningful primary care educational experiences.

Based on the above and in concert with the Educational Policy Committee, a policy-relevant timeline will be developed for assuring that essential curricular elements are incorporated into the curriculum. In particular, attention will be given to:

- Recruit additional primary care physician mentors, and identify pre-clinical mentors for students potentially interested in primary care. Establish relationship between student and mentors prior to beginning of medical school, e.g. by expanding the rural observation experience (now offered by family practice) to include urban sites and all primary care disciplines.

- Incorporate components of primary care and population-based knowledge into basic science training.

- Develop an ambulatory care rotation in 3rd year. Creation and feasibility test of continuing primary care experiences for 3rd and 4th year students, both at University-affiliated and community practice sites.

- Create additional RPAP-like experiences (electives) of 4 to 12 weeks in both rural and urban sites in pediatrics and general medicine. These should have both a clinical practice component and a community based/public health responsibility component. A component will be based at the Duluth school.

- Create a required or elective family practice clerkship.

- Identify and develop additional intellectual/scholarly experiences for students interested in primary care.

- Develop a 4th year elective and/or CME course tying developments in basic science to primary care.

No curricular changes will be implemented without evidence to support their effectiveness and without evaluation of their effects. To that end, these suggested activities may be modified if there is evidence suggesting the need to do so.

We expect to complete the study and planning process over the next year, and to have some curricular changes in place by January 1994.

C. Statewide Primary Care Conference

The Task Force will sponsor a statewide primary care conference. Participants will include: state government leaders; leaders in the managed care community; representatives for rural primary care practitioners, organized family practice, pediatrics, and general medicine in Minnesota; current medical students; recent graduates of the University of Minnesota School of Medicine and residencies in medicine, family medicine, and pediatrics who have entered rural or urban primary care practices; and community preceptors involved in teaching in all 4 years. The goals of this conference will be to:

- Create an awareness and sense of ownership and responsibility for the production of primary care practitioners on the part of the broader state community.

- Provide participants with the opportunity to tell the School how they can and want to help in the education and production of primary care physicians.

- Seek input from participants regarding the training and skills necessary to

enter primary care practice.

- Gather additional information regarding core primary care skills necessary for all practitioners of primary care, regardless of specialty.

- Seek partners (rural and urban primary care sites) for mentoring and training medical students.

D. Primary Care Faculty Development

More academically respected primary care faculty scholars must be recruited to the Medical School. This will require development and expansion of post-residency training programs in primary care research, including health services research, clinical epidemiology, preventive care, and medical education.

II. RESIDENCY AND OTHER INITIATIVES

A. FAMILY PRACTICE RURAL RESIDENCY PROGRAM

1. Program Description

The Department of Family Practice has developed a new rural residency program to train 12 family practice residents in rural community and regional medical center settings. First year residents will train in the Twin Cities clinic and hospital facilities presently used in this department's University Affiliated Community Hospitals Residency Training Program in Family Practice and Community Health, which has graduated 749 family physicians over the past 20 years. Through this new rural family practice residency, the Department will increase from 73 to 77 the number of family practitioner graduates each year.

The incoming first-year residents will participate in orientation during the last week of June. This includes courses in neonatal resuscitation, cardiopulmonary resuscitation, and other basic emergency services training. This will be following by a two-week orientation at the rural community site and regional center. During this time the residents and their families will have the opportunity to meet rural faculty, become familiar with the regional medical center, the rural hospital and its faculty, and begin participation in the training program within the rural family practice center.

After the two-week orientation, the first-year residents will return to the Twin Cities site to complete their first year of training in the basics of surgery, internal medicine, pediatrics, psychiatry, emergency room medicine, etc. At midterm of the first year there will be another two-week visit to the rural site for the purpose of maintaining contact with the residents' physician teachers, other health care professionals and the community. A third two-week visit will occur toward the end of the first year. Thus, there will be a total of six weeks of family medicine service at the rural site during the first year of the residency.

In the second and third years, residents will live in the rural community and spend five half-days per week within the rural family practice center, one-half day in academic pursuits, i.e., community health research projects, and four half-days per week at the regional medical center. At the regional medical center, they will rotate with faculty from the center through various subspecialties such as orthopedics, cardiology, radiology, obstetrics, community psychiatry and behavioral medicine, surgery and pediatrics. Major portions of these rotations will be in the ambulatory offices of the specialists noted above. Some rotations may need to be carried out longitudinally since the subspecialists involved may be consulting to the regional medical center.

The program will include additional emphasis and training in high-frequency procedures such as fractures, emergency room trauma, minor surgery, and C-sections. This training will occur in both the regional and rural hospitals. Residents will provide major contributions to weekend and night call coverage in both the rural hospital and regional medical center.

During the half-days at the family practice center, the residents will provide ambulatory care for patients and make appropriate local hospitalizations. Obstetrical patients will be hospitalized at the community hospital; community-based faculty will supervise labor and delivery. The educational emphasis will include practice management and geriatric and chronic illness management.

Medical Student Rotations. A major objective of this proposal is to establish rural family medicine as a viable professional career option for medial students. Eventually medical student rotations will be developed within the rural residency program in an effort to interest students in choosing a career in rural family practice.

2. Current Status on December 31, 1992

The planning committee for the Rural Residency Training Program has met on numerous occasions. The overall structure of the program has been identified. Interest in participation by hospital and family physicians has been assessed and potential sites which meet the committee established criteria have been identified. There were originally 77 rural sites who applied for this program, in addition to 14 regional medical centers. The planning committee has narrowed this down to two regional medical centers and seven rural sites. Additional information is being gathered from this group with an expectation of site visits occurring during January 1993.

B. PEDIATRIC RESIDENCY INITIATIVES IN PRIMARY CARE

1. Program Description

The Department of Pediatrics' new primary care initiatives include curriculum revision with nearly a 400% increase in outpatient clinic training time, development

of a new primary care clinic network, new rural and urban community-based primary care training electives, a new general pediatric post-residency fellowship in academic general pediatrics, and faculty development in primary care teaching. All of these initiatives were possible because of the HealthRight appropriation.

Child health needs have changed in the past decade, and the educational needs of pediatricians have had to change to provide a healthy future for our legacy. Childhood vaccines now prevent fatal infections, once the focus of pediatric care. Families today are challenged by lifelong health problems resulting from premature birth, birth defects, diabetes, heart disease, asthma, child abuse, learning disability, and adolescent eating disorders and suicide. Through new HealthRight-sponsored primary care pediatric training experiences, the University's Department of Pediatrics has become a national leader in equipping pediatricians to treat the new child health problems.

Care for the new child health problems is provided largely in outpatient clinics, and pediatrician training time in clinics has increased from 15% to over 50% to meet these needs. However, hospitals and health care payers, who traditionally supported and continue to support pediatric training focused on hospitalized children, have not been willing to support outpatient training. Just as the Minnesota legislature solved an identical problem in funding the education of family practitioners in outpatient clinics 20 years ago, the HealthRight appropriation for primary care education of general pediatricians was essential in permitting the Department of Pediatrics to provide the new primary care pediatric training experiences.

Through the specific initiatives described below, the Department will increase from 11 to 14 the number of pediatric residents entering a general pediatric primary care career each year. General pediatric faculty who are responsible for coordinating and teaching clinical pediatric courses for medical students will collaborate closely with the new Task Force for Primary Care Education as it addresses medical student curriculum reform.

a. Faculty Support and Development

The HealthRight appropriation allowed for a major expansion of the new Division of General Pediatrics and Adolescent Health. The Division added three new faculty positions since the passage of HealthRight. Dr. Charles Oberg was recruited in September 1992 as Associate Director for General Pediatrics and Director of Primary Care Training after seven years of pediatric practice at Hennepin County Medical Center. Dr. Oberg is responsible for development and operation of a new General Pediatric and Adolescent Helath Inpatient Service at Variety Club Children's Hospital. He directs the new resident elective in urban underserved child health. He continues as medical director of the Hennepin County Homeless Assistance Project, which has recently been added as a resident training site. Dr. Oberg also directs the new fellowship in General Academic Pediatrics, which is designed to train core faculty necessary to expand the general

pediatric training of future medical students and residents.

Dr. Marcia Shew was recruited in September 1992 to expand adolescent health training opportunities, which includes the initiation of an inpatient adolescent service in January 1993 and expanded outpatient services. Dr. Daniel Kohen was recruited in January 1993 to expand the Behavioral and Development Pediatric aspects of the program. These faculty additions will allow the Division to provide the cornerstone for the ongoing primary care training expansion.

b. **Residency Initiatives**

Curriculum changes made this year now mandate six months of primary care training in ambulatory pediatrics, behavioral and developmental pediatrics, developmental disabilities, adolescent health, and emergency medicine. These rotations were added with the HealthRight appropriation.

The HealthRight appropriation allowed the Department of Pediatrics' Office of Medical Education, directed by Dr. Michael Shannon, to expand the **Primary Care Clinic Network**. The Network includes public and private sector practices in over 40 sites including private pediatricians' offices, HMO's, and community clinics. Pediatric residents now spend one-half day each week of their three-year training in a Primary Care Clinic following a group of children continuously during three years of their growth and development

As part of the Primary Care Clinic Network program, the Office of Medical Education is developing Primary Care Symposium Series, which will provide a core curriculum in primary care to all pediatric residents.

A one-month **non-metro pediatric training** elective was recently established in three rural communities (Red Wing, Virginia, Willmar) to give third year residents a rural pediatric practice experience. Ten residents have taken the elective since its initiation in 1992.

A one-month **urban training elective** was added to the curriculum in October 1992 to give residents a health care experience in underserved areas, including the Hennepin County Homeless Assistance Project, Hennepin County Medical Center, and the Community University Health Care Clinic. Five residents have taken or will take this elective in the 1992-93 academic year. Improved pediatric care is essential in these underserved populations given their disproportionately high infant mortality rates.

The new focus on primary care training in pediatrics led to the Pediatric Department's recent submission of a federal Primary Care Training Grant proposal to expand the activities recently implemented under HealthRight.

c. Fellowship Initiatives

In September 1992, the Division of General Pediatrics initiated a new Fellowship in General Academic Pediatrics. This fellowship position builds upon a nationally renowned Fellowship program in Adolescent Health. Trainees will have completed the three-year pediatric residency, and the new fellowship will teach skills to promote effective teaching of primary care pediatrics. In 1993 a Fellowship in Behavioral Pediatrics will be initiated.

d. Program Evaluation

In collaboration with the Medical School's Office of Curriculum Affairs, the Department of Pediatrics' Office of Medical Education will conduct several studies to track career choices of its residents and delineate curriculum changes that promote optimal training of pediatricians in primary care.

e. Future Initiatives

In addition to initiatives described above, the following primary care training experiences are being developed for implementation in 1994.

- Initiation of a primary care pediatric referral clinic in Alexandria, Minnesota to provide consultation to community family practitioners. The clinic began in January 1993 with monthly clinics scheduled for the remainder of the 1992-93 year. Expansion to two days per month is anticipated for the 1993-94 academic year.

- Discussions with a number of community clinics including Central Avenue, Fremont, and the Cedar-Riverside Clinics have been initiated to expand primary care training site opportunities for pediatric residents for the 1993-94 academic year.

- Development of a 3 to 5 year faculty development and continuing education program to promote and facilitate effective teaching skills in primary care settings. This built upon a 1992 pilot program which provided teaching workshops for over 50 community pediatric clinical faculty.

2. Current Status on December 31, 1992

The members of the Department of Pediatrics' HealthRight Committee appointed by Dr. Alfred F. Michael are: Drs. Charles Oberg, (Chair), Robert Blum, Mitch Einzig, Scott Giebink, Jill Kempthorne, Susan Mahle, Michael Shannon, Joe Sockalosky, Ted Thompson, Robert Vernier, Ms. Norma Wubbena and Mr. Brian Ponto.

The Committee has met monthly since its inception in June 1992. Its mission was to formulate and implement the Primary Care Training initiative within the Department of Pediatrics. The Committee has focused its activities on programmatic

development related to the expansion of primary care opportunities, which are elucidated in greater detail throughout this report. In addition, an administrative structure has been instituted within the department to provide for optimal coordination of the HealthRight funded primary care projects.

C. MEDICINE RESIDENCY INITIATIVES IN PRIMARY CARE

1. Program Description

The Department of Medicine initiatives in primary care include new efforts in the following areas: general medicine faculty development; expansion of ambulatory care training and electives for internal medicine and med-peds residents; and expansion of general medicine fellowship support and positions for postgraduate training of general medicine leaders in the fields of public health, epidemiology and preventive medicine, and health services delivery. In addition, general medicine faculty who have responsibility for the coordination of several core clinical courses for medical students (e.g. Clinical Medicine III and the Clinical Medicine IV) will be collaborating closely with the Task Force for Primary Care Education as it engages in the tasks of curriculum reform, particularly as these reforms involve these core courses.

a. Faculty Support and Development

Dr. John Flack was recruited in January 1992 to head the Division of General Internal Medicine at the University of Minnesota. (UMHC) Currently, he and other members of this section work closely with medical students in the general medicine clinics at UMHC. In addition, Dr. Flack is coordinating general medicine faculty activities and resident continuity clinic curriculum development for the Community-University Health Care Center (CUHCC), and he is continuing to recruit four more highly qualified general medicine faculty. With a strengthened Division of General Internal Medicine at UMHC, more high quality primary care experiences for students, residents, and fellows will be possible at UMHC including the addition of a residents' continuity clinic experiences at the UMHC beginning July 1, 1993, and the development of a fellowship position based at the UMHC.

Faculty development for the entire city-wide Division of General Internal Medicine (including not only UMHC, but also the affiliated teaching hospitals) will include funding of at least two city-wide educational and training conferences for the faculty that will focus on the development of additional primary care clinical skills (e.g. clinical procedures currently referred to subspecialists but which could legitimately be performed by generalists) and on effective teaching and mentoring techniques and curriculum content for ambulatory care rotations. These conferences are in the planning stage.

Through the specific initiatives described below the Department will increase from 15 to 20 the number of internal medicine residents entering a general

medicine primary care career each year.

b. Residency Initiatives

During the current academic year (1992-93) the Department of Medicine has begun several new initiatives for ambulatory care training of medicine and residents. in the combined 4-year Medicine-Pediatrics curriculum These have included the addition of a community-based clinic site for medicine residents to gain experience in the delivery of longitudinal care in an underserved setting (CUHCC), a 33% increase over 1991-92 to a total of 20 in the number of ambulatory care elective slots available to second and third year residents, and the development beginning in February, 1993 of a new ambulatory care elective at the Interstate Clinic in Redwing for medicine residents. In addition, there has been an expansion of the involvement of primary care internists from the community as attending physicians in residents' longitudinal care clinics.

c. Fellowship Initiatives

As of July 1, 1992, the number of University of Minnesota General Medicine Fellowship positions at the affiliated hospitals was increased 50% to a total of four. This fellowship provides advanced training for leaders in general medicine in the fields of public health and preventive medicine and health services delivery.

d. Program Evaluation

In collaboration with the Medical School's Office of Curriculum Affairs and the Task Force for Primary Care Education, the Department of Medicine will initiate several studies to further delineate those factors which contribute to residents' career choices (primary vs. subspecialty care) and the effectiveness of new initiatives and training experiences in influencing these choices.

e. Future Initiatives

In addition to those initiatives already taken for 1992-93, several additional initiatives for 1993-94 are also being planned within the Department of Medicine. These include:

- Development of additional community-based sites for ambulatory care training of residents. Negotiations are currently underway with several other care providers in the community, including managed care providers and providers in underserved areas. By July 1, 993, these additional sites should be able to accommodate up to 12 residents taking ambulatory care electives.

- The Department of Medicine is exploring ways it might include more ambulatory care training for interns such as the possibility of extending

the continuity clinic experience to their first year of training.

- The Department of Medicine is negotiating with community providers to further increase their involvement as preceptors for residents' ambulatory care experiences at UMHC and affiliated hospitals.

- Increase the number of fellowship positions an additional 25% to a total of five.

2. Current Status on December 31, 1992

The members of the Department of Medicine HealthRight Committee appointed by Thomas F. Ferris, M.D., are: Terese Collins, M.D., John Flack, M.D., Kristin Nichol, M.D., and Peter Mitsch, Associate to the Chairman. This committee has met several times and will work in close collaboration with other general medicine faculty and the Task Force for Primary Care Education on these and other Department of Medicine Initiatives.

D. CONTINUING MEDICAL EDUCATION

University of Minnesota Medical School faculty have designed and taught a number of continuing education courses for primary care physicians during the 1992-93 academic year. The following courses are comprehensive reviews of primary care skills and medical advances taught in the Twin Cities area. Total attendance at our calendar year 1992 courses was 6,859; and 4,115 were from Minnesota. About 40% (1,700) of the Minnesota physicians were from greater Minnesota.

Courses offered for primary care physicians in 1992:

Course Title	No. credit hours	Attendance
Infectious Disease Update	5	171
Primary Care Update	20	26
Geriatric Drug Therapy Symposium	13.5	144
Prevention and Management of Atherosclerosis	6.5	112
Medical Update	27.5	99
Allergy and Immunology	14	72
Colon and Rectal Disease	6.75	32
Pediatrics-Obstetrical Update	7	54
Medical Directors Training Program	21	14
Family Practice Review	35	226
Daily Management of the Patient with HIV	6.25	90
Smoking Cessation	6.25	90
Clinical Hypnosis	16.25	319
Topics and Advances in Pediatrics	18.5	150
Preventive Health Issues for Women	5.75	125
Prevention and Management of Osteoporosis	3.5	21

Topics in Aging	5	72
Medical Directors Training Program	21	14
Nursing Home Medical Directors Conference	11.75	95
Adolescent Medicine and Healthcare	10.5	136
Weekend Update: Cardiology (Red Wing)	4	28
Internal Medicine Review	21	166
Annual Ob/Gyn Review	14.5	190
Weekend Update: Infectious Disease	4.75	56
Improving the Quality of Your Practice	6.25	190
Medical Directors Training Program	21	14

In addition, we conducted four audio teleconferences of lectures that went out to 15 to 20 sites in Minnesota and the Dakotas. Each site had 10 to 20 physicians. In all, these teleconferences reached 450 primary care physicians throughout the state. Also excluded from the list above are courses that we jointly sponsored with organizations such as the Northwestern Pediatrics Society and other state and regional organizations. These courses reached a total of over 8,000 physicians and other health professionals in 1992. Medical School faculty also provided continuing education to primary care physicians in their communities. The following is a partial list of these community-based activities in 1992:

Site	Speaker	Topic
Willmar	Roby Thompson	Diagnosis of osteogenesis sarcomas
Mankato	William Meller	New treatments for depression
Willmar	D. Ingbar	Advances in and management of nosocomial and serious pneumonia
Willmar	J.M. Hubell	Comorbidity of depression and eating disorders
Hibbing	John Hulbert	New perspectives in laparoscopic surgery in urology
Mankato	Ann Russel	Medical liability issues and concerns
Mankato	Richard Latchaw	MRI
Hibbing	James Radford	Autologous bone marrow transplantation for Lymphomas and solid tumors
Willmar	C. White	Indications for angioplasty
Willmar	M. Joseph	Hormone therapies are an evolving art
	Ted Thompson	Group B streptococcal infection/ Hepatitis B
Willmar	Neil Holton	Tuberculosis
Hibbing	Jesse Goodman	Lyme disease 1992: A review and update
Willmar		New antibiotics and their role in infectious disease
Hibbing	James House	Wrist pain- injuries and overuse
Willmar	Praston William	Testing techniques during pregnancy
Willmar	Bonnie LeRoy	Genetic counselin
Willmar	Susan Berry,	Diagnostic techniqes and management of the newborn with genetic disorders

Hibbing	John Eggert	Diagnostic and therapeutic approach to rheumatoid arthritis
Willmar	L. Sabbath	New offic antibiotics
Hibbing	Ronald Soltis	Gastroesophageal reflux disease
Albert Lea	William Jacott	CLIA-88 and the office lab
Willmar	Donald Asp	Pelvic ulcer disease
Hibbing	Dennis Weslander	Chain saw injuries
Princeton	David Current	Life expectancy vs. life span
Mora	Ruth Bolton	Warts & new treatment
Winona	Kent Berg	Doctor-patient interviewing
Montevideo	Maurice Lindblom	Seasonal allergic rhinitis
Bemidji	Thomas Day	Doing research away from the University setting
Bemidji	Elizabeth Seaquist	Diagnosis of new Tx approaches to diabetes
Canby	Jeff Hoffman	Screening for colorectal CA
Brainerd	Dale Hammerschmidt	Amenia: weird cases and common lessons
Aitkin	Dorothy Uhlman	Molecular genetics of colon CA
Buffalo	David Ingbar	Treatment of COPD/Asthma
Glencoe	Spencer Kubo	Update on treatment of congestive heart failure
Hastings	Thomas Hostetter	Renal disorders
Albert Lea	Paul Yakshe	Gastrointestinal disorders
Ely	Harry Jacob	Diagnosis of erythrocytosis
Hutchnson	Linda Carson	Cervical cancer
Crosby	Preston Williams	Gestational diabetes
Cambridge	Leo Twiggs	Gynecologic oncology
Crookston	Jeffrey Fowler	Ovarian cancer screening
Hastings	Donald Prem	Ovarian CA, family history, CA125, treatment
Benson	Lowell Byers	Office gynecology
Brainerd	Lowell Byers	Pelvic examination
Blue Earth	Doris Brooker	MOMI trials
Hibbing	Jacques Stassart	Evaluation of infertility
Hastings	Robert Fisch	Repiratory distress/medical usage
Ely	Pete Anderson	Vaccination update
New Ulm	Alfred Fish	Hematuria and asymptomatic proteinuria
Moose Lake	Pete Anderson	Vaccines/ Lead poisoning
Waconia	Michael Georgieff	Life after the NICU-follow-up of the high risk infant
Canby	Paul Quie	Update on treatment of meningitis
Park Rapids	Peter Blasco	Developmental disabilities of kthe young child
Forest Lake	Toni Moran	Endocrinologic abnormalities of the child
Little Falls	Robert O'Dea	Clues to diagnosin metabolic disorders
Hibbing	J. Ernesto Molina	Thrombolytics in vascular surgery
Winona	Edgar Pineda	Cardiac valve replacement

Wadena	Jerome Abrams	Diagnosis/treatment of GI bleed
St. Peter	Herbert Ward	Indications for coronary surgery
Crosby	Steven Eyer	Rural trauma care
Marshall	David Dunn	Management of serious surgical infections
Park Rapids	Roderick Barke	ARDS in SICU patients
Willmar	Arnold S. Leonard	Laser for angiomas, chest deformities
Buffalo	Paul Gores	Transplantation of pancreatic islet cells

III. BUDGET

The HealthRight appropriation is divided among the three primary care departments and the Medical School as follows:

Initiatives	Faculty	Residents	Purchased services	Medical education expenses	Total
Medical School	332,179	–	15,000	110,403	457,582
Family Practice	224,392	–	12,600	172,876	409,868
Pediatrics	198,500	442,500	286,047	135,847	1,062,894
Medicine	77,025	148,797	31,215	12,619	269,656
TOTAL	832,096	591,297	344,862	431,745	2,200,000

Medical School Student Initiatives
1992 - 93 Academic Year

	% Effort	Amount
STUDENT DEMOGRAPHIC ADMISSIONS STUDY		**40,000**
CURRICULM DESIGN / CENTRAL COORDINATION		
Director: N. Lurie, M.D.	40%	60,923
Associate Faculty for Planning		
Family Practice	25%	30,600
Internal Medicine	25%	30,600
Pediatrics	25%	30,600
Education Policy Committee Representative	20%	31,100
Primary Care Faculty for Course Development		
Family Practice	10%	12,800
Internal Medicine	10%	12,800
Pediatrics	10%	12,800
Education Policy Committee Representative	10%	12,800
Primary Care Conference		15,000
Other Conferences / Retreats		4,000
SUBTOTAL		**254,023**
CLINICAL EXPERIENCES IN PRIMARY CARE		
Primary Care Associate, Minneapolis Campus		12,903
Primary Care Director, Duluth Campus	75%	81,600
Program Associate, Duluth Campus	50%	22,400
Secretarial Support	25%	8,156
Travel		7,500
SUBTOTAL		**132,559**
PRIMARY CARE FACULTY DEVELOPMENT / CME		
Consulting (10 days @ $600/day)		6,000
Mentor teacher training and evaluation		25,000
SUBTOTAL		**31,000**
TOTAL EXPENSE		**457,582**

1. Medical School Initiatives

Student Demographic Admissions Study, as described on pages 3 to 4.

Curriculum Design / Central Coordination

Dr. Nicole Lurie, chair, Task Force for Primary Care Education, will spend 40% of her time in this role. She will be responsible for implementing the activities described above, and will have the authority to spend funds as outlined in the budget. The Task Force will coordinate with other Health Sciences disciplines the development and implementation of formal primary care research training programs. those programs will include research in health services delivery, primary care, outcomes assessment, population-based studies and technology assessment. These training efforts must have the same degree of rigor and experience as are traditional in other facets of biomedical research.

Associate Faculty for Planning The Primary Care Education Task Force will have representation by faculty in each of the primary care departments. A faculty member from the department of medicine, family medicine, and pediatrics will serve on the Task force. They will each spend 20% of their time on this activity.

Primary Care Faculty for Course Development. In addition, 4 primary care faculty will each spend 10% of their time developing and/or altering courses to enhance the undergraduate primary care curricula. These individuals will work closely with the task force to translate the work of the Task Force into action.

Primary Care Associate, Minneapolis Campus. This part-time person will conduct literature reviews, assist with the focus groups and cohort studies, and work with scheduling and coordination of course directors and community practitioners.

Primary Care Director, Duluth Campus will direct its new Department of Family Practice. He/she will be responsible for assisting with admissions and student cohort studies and with choosing and providing faculty development and supervision for primary care practitioners who provide clerkships, mentorships, or other training for students in Northern Minnesota. That individual will work closely with the Task Force.

Program Associate, Duluth Campus will assist the Primary Care Associate in Duluth in expanding student-oriented primary care activities.

Secretarial support will be required to set-up meetings, coordinate correspondence with community providers, and provide word processing support.

Primary Care Conference funding is necessary to conduct the statewide

conference described in page 4.

Other Conferences and Retreats are necessary to discuss with basic science faculty the incorporation of primary care education in the basic science components of years 1 and 2 of the medical students' curriculum.

Travel. The Task Force will visit 3 to 4 schools with particularly innovative primary care curricula.

Consulting. This will be a "teaching the teacher" consultant who will assist with the infrastructure for training our community teachers.

Mentor teacher training and evaluation. Faculty development will be required to assure that the participating community practitioners have appropriate teaching skills. Likewise, some University specialty faculty would benefit from learning how to teach primary care skills. In addition, ongoing monitoring of the quality of teaching and the student experience will be necessary.

Most of the expenses outlined are recurring expenses that will be required to maintain and increase primary-care related education and research. We anticipate that after Year 1, the funding for the non-recurring items (conferences, studies, consulting and travel) will become available to support and test new innovations in primary care educational. These activities may range from the undergraduate level to continuing education for physicians in practice.

Family Practice Rural Residency Initiatives
1992 - 93 Academic Year

	% Effort	Amount
FACULTY SUPPORT AND DEVELOPMENT		
E.W. Ciriacy, M.D.	10%	0
M. Bixby, M.D.	10%	12,338
K. Bergh, M.D.	10%	11,624
M. Lindblom, M.D.	10%	15,860
E. Peterson, M.D.	50%	51,953
S. Patten, Ph.D.	20%	16,093
Residency Director	50%	61,686
Rural M.D. Faculty #1 (FTE)	5%	6,169
Rural M.D. Faculty #2 (FTE)	5%	6,169
Program coordinator	50%	25,900
Principal secretary	25%	8,706
Accountant	20%	7,894
SUBTOTAL		**224,392**
PURCHASED PROFESSIONAL SERVICES		
Contract with Rural Physicians		**12,600**
MEDICAL EDUCATION EXPENSES		
Computers for 2 locations		10,000
Office equipment		5,000
Office supplies		1,200
Photocopies		600
Computer supplies		720
Facilities - Lease & Lease-holding improvements		123,850
Staff Travel		13,976
Other (Overhead/Supplies)		17,530
SUBTOTAL		**172,876**
TOTAL EXPENSE		**409,868**

2. Family Practice Rural Residency

Although the financing details of this program have not been finalized, we have based our projected costs on our current experience with the Affiliated Community Hospital Training Program. We anticipate that geographic differences associated with the two programs will have a significant impact on the distribution of costs. We believe that even though there will be added costs associated with communication and travel, there will be additional contributions of voluntary teaching time from local physicians which will enable us to stay within the same total budgetary projections utilized for our present operations.

Our current costs for the Affiliated Community Hospital Training Program are projected to be $121,073 per resident per year. For the twelve residents participating in the rural residency, this would suggest a total cost per year of $1,452,876.

Funding sources available to offset these costs are projected as follows:

1. Hospital support @ $46,187 per resident per year:
   12 residents $554,244 (38% of total cost)
2. Patient Care generated by the program is estimated to be:
   $288,764 (34% of total cost)
3. HealthRight Funding
   $409,868 (28% of total cost)

The previous page denotes the allocation of these moneys. The following budget justification provides the rational for these expenditures.

Budget Justification

Personnel

E.W. Ciriacy, M.D. - Department Head, 10% time, donated. Dr. Ciriacy is the Head of the Department of Family Practice and Community Health and will have overall responsibility for planning and implementation of the Rural Family Practice Residency Training Program.

M. Bixby, M.D. - Physician Faculty, 10% time, funded. Dr. Bixby is a physician faculty member in the department. He has several years experience as a practicing family physician in rural Minnesota. Dr. Bixby serves on the Rural Residency Task Force in the department. He will participate in site visits elsewhere in the United State to observe other successful rural family practice residency training programs. Dr. Bixby will be involved in reviewing application materials from rural practices and hospitals that are applying to participate in this program and will be involved in site visiting applicant clinics and hospitals in the state of Minnesota. He will participate in all aspects of planning for this new residency program.

K. Bergh, M.D. - Physician Faculty, 10% time, funded. Dr. Bergh is a physician

faculty member in the department who had several years experience as a rural family physician in Western Minnesota prior to joining the faculty. He is fellowship trained and has rural health care delivery as one of this major teaching and research interests. Dr. Bergh is a member of the Rural Residency Task Force. He will participate in site visits both out of the state and within Minnesota, will be involved in reviewing documentation from applicant clinics and hospitals and will participate in all aspects of planning in this new residency program.

M. Lindblom, M.D. - 10% time, funded. Dr. Lindblom is presently the Associate Director of the department's urban based Affiliated Residency Training Program in Family Practice. He has extensive experience in both North Dakota and Minnesota in all aspects of implementing a family practice residency training program. He participates in the Rural Residency Task Force, will conduct site visits, and will be involved in reviewing application packets from clinics and institutions who wish to participate in the rural residency. Dr. Lindblom is very well acquainted with Residency Review Committee requirements for accreditation of family practice residencies and will have much of the responsibility for making sure that the rural residency meets all accreditation requirements.

E. Peterson, M.D. - 50% time, funded. Dr. Peterson is a fellowship trained physician faculty member in the Department of Family Practice and Community Health. He has many years experience as a family physician in rural Minnesota. Both his residency and his fellowship were completed in this department. A major portion of his effort will be committed to the planning aspects of the new rural residency program. He will have major responsibilities for spending time at the rural site once it is identified working with local physicians who will become faculty members in the rural residency.

S. Patten, Ph.D. - 20% time, funded. Dr. Patten is a member of the Rural Residency Task Force. She has primary responsibility for review and triage of site applications which are received. She will be involved in all aspects of planning for this residency training program. She is a behavioral scientist with research experience in rural Minnesota and other rural areas.

TBA M.D. Residency Director - 50% time, funded. This is a new position. This individual will have major responsibility for planning, implementing, and directing the new residency training program. This individual will also have primary responsibility for the residency application process. Curriculum development for clinical and academic portions of the residency will be the primary responsibility of this physician.

Rural M.D. Faculty #1 - 5% time, funded. This physician faculty member in the rural residency will be recruited from the community in which the rural residency is located. All of this physician's time commitment to the residency during the planning year will take place during the last three to four months of

that year. Thus, a 15-20% time commitment during these three to four months will be expected. This time will be devoted to final aspects of planning and to faculty development activities which will prepare this physician to become a faculty member of the rural residency.

Rural M.D. Faculty #2 - 5% time, funded. The justification for this position is identical to that for Rural M.D. Faculty #1 (see above).

Program Coordinator TBA - 50% time, funded. This individual will provide administrative support for all aspects of planning and implementation of the rural residency.

Principal Secretary TBN - 25% time, funded. It is expected that the support of a principal secretary will be needed throughout the planning year. This individual will have responsibility for correspondence, arranging phone conferences, setting up meetings, record keeping, and establishing a filing system for all documentation regarding the rural residency training program.

Accountant TBN - 20% time, funded. It is expected that the support of an accountant will be needed throughout the planning year to assure appropriate expenditure of funds and financial record keeping.

Consultants - $12,600, funded.
The planning group has utilized the services of rural physician consultants in this deliberations. Consultants are named form the Minnesota Academy of Family Physicians which include: Dr. Ray Christianson, Dr. Steve Medrud and Dr. Darrell Carter; a consultant for the Minnesota Hospital Association, Mr. Thomas Evans; and a consultant representing the Minnesota Medical Association, Dr. Paul Sanders.

Equipment - $15,000, funded.
When final site selection for the rural residency has been made, the rural facility will be provided with computer equipment and office equipment necessary for physician faculty and residents. Computer equipment will be purchased for both the rural family practice center and the rural hospital. This equipment will be for the dedicated use of the rural residency program. Desks, chairs, files, and other office equipment will be purchased as needed.

Supplies - $2,520, funded.
Normal office supplies, duplicating supplies, and computer supplies will be purchased for the rural residency site. Supplies will also be required by the Department of Family Practice and Community Health administrative offices in order to conduct the planning and site selection process.

Facilities - $123,858, funded.
It is estimated that the lease and lease-holding improvements costs for the rural family practice center will approximate $123,858.

Staff Travel - $13,976, funded.
Site visits will be conducted by members of the rural residency planning group to four different rural family practice residency training programs in the United States. Information acquired will be used in the planning and implementation of this department's rural residency training program. It is estimated that a total of nine visits to rural site applicants will be required in order to allow the planning group to finalize site selection. When the rural site has been established, it is estimated that travel will occur from the metropolitan area to the rural site, or from the rural site to the metropolitan area, on average one every two weeks for the last six months of the planning year. This will include travel by the rural M.D. faculty to the metropolitan area for purposes of faculty development.

Other Costs - $17,530, funded.
The planning group will oversee the preparation of a brochure regarding the rural residency training program. This will be an important aspect of recruitment activities. Estimated cost for brochure preparation is $5,000. Estimated costs for mailing 5,000 brochures at the cost of $.52 per brochure is $2,600. Estimated telephone costs for all planning an recruitment activities is $1,930. The estimated cost of purchasing books and subscribing to journals for the rural family practice residency library is $8,000.

Pediatric Residency Primary Care Initiatives

1992 - 93 Academic Year

	% Effort	Amount
FACULTY SUPPORT AND DEVELOPMENT		
M. Shannon, M.D., Director, Residency Program	60%	78,000
C. Oberg, M.D., Director, Primary Care Training	50%	65,000
D. Kohen, M.D., Behavioral Pediatrics	50%	59,800
M. Shew, M.D., Adolescent Medicine	25%	24,500
J. Sockalowsky, M.D., CHSP Medical Education Director		10,000
M. Einzig, M.D., MCMC Medical Education Director		10,000
J. Tobin, M.D., HCMC Medical Education Director		10,000
Group Health Coordinators		10,000
General Pediatrics Faculty Development Coordinator	15%	15,500
SUBTOTAL		**282,800**
RESIDENT STIPEND SUPPORT OF PRIMARY CARE ROTATIONS		
Ambulatory, behavioral, developmental, E.R, adolescent, developmental disability, rural, and urban rotations		**442,500**
PROGRAMMATIC AND CURRICULUM DEVELOPMENT		
Primary care clinic network		15,450
Primary care preceptors educational honorarium		22,000
Preceptorship in non-metro Minnesota		53,400
Preceptorship in urban underserved Minnesota		15,000
Behavioral pediatrics		38,200
Adolescent medicine		15,000
Developmental disabilities		16,000
PL-1 Orientation/Communication workshop		5,811
PL-2 Orientation/PALS/In-Training Exam		6,216
PL-3 Workshop/Educational allowance		12,750
Medical student introduction to pediatrics		720
Pediatric career days		1,200
SUBTOTAL		**201,747**
MEDICAL EDUCATION EXPENSES		
Residency program coordinator		24,000
Residency selection coordinator		17,000
HealthRight medical education coordinator		36,000
Chief residents 3 FTE's		26,082
Educational policy committee		1,200
Residency review committee		1,200
Clerical support person		4,800
Other (overhead/supplies)		25,565
SUBTOTAL		**135,847**
TOTAL EXPENSE		**1,062,894**

3. Pediatric Residency Primary Care Initiatives

The Department of Pediatrics proposes to direct HealthRight appropriations into the following four categories:

Faculty Support and Development	$282,800
Resident Stipend Support for Primary Care	442,500
Programmatic and Curriculum Development	281,747
Medical Education Expenses	135,847
Total Pediatric Appropriation	$1,062,894

a. Faculty Support and Development

A stated goal of the Minnesota HealthRight Act is to increase by 20% over an eight year period, the number of pediatricians who practice primary care. This comes at a time when the Department of Pediatrics has undertaken a large-scale primary care educational initiative. To accomplish this initiative requires a faculty committed to the training of primary care pediatrics. The total Department of Pediatrics allocation for Faculty Support and Development is $282,800.

Personnel

Michael Shannon, M.D. -- Director of the Pediatric Residency Program and Medical Education, 60% funded. Dr. Shannon's responsibilities include overall responsibility for implementation of the overall educational curriculum for the Pediatric Residency Training Program. In addition, he has full responsibility for the pediatric residency application and selection process.

Charles N. Oberg M.D., M.P.H. -- Associate Director, Division of General Pediatrics and Adolescent Health, 50% funded. Dr. Oberg is the new Director of Primary Care Training for the Department of Pediatrics. He will have overall responsibility for the development and implementation of the Department of Pediatrics Primary Care Initiative. This includes curriculum development, identification of additional sites of primary care training and coordination with community-based pediatric practices, as described on page 9. Dr. Oberg's responsibilities for general pediatric aspects of the residency program are distinct from Dr. Shannon's responsibilities, which are primarily in resident selection and coordination of the overall inpatient and outpatient residency curriculum.

Daniel Kohen, M.D. -- Assistant Professor and Director of Behavioral and Developmental Pediatrics, 50% funded. Dr. Kohen was recently recruited from Minneapolis Children's Medical Center to coordinate and implement a new behavioral and developmental pediatric rotation and to help in the development of a new pediatric and adolescent mental health service.

Marcia Shew, M.D., M.P.H. – Assistant Professor and Director of Adolescent Health Services, 25% funded. Dr. Shew was recently recruited from the University of Oklahoma. Dr. Shew's training is as an internist in Adolescent Medicine and Clinical Epidemiology. She will be intricately involved in the pediatric educational program and will coordinate the adolescent health rotation for second year pediatric residents.

Mitch Einzig, M.D.; John Tobin, M.D., M.P.H.; Joe Sockalosky, M.D. – Directors of Medical Education at Children's Hospital of St. Paul, Minneapolis Children's Medical Center, and Hennepin County Medical Center, 10% funded. These three outstanding medical educators from the three integrated institutions will continue the coordination of the primary care teaching which occurs at these training sites.

Drew Thomas, M.D.; Hilary Stecklein, M.D.– Medical Education Coordinators from Group Health Inc., 10% funded. Drs. Thomas and Stecklein have been instrumental in the expansion of the primary care training program into the Health Maintenance Organization setting. They presently coordinate the ambulatory pediatric rotation for first year pediatric residents at Group Health Inc.

General Pediatric Faculty Development Coordinator (TBA) – 15% funded. This person's responsibilities will include development and implementation of the Primary Care Teaching Faculty Development Program. This person will coordinate the development of a 3 to 5 year strategic plan to facilitate the ongoing acquisition of effective teaching skills for community clinical faculty through a continuing medical education program.

b. Resident Stipend Support For Primary Care.

Curriculum changes now mandate six months of primary care training in ambulatory pediatrics, behavioral and developmental pediatrics, developmental disabilities, adolescent health, and emergency medicine as well as a community-based pediatric elective which can be done in either a rural or urban underserved metropolitan area. To cover the resident stipends for these rotations the utilization of 13 FTE residents on an annual basis is required. These stipends, which are incurred during outpatient training, are not paid by hospitals. The overall cost is **$442,500.**

c. Programmatic and Curriculum Development.

As mentioned, the Department of Pediatrics has undertaken a large-scale primary care educational initiative that encompasses overall curriculum revision, development of a primary care clinic network and new community-based health electives. The Department of Pediatrics has allocated **$201,747** to accomplish this effort. The following is a highlight of specific programmatic

initiatives.

(1) **Primary Care Clinic Network.** Pediatric residents now spend one-half day each week of their three-year training in a Primary Care Clinic. The Primary Care Clinic Network spans both public and private sector practices in over 40 different sites, including private pediatricians' offices, HMO's, and community clinics. Funds are allocated to provide an educational honorarium of $500 annually to the primary care preceptors within the Primary Care Network.

(2) **Preceptorship In Non-Metro Minnesota.** A one-month rural pediatric training elective was established this year in three rural communities to give third-year residents a rural pediatric practice experience.

(3) **Preceptorship In Urban Underserved Communities.** A one-month urban health elective was recently developed to give third-year residents a health care experience in underserved areas, including the Hennepin County Homeless Assistance Project, Hennepin County Medical Center, and the Community University Health Care Clinic. Improved pediatric care is essential in these underserved populations given their disproportionately high infant mortality rates.

(4) **Expansion Of The Divisions Of General Pediatrics And Adolescent Health.** The Department of Pediatrics has allocated funds to expand the curriculum and programmatic development in the domains of Behavioral Pediatrics, Adolescent Medicine, Developmental Disabilities, and General Academic Pediatrics.

d. **Medical Education Expenses.**

Primary care pediatric medical education costs are **$135,847.** The administrative expenses identified are critical to the overall training and education of the pediatric residents. The Department of Pediatrics determined these expenses should be covered at a 60% level with HealthRight funding, since 60% of the residents enter primary care general pediatric practices.

Internal Medicine Primary Care Initiatives

1992 - 93 Academic Year

	% Effort	Amount
FACULTY SUPPORT AND DEVELOPMENT		
T. Collins, M.D., Co-Director, Med-Peds Residency	20%	16,930
J. Flack, M.D., Director, UMHC Fellowship & residents' continuity clinic (UMHC &CUHCC)	10%	11,720
K. Watson, M.D., Director, Medical Student Clinical Medicine IV Course	15%	16,255
J. Kvasnicka, M.D., Director, UMHC sites for Clinical Medicine I, II, III courses	8%	7,180
City-wide conferences		18,000
Community-based preceptor stipends for ambulatory care training		30,000
Clerical support	20%	5,165
SUBTOTAL		**105,250**
RESIDENT AND FELLOW STIPEND SUPPORT		
Resident salaries for community-site ambulatory care rotations (2 salaries)		66,008
General medicine fellow salary at UMHC		37,789
General Medicine training and conference fund -- affiliated hospitals		16,000
SUBTOTAL		**119,797**
MEDICAL EDUCATION EXPENSES		
Education specialist	50%	26,050
Clerical support (data entry)	20%	5,165
Recruitment expenses		5,034
Photocopying, supplies		2,265
Postage		4,100
Accreditation fees		1,995
SUBTOTAL		**44,609**
TOTAL EXPENSE		**269,656**

4. Internal Medicine Residency Primary Care Initiatives

The Department of Medicine committee proposes to direct HealthRight appropriation dollars into the following general categories;

Faculty Support	$77,025
Fellowship Programs	52,789
Residency Program Development	96,008
Program Evaluation	31,215
Medical Education Expenses	12,619
Total Medicine Appropriation	$269,656

a. Faculty Support and Development

Dr. Terese Collins. The University of Minnesota is in its fourth year of an innovative Internal Medicine-Pediatrics combined residency program. Dr. Collins will devote 20% of her time to the duties of Co-Director of this residency program. This will include ensuring that these residents receive adequate internal medicine ambulatory care training and that they participate as fully as possible in the other Department of Medicine initiatives outlined above.

Dr. John Flack is currently coordinating the general medicine faculty and their involvement with teaching of residents at CUHCC. He will also coordinate the new residents' continuity clinic at UMHC beginning July 1993, the new general medicine fellowship position at UMHC, and many of the program evaluation activities. Dr. Flack will devote 10% of this time to these duties.

Dr. Kathy Watson is the coordinator for the core medical student course, Clinical Medicine IV (Ambulatory Medicine). This course has achieved national recognition as a model course for medical student ambulatory care training. She will work closely with the Task Force for Primary Care Education to ensure that this course meets the overall goals and needs of the medical school curriculum and will devote 15% of her time to course coordination and Task Force activities.

Dr. John Kvasnicka is the University coordinator for the core medical student courses, Clinical Medicine I, II, and III. These courses introduce students to basic medical interviewing and physical examination skills and the patient-provider relationship. He will devote 8% of this time to these activities and will work closely with the Task Force for Primary Care Education to explore ways that these courses might better meet the overall goals and needs of the medical school curriculum.

City-wide faculty development conferences will each span 1-2 days and will utilize both local and national experts to achieve the goals of enhanced clinical

and teaching skills for the general medicine faculty. Total costs for the conferences are estimated at $18,000.

Community-based preceptors will be involved at each of the teaching hospitals as attending physicians for residents' ambulatory care rotations. They will attend one-half day each week (20 hours/month at $25/hour), at each three hospitals ($10,000 for each site).

Clerical support for these faculty initiatives will involve 20% of one secretary ($5,165). Support needed will include correspondence, arranging meetings, record keeping, establishing and maintaining a filing system, and other clerical duties.

b. Residency and Fellowship Initiatives

The Department of Medicine will support residents' salaries while they are taking a full-time, one-month elective at a non-UMHC or affiliated hospital site, such as at the Interstate Clinic in Redwing. The Department of Medicine will also support residents' salaries while they are taking a continuity clinic rotations at a non-UMHC or affiliated hospital site (one-half day per week per resident). The equivalent of two resident positions will be used to allow for these community-based ambulatory care training experiences for residents.

The general medicine fellowship position at the UMHC will allow for a 25% increase in the total number of University of Minnesota General Medicine Fellows. Fellowship training at the UMHC and affiliated sites will be coordinated to provide a consistent curriculum and significant emphasis will be placed on advanced training in public health and preventive medicine and health services delivery. Funding from HealthRight will include one full-time fellow salary as well as support for fellows at the affiliated hospitals to receive advanced training in public health and preventive medicine, health services delivery, and other areas critical for general medicine leaders. In addition, their will be support for these fellows to attend regional and national meetings such as the Society of General Internal Medicine meetings (total $16,000 support for fellows at affiliated hospitals).

c. Program Evaluation

The program evaluation efforts for the Department of Medicine will include a 50% time education specialist with expertise in program evaluation including the design, conduct, and assessment of surveys. This person will require a 20% time clerical support and data entry person for these activities.

d. Medical Education Expenses

Medical education expenses for the Department of Medicine initiatives include partial coverage for expenses for resident recruitment, office supplies including

photocopying, postage, envelopes, and accreditation fees. Total support requested from HealthRight is $13,394.