Using Residency Learning Communities in a 4+1 System to Improve Mentoring, Scholarly Activity, and Wellness

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Background

- 4+1 Block Schedule rolled out for AY2015-16 for Categorical Residents and gave our residency program the opportunity for many educational innovations.
- All Residents (Categorical & Preliminary) were divided into 5 Resident Learning Communities ("Firms"). Each firm has PGY1s, PGY2s, and PGY3s.
- Creation of 5 Firms allowed us to align key faculty to focus on mentoring and scholarly activity.
  - Coincidentally, we had 1 PD, 4 APDs, and 5 Master Clinician Educators
  - All were selected for teaching ability; no attention to medical specialty
  - Prior to creation of firms. MCEs were policing inpatient teaching teams
- UMMS IM Residency statistics:
  - 84 categorical residents (28 per 3 years), 9 preliminary interns
  - 70% pursue Fellowship
  - 18% hospitalist, 6% primary care

Residency Learning Communities/Firms

- Each Firm has an assigned APD or PD and Master Clinician Educator (MCE)
  - APD (25% time) = Regulation and Mentoring
    - Evaluation Review & Biannual Meetings
    - Present Resident to CCC for Milestone Ratings
    - Career Mentoring & Coaching/Remediation
    - Recruitment Interviewing (approximately 50 per year)
  - MCE (25% time) = Scholarly Growth and Mentoring
    - Works with each resident for their annually required scholarly activity (PGY1-Landmark Paper, PGY2-Journal Club, PGY3-CPC)
    - Career Mentoring & Coaching/Remediation Resident Advocate
    - Recruitment Interviewing (approximately 50 per year)
  - Firm Social Activities during ambulatory week
  - Scheduling of ITE, End of Life OSCE, Opioid Training, Lean Training
  - Firm identity (Lapel Pins, Pens) developing
  - Primary Care Leadership Pathway housed in Quinsigamond Firm

UMMS Internal Medicine Residency Learning Communities

Quinsigamond	Tatnuck	Blackstone	Burncoat	Kelley
Program Director Hospital Medicine	APD Primary Care	APD Hospital Med	APD Pulmonary	APD Primary Care
MCE Infectious Disease	MCE Primary Care	MCE Hospital Med	MCE Infectious Disease	MCE Hospital Med

Methods

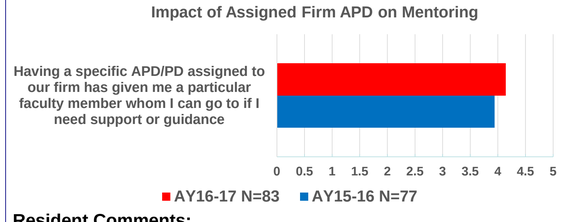
- Surveyed all Categorical IM residents at end of AY2015-16 (77/83, 92.7%) and AY2106-17 (83/83, 100%) on last day of last Ambulatory didactics

Results

All Surveys used a 1-5 Likert Scale

5=Strongly Agree
4=Agree
3=Neutral
2=Disagree
1=Strongly Disagree

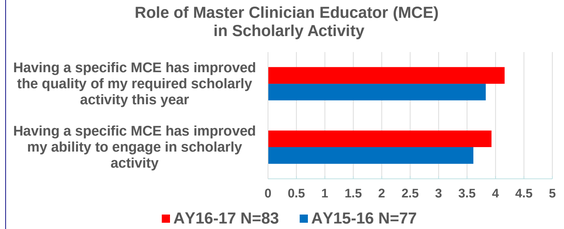
Mentoring



Resident Comments:

- Great initiative!
- I really appreciate the firms and do feel comfortable going to my APD.
- Mentors should be more diverse. Everyone is either a hospitalist or PCP with the exception of SK. Most people in our class are applying to fellowship, so mentors should be from fellowships to help with career goals.

Scholarly Activity

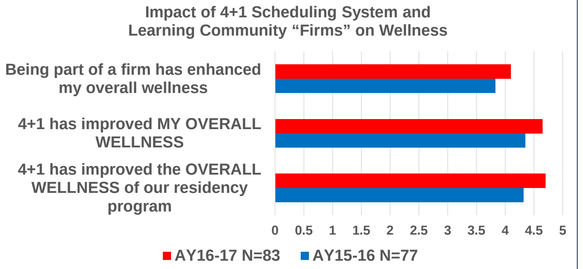


Resident Comments:

- MCE is super helpful with presentations.
- Having a MCE as a mentor greatly improved my scholarly activity, especially my CPC.
- Having the MCE available is an excellent asset.

Results

Wellness



Resident Comments:

Best Thing about 4+1

- Golden Weekend allows you a break and adds to my overall wellness
- Allows you to focus on outpatient experience. Gives more importance to developing outpatient skills.
- It's a nice break from wards. I love clinic and wish it was more than 4+1.
- Separation of inpatient and outpatient responsibilities
- Don't have to leave for clinic on wards; full team engagement everyday

Worst Thing about 4+1

- Nothing. I love 4+1!
- Loss of elective time
- Decreased schedule flexibility
- Some subspecialty clinics (only a few) are not educational
- I find it difficult to follow-up on studies ordered for patients who choose not to get them done during ambulatory week.
- Increased frequency of housestaff turnover on inpatient rotations due to staggered Y weeks between firms
- Too much to do during ambulatory

Comments about Firms

- The social activities and mentorship have added to my overall wellness
- I enjoy being part of a firm. Helps with bonding with other residents. Helps to be more involved with our mentors.

Discussion

- Most residents liked having an assigned APD as a mentor, though some residents requested mentors in their career area of interest.
- Most residents felt having an assigned MCE improved the quality of their required scholarly activity.
- 4+1 Block Scheduling and being part of a Residency Learning Community Firm improved overall residency program wellness and individual categorical resident wellness.
- Preliminary interns felt more fatigued from consecutive service blocks and not being able to participate in Firm activities.
  - Led to Prelim 4+1 Schedule for AY17-18
- Loss of total number of electives for all residents impacted number or residents available for coverage during Fellowship Interview season .
  - Led to Interview Assist Pool "IAP" for AY16-17
- Medicine-Pediatric residents (16) were added to firms in AY16-17, but were not able to participate in 4+1 schedule due to weekly clinic responsibility.
- Some Firms were more "Socially active" than others.
- Some residents felt there was too much to do during Ambulatory week (assignments, QI projects).

Future Plans

- We are in year 3 of an evolving educational innovation
- We are refining the distinct roles of APD vs. MCE in the Residency Learning Communities/Firms
  - May have to treat MCEs differently in Corrective Action Plans to avoid conflict of interest as advocate vs. voter on Clinical Competency Committee
- Due to GME budget cuts, we had to decrease MCE to 20%
- We are developing a Firm Cup Competition to foster Firm pride
- We hope for Vertical Integration with UMass Medical School Learning Communities ("Houses")
  - Physical Diagnosis Rounds
  - MD-PhD continuity of clinical training
  - Mentoring (Career and Residency Application Process)
  - Social Activities
- We are looking at decreasing ambulatory assignments, while maintaining academic rigor of all rotations