



Principles for Practice Management Training in PGME

December 2016

Executive Summary

There is a significant transition when residents graduate from the supervised learning environment to become independent practitioners. One important aspect of this transition is Practice Management (PM), which refers to the non-clinical (e.g., legal, administrative, financial) detail of running a practice. PM is a requirement of both CanMEDS and CanMEDS-FM.

Background

Although residency program accreditation standards across Canada specify the need for PM training, there is no national curriculum that directs its timing, breadth, or form. A literature review found no published research to guide PM training in Canada. The 2015 RDoC National Resident Survey found that residents have limited access to structured PM training, with significant variation among disciplines in the availability and quality of such training. Residents reported low levels of satisfaction with the training they did receive, and expressed a preference for didactic or experiential training. Overall, it is unclear whether existing PM training is effective in preparing residents for the realities of medical practice.

Principles

RDoC has identified four principles to promote successful PM education for Canadian residents:

1. Universal – to enable residents of all disciplines to access protected, targeted training.
2. Comprehensive – to provide wide-ranging understanding of all aspects of non-clinical practice (e.g., legal, administrative, financial).
3. Evidence-based – to ensure the material and how it is presented translates into an effective educational program applicable to real practice.
4. Collaborative – to promote best practices and broad understanding through collaboration with experts in relevant fields.

Conclusion

RDoC believes that PM training during residency is essential for physicians who are preparing to begin independent practice. Accordingly, RDoC has identified a strong need

to help residents acquire PM skills. **Practice management training must be delivered universally to all resident doctors, through a curriculum that is consistent, comprehensive and evidence-based, and in collaboration with relevant organizations and sectors.**

Principles and Calls to Action

PRINCIPLE 1 – UNIVERSAL

Residents in Canada have inconsistent access to PM training. Specialty discipline, level of training, and location are factors that contribute to this disparity. These inconsistencies are of concern, because residents in all disciplines need training in practical matters like medicolegal regulations or financial management. Because practice management skills are essential to every physician, residents of all disciplines should be able to access protected, targeted training.

Calls for Action:

1. PM training should be integrated throughout residency and modified for each level of training.
2. PM training should include protected time for academic sessions and clinical work.
3. PM training should accommodate variation in residents' specialty, geographic location, and practice setting.

PRINCIPLE 2 – COMPREHENSIVE

Running a medical practice is a complex process that requires financial, business, and management skills. Considering physicians' role in the national health system, training in all aspects of resource stewardship – including running a medical practice – is essential. However, Canadian medical residents do not have equal access to quality practice management training. Current training programs are variable and their limited content may not adequately prepare residents to successfully pursue clinical practice in diverse specialties, practice settings, and geographic locations. Resident physicians across Canada reported low satisfaction with the breadth, delivery, and applicability of current PM training. It is clear that measures are needed to improve PM training.

Calls for Action:

1. PM training should include the financial, administrative, and legal aspects of practice.

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2. PM training should include both didactic and applied or experiential learning opportunities.
3. There should be a standardized approach to curriculum development.
4. Faculty should be prepared to deliver PM training through formal/didactic sessions and on the job, during clinical time.
5. PM training should be delivered in the context of resource stewardship.

PRINCIPLE 3 – EVIDENCE-BASED

It is generally accepted in medical education that learning interventions and curricula should be designed and delivered in accordance with the best available evidence. PM training is no exception. However, the paucity of data pertaining to PM training, especially in the Canadian context, is of significant concern. It underlines the need for an evidence-based approach to ensure that PM training effectively prepares residents to competently manage a practice when they graduate. Continuous evaluation and quality improvement will be important to ensure that PM education is effective, current, and relevant.

Calls for Action:

1. PM curricula should be developed using the best available evidence.
2. PM curricula should be evaluated and modified on an iterative basis for continuous quality improvement.
3. There should be dedicated research in PM training in the Canadian context, particularly in terms of outcomes and effectiveness.
4. PM training should be evaluated with consistent standards and rigor by all residency programs.

PRINCIPLE 4 – COLLABORATIVE

Physicians practice in a complex organizational and inter-professional context, and PM training should reflect this collaboration.

Calls for Action:

1. PM training should be developed in consultation with relevant stakeholders, including national medical, educational, and learner organizations.
2. PM curriculum development should be interdisciplinary and include objective content experts from legal, administrative, and financial management backgrounds.
3. PM training should continue to be an accreditation standard of the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada.
4. PM training objectives should be developed using the CanMEDS framework.

Complete Findings

In the context of medicine and the medical profession, the term Practice Management (PM) refers to the non-clinical aspects of running a practice, including legal, administrative, and financial matters. As these are integral components of medical practice, all physicians need to acquire competency in practice management during residency to ensure they are able to effectively transition to independent practice.

Practice management covers many issues. Key topics include financial planning, insurance, accounting and taxation, legal issues, medical records management (electronic systems and others), physician remuneration options, negotiation, setting up a medical or clinical office, and human resources. Practice management may also involve time management, interpersonal and communication skills, professionalism, practice-based learning and improvement, and system-based practice. The latter topics in particular correspond to the physician's role in responsible stewardship of health care resources, continuous quality improvement, and patient safety. Competency in practice management is therefore essential for physicians not only at in an individual practice, but also in the broader health care system.

Background

Current PGME landscape

The purpose of our medical education system is to prepare an appropriate number and mix of physicians with the knowledge and skills to meet the needs of Canadian society. To that end, residency training programs and curricula are developed and delivered in accordance with the educational framework of physician competencies (CanMEDS and CanMEDS-FM) and must meet national standards for evaluation and accreditation.

Currently the PGME system is undergoing major changes driven by the move to competency-based education (CBME¹) and the need to better align training with societal need. This coincides with implementation of the new CanMEDs 2015 Framework and the extensive reform of all national accreditation standards. As all of this has implications for the future of PM training in Canadian residency programs, it is necessary to clarify how changes will impact PM training as a key area of physician competency.

Required physician competencies

Practice management training is a well-established requirement of both CanMEDSⁱ (Royal College, 2005 and 2015) and CanMEDS-FMⁱⁱ (CFPC, 2009), which set out the educational framework of physician competencies – the abilities physicians require to effectively meet the health care needs of the people they serve.² In CanMEDS-FM, the “Manager” role requires physicians to “manage their practice and career effectively” through a series of enabling competencies, in

¹ CBME/Competence by Design (CBD) represents “a move away from the practice of credentialing physicians solely on the basis of time spent on rotations and activities, and toward forms of learning and assessment that examine the learner's achievement and maintenance of competence in learning and practice.” Royal College: <http://canmeds.royalcollege.ca/en/about> Accessed June 3, 2016.

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particular: “2.2 Manage a practice including finances and human resources, collaboratively when indicated,” and “2.3 Implement processes to ensure continuous quality improvement within a practice.”

The updated 2015 CanMEDS Framework renames the “Manager” role as “Leader” and describes physicians as “active participants/architects within the health care system.” The new Leader role identifies specific competencies around the physician’s ability to “manage career planning, finances, and health human resources in a practice,” including: “4.1 Set priorities and manage time to integrate practice and personal life, 4.2: Manage a career and a practice, and 4.3 Implement processes to ensure personal practice improvement.”

With the introduction of a new competency-based curriculum for residency training that is guided by the CanMEDS and CanMEDS–FM frameworks, there is greater emphasis on non-clinical skills as key and enabling physician competencies within the Leader role. This further underscores the importance of PM training as a core component of residency education.

Program accreditation standards

The Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, and the Collège des médecins du Québec maintain national standards for the evaluation and accreditation of Canadian residency programs to ensure that all adhere to a set of minimum standards (General Standards of Accreditation). Practice management is included within the current B Standardsⁱⁱ.

Standard B5: Clinical, Academic and Scholarly Content stipulates that the program must “adequately prepare residents to fulfill all of the CanMEDS/CanMEDS-FM Roles” and “the design of teaching and learning of the individual competencies takes best practices into account.” Residency program requirements specific to the Manager role (4. Manager) further stipulate that “4.3 *The program must be able to demonstrate that it provides effective teaching to assist residents with the successful management of their practice and career*”³ in addition to several related requirements.

It is of significant concern to RDoC and other learner organizations that although residency programs are assessed and evaluated for compliance with these general standards, many residents report they do not receive any form of PM training, or have low levels of satisfaction with the training

they do receive (see “Resident doctors’ perspectives/experiences”).

Reform of the residency accreditation system presents an opportunity to address concerns related to access and quality of PM training. Program standards are being updated to align with CBME and reorganized according to 6 new domains⁴ that correspond to the new 2015 CanMEDS framework of physician competencies, including the change from Manager to Leader. The revised program accreditation standards should acknowledge the importance of obtaining PM skills during residency.

Findings from the literature

A need for change

A review of the academic literature⁵ on practice management in the PGME setting provides a clear message: practice management is an important and necessary part of a physician’s training, yet existing training is lacking. The need for better PM training in PGME is well documented, with surveys dating back to the 1970s showing the majority of residents, program directors, and practising physicians across many specialties feel their programs do not provide enough preparation for the business or practical aspects of medicine.^{iv, v, vi, vii, viii, ix, x, xi, xii, xiii, xiv, xv, xvi, xvii}

Format of Practice Management training

PM training initiatives vary widely in delivery method, timing, and topics, with most designed for residents in a specific discipline. PM training commonly is offered in the form of retreats^{xviii} workshops,^{xix} longitudinal courses, or ongoing mentorship.^{xx, xxi, xxii, xxiii, xxiv} Topics most frequently covered include time management, billing and coding, personal finances, ethics and liability, and the business aspects of running a practice. The timing of PM training is also important, as residents are less motivated to learn PM when they do not see an immediate need to learn the material, especially when faced with a multitude of competing learning priorities.^{xxv}

One group of researchers proposed a standard national curriculum that could be modified to fit the needs of individual programs.^{xxvi} Based on a systematic review of the literature from 1990–2008, they recommended 4 curriculum design features: case-related method, active learning strategies (e.g., longitudinal hands-on projects), external experts, and faculty champions. These researchers emphasized the need for annual, objective outcomes assessment

2 CanMEDS is an educational framework first created by the Royal College in the 1990s that describes the abilities physicians require to effectively meet the health care needs of the people they serve. The framework is organized into seven thematic groups of competencies, which are expressed as CanMEDS Roles. Within each Role are a defined number of essential abilities known as Key Competencies, and for each key competency there are several Enabling Competencies (the essential components of a key competency). Royal College: <http://canmeds.royalcollege.ca/en/about> Accessed June 3, 2016.

3 This is further explained in the corresponding “descriptor” as “There is teaching in management skills pertinent to the residents’ future career needs.”

4 In particular, practice management skills/competencies will be integrated in 2 of the 6 new domains of program standards: the education program section, and the section on learners, teachers and administrators.

5 An initial search of PubMed and Google Scholar was performed in December 2015 using the key words “practice management,” “transition to practice,” “physician,” “medical/medicine” and “training.” This led to the retrieval and review of 3 articles on the need for PM training and another 5 that discussed PM training initiatives. A second, more extensive search of Ovid Medline was performed January–February 2016 using the key words “practice management,” “medical,” “education,” “graduate” and “internship and residency.” The search was limited to the English language and to articles published since 2000. This led to the review of 24 articles (with a further 14 identified as potentially valid but not accessible) that were grouped into 4 types of investigation (needs assessment, program evaluation, program description, and opinion/commentary). There was very little overlap in the reviewed articles and no published Canadian studies were found.

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for quality assurance and improvement, and to prove competency of the individual learners. They also discussed assessment methods such as portfolios, written tests, OSCEs, and checklists – an approach that was echoed by a general practitioner in the UK who suggested practice management be tested on licensing examinations, such as through an OSCE scenario.^{xxvii}

Resident responses and preferences

Regardless of the form or content, residents generally responded positively to PM training, although only small numbers of residents were asked for feedback.

Experiential learning is the preferred method for PM training. The literature cites examples that range from a unique 5-day systems-based practice rotation that exposes residents to “many of the financial, economic, and regulatory factors that affect patient care,”^{xxviii} to resident-run clinics set up for residents to learn by doing.^{xxix} Other approaches include “train the trainers” and structured, hands-on, practical curriculum,^{xxx} and interactive, didactic teaching combined with case-based homework assignments.^{xxxi}

Evaluation of Practice Management training

Despite the numerous and varied approaches to teaching PM, the literature review found a lack of robust evaluation. One limitation that was identified is that many PM teaching initiatives have elective enrolment,^{xxxii, xxxiii, xxxiv, xxxv} which introduces selection bias since participants are motivated and have the time to learn about the non-clinical subject. However, such pilot programs may not be generalizable to mandatory PM curricula. Given the lack of strong evidence about best practices, it is important that in future PM training and curricula are studied to allow for quality improvement and growth.

Practice Management training in Canada

The somewhat analogous situation in the United States is worth noting. Despite the fact that the Accreditation Council for Graduate Medical Education (2002) identified 6 domains of competency⁶ (PM skills are prevalent in 3 of these domains), and although PM is considered a major component of the TransforMED new model of care, there is no national curriculum to guide training in these competencies. A similar situation exists in the Netherlands where CBME was introduced in 2005 (using the CanMEDS roles); despite the Manager role being one of the key competencies, most post-graduate curricula have no recognized PM course.

Most research on PM training pertains to education in the US and other countries, and there does not appear to be any published evaluation of PM programs in Canada. There is a compelling need for Canadian research to evaluate the

effectiveness and outcomes of existing PM training, and to make recommendations for curriculum design and delivery in Canadian PGME.

It is also notable that in Canada today, PM training is less structured, is delivered primarily in workshops and seminars, is largely optional or self-directed, and exists outside the prescribed PGME curriculum. A key challenge will be supporting Canadian program directors as they make room for PM training in the PGME curriculum so that it is prioritized and fully integrated, with dedicated, protected time.

Resident doctors’ perspectives/experience

To better understand the current situation in Canada, RDoC surveyed residents about their experiences and preferences related to PM training.⁷ Most striking was the varied and disparate access to training among residents of different disciplines. As Figure 1 depicts, the majority (85%) of family medicine residents received some form of PM training during their residency but less than 60% of residents in medical, surgical, and other specialties had the same experience. More than one-third of respondents received no PM training.

There was a strong preference for didactic and experiential training. Residents of all disciplines responded that “formal academic half day or workshop,” “formal practice management seminar or course,” or “informal guidance during clinical training (e.g., billing in the clinical setting, specific guidance from staff)” were most popular. Very few residents reported receiving PM training through “self-selected online resources,” which may reflect a lack of protected time for this method of learning. PM training also tends to occur toward the end of residency; only 14% of final-year residents reported they had not received any PM training compared to 30% of first-year residents.

When asked to rate their level of satisfaction with the PM training or resources available to them, more residents reported dissatisfaction (25% not satisfied, 45% neutral, 12% unsure/no response); only 10% were satisfied. The method of PM training was a factor, with greater satisfaction reported by those who received formal teaching compared to those who relied on informal guidance or self-selected online resources. Medical discipline was also a factor, with family medicine residents expressing the most satisfaction and surgical specialty residents reporting the least. This may be related to the fact that family medicine residents were more likely to receive PM training, and residents who received PM training reported higher levels of satisfaction. Senior residents were also more satisfied than more junior residents, which is consistent with the fact that PM training often occurs toward the end of residency.

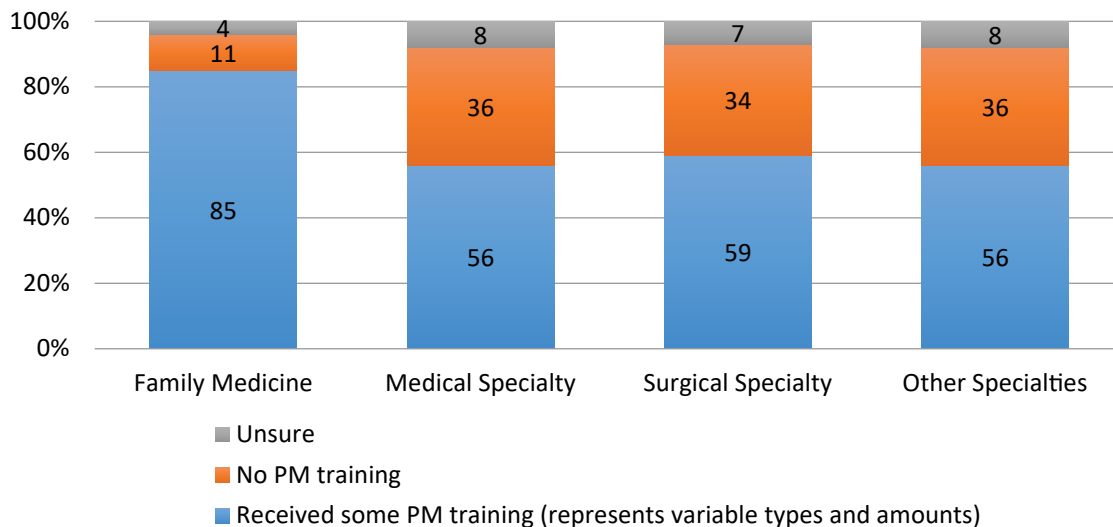
The majority of residents felt that financial planning (71%), physician remuneration (67%), setting up a medical or clini-

6 US ACGME and ABMS in 2002 endorsed 6 domains of physician competency: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice.

7 The 2015 National Resident Survey was in the field April 15-May 15. A total of 1,676 RDoC members from across Canada (excluding Quebec) participated; the response rate was 15.8%. Residents were asked a series of questions on practice management, which the survey defined as “the non-clinical aspects of running a practice – i.e., the legal, administrative, and financial skills physicians need to effectively manage their practice.”

Figure 1.
Percent of Residents Per Program Type Across Canada Not Receiving or Receiving PM Training

*Based on 2015 National RDoC Resident Survey, 1,676 participants



cal office (61%), and accounting/taxation (60%) were the top priorities for PM training. These responses were consistent across all specialties and years of training. When asked about training methods, residents indicated their preference for formal didactic sessions (73%), on-the-job training (61%), and informal teaching by preceptors and peers (56%). These results were similar across specialties, years of training, and gender.

RDoC believes that teaching the complex, non-clinical skills that every new graduate requires to enter practice successfully is an essential part of a comprehensive post-graduate medical education. However, it is a significant concern that a large percentage of residents – particularly those in medical, surgical, and other (laboratory/diagnostic) specialties – receive no PM training. The survey also indicated that family medicine residents completing a third year⁸ (R3 FM) are considerably less likely to have PM training than other family medicine residents. There is a clear need for a standard and consistent approach to PM training in Canada, across all programs with content tailored to the individual needs of residents.

Conclusion: Need for PM training

To ensure a seamless transition from training to practice, it is important that all residents receive PM training in the non-clinical (e.g., legal, administrative and financial) skills necessary for physicians in all disciplines. PM training should be part of the PGME curriculum.

At present the need for PM education and training is not being met. Current PM training is largely informal and self-guided by resident physicians. PM education is also of varied quality due to lack of standards, faculty training, and evidence-based research on best practices.

Taking a leadership role in examining and evaluating current practices, Resident Doctors of Canada has developed a set of principles and calls to action to help guide implementation and curriculum for practice management in Canadian residency education. **We believe that practice management training must be delivered universally to all resident doctors, through a curriculum that is consistent, comprehensive and evidence-based, and in collaboration with relevant organizations and sectors.**

⁸ Family medicine residents training in an PGY-3 program were more likely to report not having received practice management training (26%) compared to other family medicine residents.

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