Transforming the primary care teaching clinic

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Session objectives

- Identify six principles for creating high-functioning primary care teaching practices using the Clinic First model

- Discuss strategies to implement transformation in specific primary care teaching clinics
Presenter disclosures

- This presenter has nothing to disclose.
“When I started in the clinic, there was chaos. There were too many patients and we couldn’t take good care of them. [The residents] always had someone sicker in the hospital they needed to go back to… Clinic was leftovers – the action was in the hospital. Now, for the first time, clinic is the most important place for the residents and that shows in how the clinic operates and the care we provide.”

- Faculty Preceptor at internal medicine teaching practice
The “double helix”

Dualistic and potentially synergistic relationship between:

- **clinical care/quality mission**
- **teaching/academic mission**

References:


Faculty physicians and residents often spend only 1 – 2 half-days in teaching clinic.

Leads to challenges with:
- Continuity
- Access
- Team based care
Vicious cycle

- Poor student modeling
- Chaotic teaching environments
- Frustrated teachers
- Frustrated learners
- Frustrated staff

Vicious cycle
Teaching clinic study

23 primary care family medicine, internal medicine, and pediatric residency practices
10 + 3 Building Blocks

1. Engaged leadership
2. Data-driven improvement
3. Empanelment
4. Team-based care
5. Patient-team partnership
6. Population management
7. Continuity of care
8. Prompt access to care
9. Comprehensive-ness and Care Coordination
10. Template of the future

- Resident Scheduling
- Resident Engagement
- Resident Worklife
4. Team-based care

**Challenges of teaching practices**

- How do we consistently pair residents with MAs when residents are so part-time?
- How do we create teams that are the same size every day when scheduling leads to 6 residents in clinic some days and none other days?
- How do we make our teams small enough so that patients feel comfortable with their team?
7. Continuity of care

Interpersonal Continuity of Care and Care Outcomes: A Critical Review

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ABSTRACT

PURPOSE: We wanted to undertake a critical review of the medical literature regarding the relationships between interpersonal continuity of care and the outcomes and cost of health care.

METHODS: A search of the MEDLINE database from 1966 through April 2002 was conducted by the primary author to find English language articles focusing on interpersonal continuity of patient care. The articles were then screened to select those articles focusing on the relationship between interpersonal continuity and the outcome or cost of care. These articles were systematically reviewed and analyzed by both authors for study method, measurement technique, and quality of evidence.

RESULTS: Forty-one research articles reporting the results of 40 studies were identified that addressed the relationship between interpersonal continuity and care outcome. A total of 81 separate care outcomes were reported in these articles. Fifty-one outcomes were significantly improved and only 2 were significantly worse in association with interpersonal continuity. Twenty-two articles reported the results of 20 studies of the relationship between interpersonal continuity and cost. These studies reported significantly lower cost or utilization for 35 of 41 cost variables in association with interpersonal continuity.

CONCLUSIONS: Although the available literature reflects persistent methodologic problems, it is likely that a significant association exists between interpersonal continuity and improved preventive care and reduced hospitalization. Future research in this area should address more specific and measurable outcomes and more direct costs and should seek to define and measure interpersonal continuity more explicitly.

How do you promote continuity with very part time providers?

- Patient’s continuity with their PCP
- Residents’ continuity with their panel
Clinic First

1. **Consistent resident schedules** to prioritize continuity and eliminate inpatient/outpatient tension

2. Develop **small core of clinic faculty**

3. Create **operationally excellent practices**

4. Build cohesive and stable clinic **teams**

5. Increase resident clinic **time** to enhance learning and access

6. **Engage residents** as co-leaders of transformation
Resident scheduling

1. **Consistent resident schedules** to prioritize continuity and eliminate inpatient/outpatient tension

5. Increase resident clinic time to enhance learning and access

- Residents are scheduled in clinic
- Regularly, predictably, far in advance
- With short intervals between clinic time
- Eliminate inpatient/outpatient tension
Case: Baystate-Tufts Internal Medicine

- **Consistent 2-week mini-block** schedule separates inpatient and outpatient duties

- Residents not away from clinic more than 2 weeks

*Continuity* from patient perspective with team increased to 80%
(almost always with one of two providers)
Case: Group Health Cooperative Family Medicine

- **One week blocks.** Residents are not absent from clinic for more than 7 days at a time. One week inpatient bursts.

Overall **clinic time** increased to 30% of total training time with 80% patient **continuity**
Case: University of Cincinnati Internal Medicine

- **Long outpatient block** – months 17-29 of residency fully dedicated to clinic. Aim to provide authentic 12-month experience of primary care.

Did not increase total clinic time for residents, but focuses that time during 12 months.

Enhanced **resident and patient satisfaction**, improved **preventive care and continuity**
Minimizing inpatient/outpatient conflicts

“It’s very difficult to focus on outpatient care when on the wards. Long block was a reprieve – and it was really nice to focus on outpatient. I felt like I could be a real primary care doc and prepare for the real world. It’s amazing how comfortable you get managing a panel independently after a year.”

- Resident at Cincinnati Internal Medicine
Scheduling and continuity

- Minimize duration between clinic-heavy blocks
  - Short “mini-blocks”

- Frequent clinics per week during clinic-heavy blocks (set minimum of half days)

- Increasing overall clinic time throughout residency

- Schedule residents’ clinic predictably/far in advance, with some slots saved for same/next-day appointments
Small core faculty

Many sites have small core clinic faculty, with each faculty attending in clinic for at least 0.5 FTE.

Small, strong core clinic faculty important for:

- Engagement and leadership in the clinic
- Resident teaching
- Continuity
- Stable teams
Team-based care

Build cohesive and stable clinic teams

1 team, 3 teamlets

- Patient panel
  - Clinician/MA teamlet
    - Social worker
  - Pharmacist
  - Nutritionist
  - Care manager
  - Panel manager
- Patient panel
  - Clinician/MA teamlet
  - Health coach
- Patient panel
  - Clinician/MA teamlet
  - RN
Traditional vs. teamlet model

Traditional model

Teamlet model

Over the week:
Case: Greater Lawrence Family Medicine

- 4 color teams, each divided into 2 mini-teams: 2 faculty, 3 residents, 1 MA, 1 RN

- Team members are rarely shifted away from their home team, and seen on the same mini-team even when primary provider away, creating continuity

- While MAs work with several clinicians, residents and faculty work with the same MA 75-80% of the time.
Case: Crozer Keystone Family Medicine

- Three larger color teams (3 attendings, 2 MAs, 9-10 residents), each divided into teamlets

- Each teamlet in clinic consists of one resident, one MA, and one medical student

- Residents usually work with one of the two MAs on their color team
Share the care

- Moving from a physician-centered paradigm to a share the care philosophy

- All team members contribute to and feel ownership of the health of the team’s patient panel

- Culture shift towards empowerment, rather than delegation

- Allows expanded team roles
Co-location

Traditional workrooms

MA room

MA 1
MA 2
MA 3

Resident room

Resident 1
Resident 2
Resident 3

Co-located workroom

MA 1
Resident 1

MA 2
Resident 2

MA 3
Resident 3

Attendings, RN, SW

Co-location
Co-location
Using teams for continuity

- Team continuity anchor:
  - A full time faculty physician/NP/PA mainly sees team’s patients when resident PCP not available

- Practice partners/shared panels within a team

- Other stable team members, ex. Team RN
Using teams for continuity: Patient scheduling

- Scheduling algorithms for patient appointments
  - Ex. if PCP not available on day requested:
    - sees PCP on different day
    - sees different resident on same team (R1 → R2 → R3)
    - sees faculty member on same team
    - sees resident on different team
    - sees faculty on different team
    - sees urgent care

- Patient messaging/education
  - Who is on their empaneled team
  - Importance of continuity
Quality of clinic experience

6. Engage residents as co-leaders of transformation
   - Meaningful, experiential education in PCMH, QI
   - Empowering residents as leaders in clinic

3. Create operationally excellent practices
   - Training leaders in primary care requires experience with high functioning clinics
   - Well functioning clinics lead to positive clinic experiences

Resident Engagement
Resident Worklife
Case: Erie Family Health Center

• Didactics paired with **hands-on**, skills-based clinic improvement work; residents engage in PDSAs

• Collaborative **team education**
  • Residents taught spirometry by RNs, clinic flow by MAs
  • MAs and RNs encouraged to give residents feedback; they evaluate residents twice a year

• Clinic morbidity and mortality case conferences include staff participation

• Residents accompany clinic leaders to local and national policy meetings, testify at legislative hearings
Case: Crozer Keystone Family Medicine

“The clinic is the curriculum”

- Learning about practice transformation through hands-on experience

- Resident involvement integral to clinic’s PCMH redesign

- “Medical home” class representatives

- “Teaching resident” role
Worklife in high functioning clinics

“It’s hard to find a place to work like this [clinic]… I feel like I’ve kind of been spoiled.”
- Resident at Crozer Keystone Family Medicine

 “[This] is what I would want to do for patients in my practice.”
- Residents at Wright Center Internal Medicine
Good education for tomorrow’s workforce requires excellent care for today’s patients

- Residency Program Director
Clinic First

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Acknowledgements

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High-Functioning Primary Care Residency Clinics
Building Blocks for Providing Excellent Care and Training
List of practices

- Baystate-Tufts Internal Medicine Residency
- Brigham and Women’s Hospital Internal Medicine Residency, South Huntington
- Crozer Keystone Family Medicine Residency, Center for Family Health
- Family Medicine Residency of Idaho
- Greater Lawrence Family Medicine Residency
- Group Health Cooperative Family Medicine Residency
- Harlem Residency in Family Medicine, Institute for Family Health
- Massachusetts General Hospital Internal Medicine Residency Program
- Northwestern Family Medicine Residency Program at Erie Family Health Center
- Tufts University Family Medicine Residency Program, Cambridge Health Alliance
- UCSF Internal Medicine Residency at San Francisco General Hospital (SFGH)
- UCSF Internal Medicine Residency Veterans Administration Medical Center
- University of Colorado Family Medicine Residency
- University of Colorado Pediatrics Residency
- University of Cincinnati Internal Medicine Residency
- University of Kansas Family Medicine Residency
- University of North Carolina Family Medicine Residency
- University of North Carolina Internal Medicine Residency
- University of Rochester Family Medicine Residency
- University of Rochester Pediatrics Residency
- University of Utah Family Medicine Residency
- Virginia Tech Carilion Family Medicine Residency
- Wright Center for Primary Care Internal Medicine Residency, Pennsylvania
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