Clinic First

The road to excellence in primary care teaching clinics

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"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 in a teaching practice

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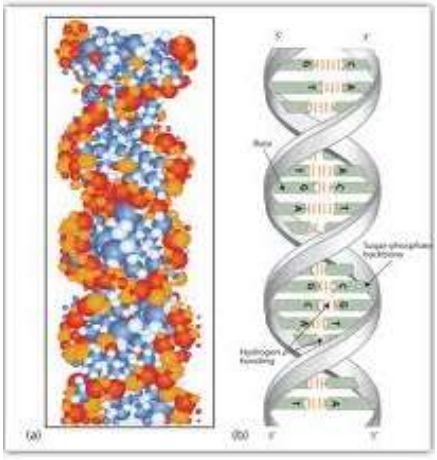
The Dilemma

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

Leads to challenges with:

- Continuity
- Access
- Team based care

The solution: the “double helix”



Dualistic and potentially synergistic relationship between:

clinical care/quality mission

and

teaching/academic mission

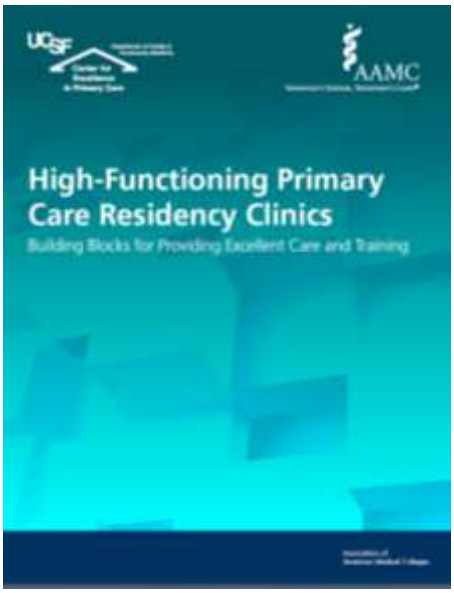
Teaching clinic study

45 primary care family medicine, internal medicine, and pediatric residency practices

UCSF Center for Excellence in Primary Care

THE JOSIAH MACY JR. FOUNDATION

AAMC



Detailed report available at:

www.aamc.org/buildingblocksreport

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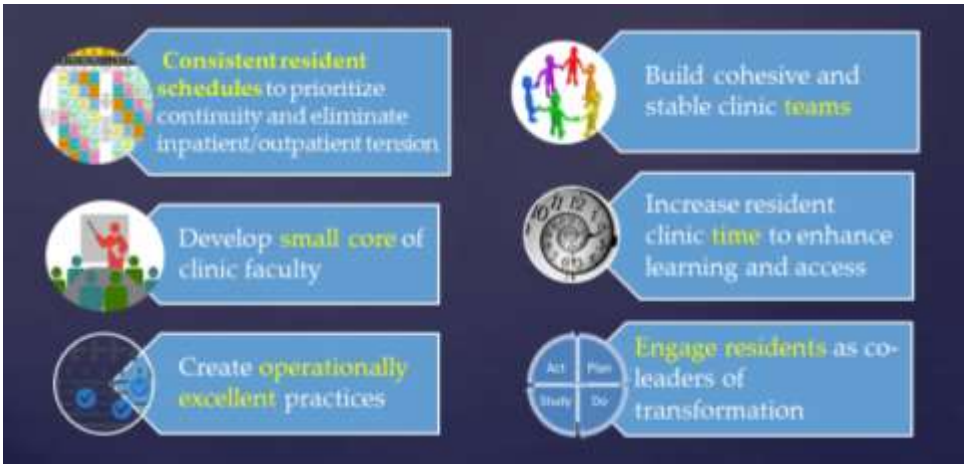
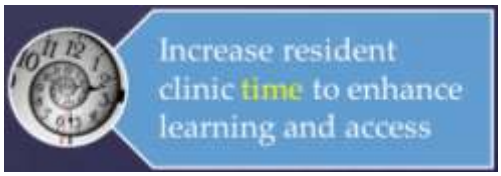


The spectrum

Hospital First **Clinic First**

Resident scheduling

- Residents need to be scheduled in clinic
  - **Regularly, predictably, far in advance**
  - With **short intervals** between clinic time
  - With minimal inpatient/outpatient **tension**



- Increase **total clinic time**
  - Average # half days in clinic during training for 9 FM clinics was 350 (range 250-550)

Baystate IM, Oklahoma-Tulsa FM

- 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% at Baystate (almost always with one of two providers)

University of Cincinnati IM

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

University of Washington IM Residency

- Retains 13 4-week block scheduling, but residents attend primary care clinic **for entire days** rather than half-day sessions
- In many rotations, residents attend primary care clinic on the same day each week.
- "Accordion model:"
  Inpatient → 2 full-day primary care clinics/month
  Specialty rotations → 4 full-day clinics/month
  Ambulatory blocks → 4 or more full-day clinics/month

  Ray et al, Improving ambulatory training in internal medicine: X + Y (or why not)? JGIM 2016;31:1519-22.

Minimizing inpatient/outpatient tension

"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

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Small core faculty

- Many sites have small core clinic faculty, with each faculty attending in clinic for **at least 0.5 FTE**. Important for:
  - Engagement and leadership in the clinic
  - Resident teaching
  - Continuity
  - Stable teams

The dispersed – core faculty spectrum

Many very-part-time faculty

Hybrid

A few almost-full-time faculty

Discussion

- Get together with someone at your table or a nearby table who is not from your residency program.
- Discuss with your partner:
  - Whether your primary care teaching clinic has a very-part-time faculty model or a near-full-time faculty model?
  - Do you like your model?
  - If you have many very-part-time faculty in your primary care teaching clinic and would like to move in the direction of more near-full-time faculty, how would you start that process?
- Keep a few notes of good ideas coming from your discussion and e-mail them to margae.knox@ucsf.edu

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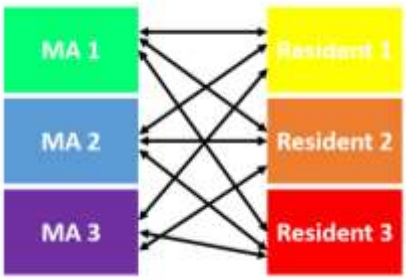
Team-based care

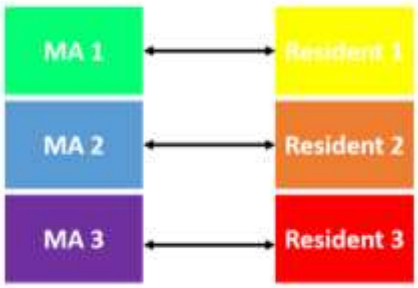
Challenges in teaching practices

- **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?**

Traditional vs. teamlet model

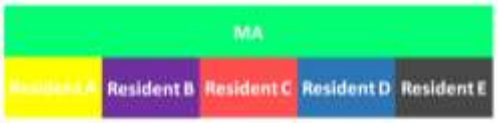


Traditional model



Teamlet model

Over the week:



Clinician-MA pairing spectrum

Clinicians look for any available MA

Each day, MAs are paired with 1 – 2 clinicians who may be different each day

Clinicians work with same MA each day in stable teamlets

Stable teamlets

- Greater Lawrence FM:
  - 3 residents to 1 MA per mini-team
  - Team members are rarely shifted away from their home team
  - MAs work with several clinicians, residents and faculty work with the same MA **75-80%** of the time.
- FM Residency at Natividad Medical Center:
  - 4 residents to 2 MAs per team
  - Residents work with one of their 2 MAs **80-90%** of the time
  - Priority for team pairings to R3s, then R2s, then R1s

Co-location

Traditional workrooms

Co-location

Central Washington FM at Yakima

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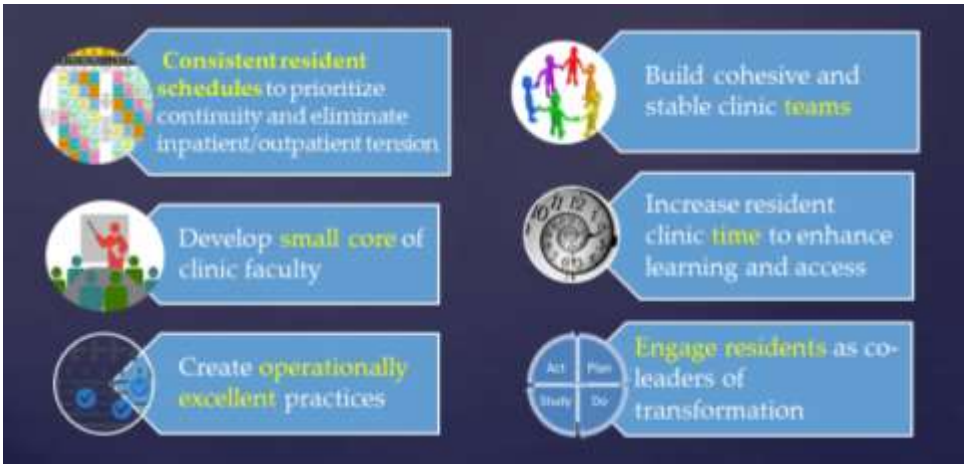

Quality of clinic experience

- Meaningful, experiential education in PCMH, QI
- Empowering residents as leaders in clinic

- Training leaders in primary care requires experience with high functioning clinics
- Well functioning clinics lead to positive clinic experiences

Erie Family Health Center

- Didactics paired with hands-on, skills-based clinic improvement work; resident PDSAs
- Collaborative team education
  - Residents taught spirometry by RNs, clinic flow by MAs
  - MAs and RNs encouraged to give residents feedback, 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

Family Medicine Residency of Idaho

- Legal advocacy training, resolution writing, serving on boards of directors
- Team-based QI projects
- Residents on key administrative committees
- Annual residency feedback
  - Roses, Thorns and Buds
- Retreats, individual wellness plans

- "The resident voice guides what we do." –Director of Education
- "Faculty and administration listen to us. We are heard and considered." –R3

Worklife in high functioning clinics

"The systems level thinking, primary care transformation, and quality improvement activities trickle down to the **day-to-day, on the ground clinic experience**."

– Resident at FM Residency of Idaho

"This is what I would want to do for patients in my practice."

– Resident at Wright Center IM

Good education for tomorrow's workforce requires excellent care for today's patients

- Residency Program Director

Acknowledgements

Research Team
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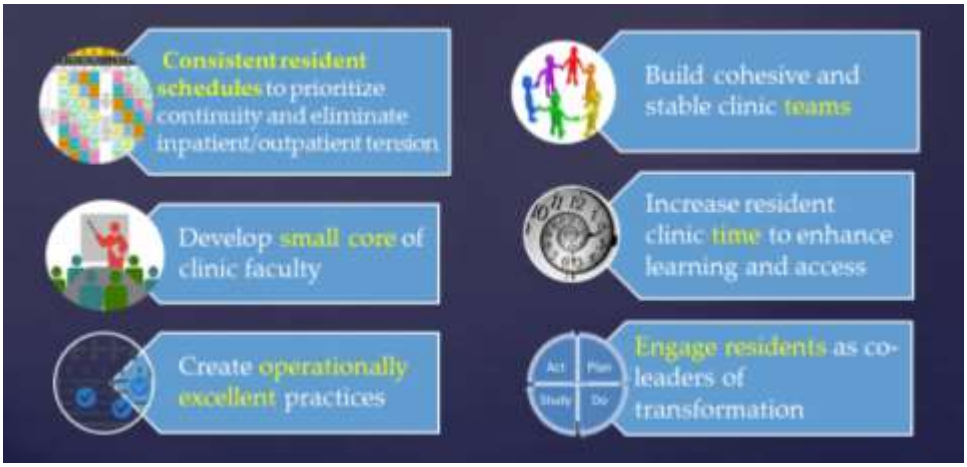

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Kaiser Permanente of Washington FMR at Seattle

Carl Morris, MD, MPH

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Kaiser Permanente of Washington FMR at Seattle

Our Clinic First – First Principles

- **Advanced primary care best classroom**
- **Train like full-spectrum FP**
- **Continuity is the "Secret Sauce"**

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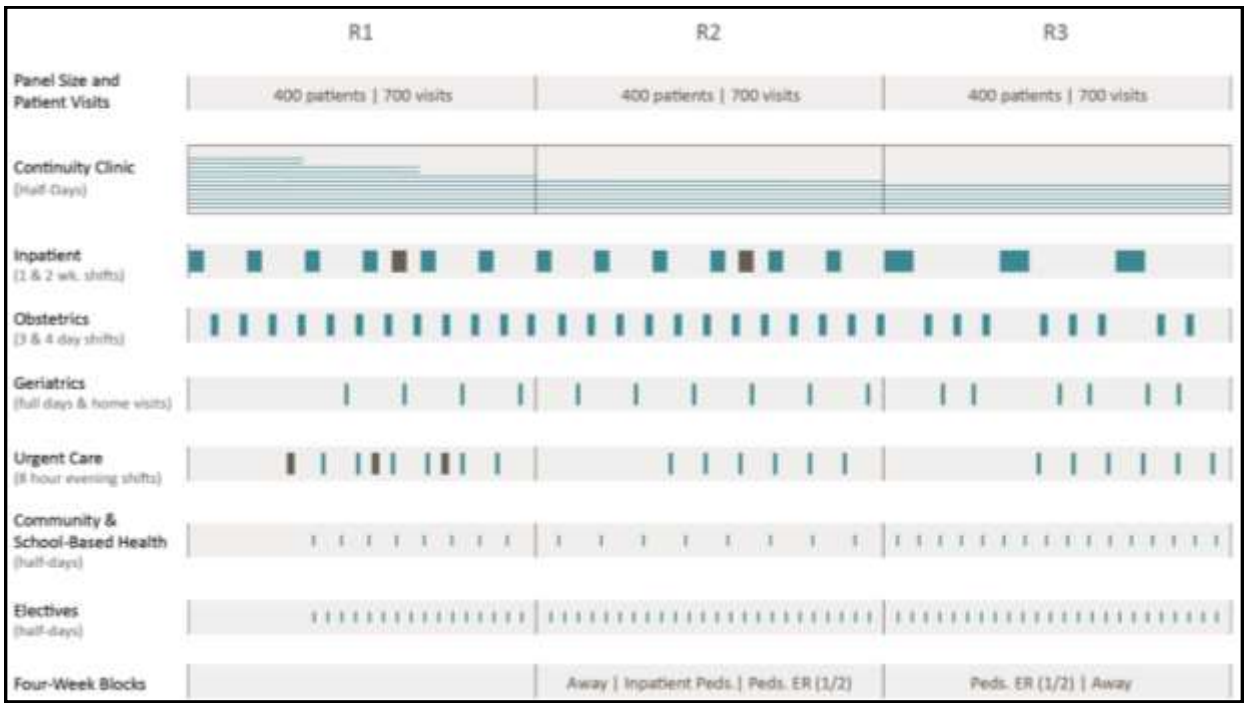
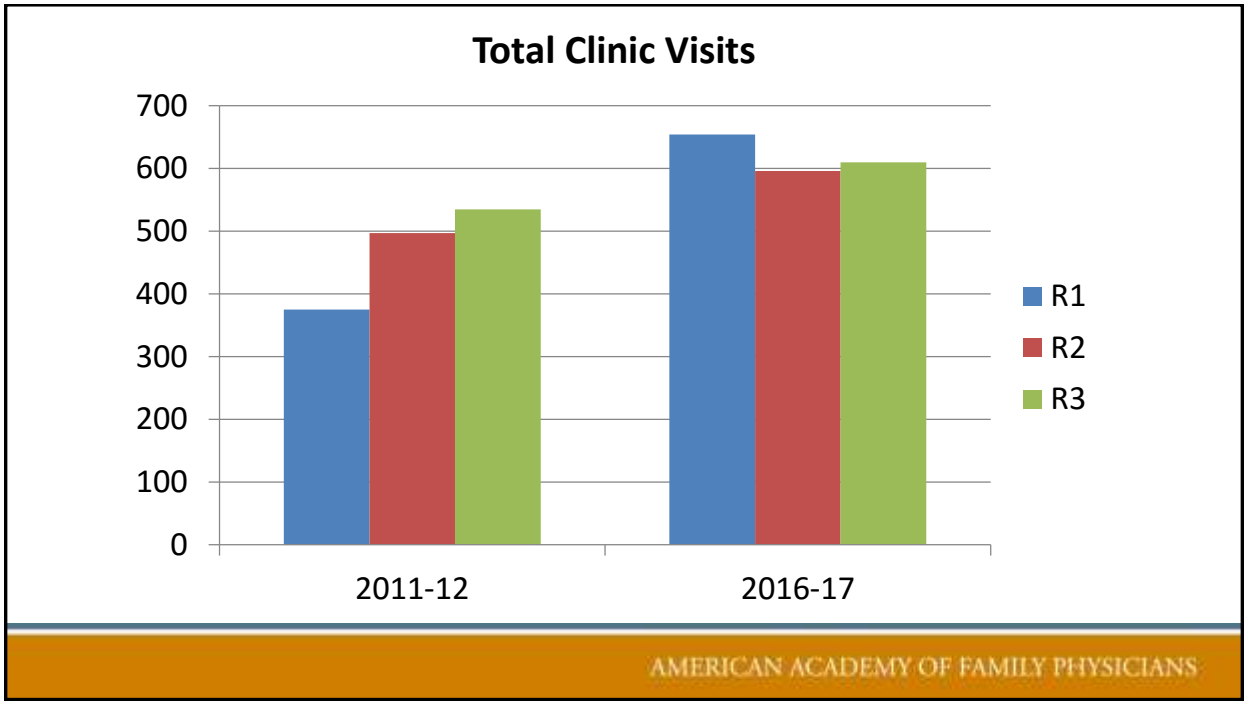
Block 1 (6/20-7/24)
Block 2 (7/25-8/21)
Block 3 (8/22-9/18)
Block 4 (9/19-10/16)
Block 6 (11/14-12/11)
(12/12-1/8) R2 Class retreat
(1/9-2/5) R1 Class retreat
(2/6-3/5) R3 Class retreat
Block 10 (3/6-4/2)
Block 12 (5/1-5/28)
Block 13 (5/29-6/25)


R1
R2
R3
Panel Size and Patient Visits
400 patients | 700 visits
400 patients | 700 visits
400 patients | 700 visits
Continuity Clinic
(Half-Days)
Inpatient
(1 & 2 wk. shifts)
Obstetrics
(3 & 4 day shifts)
Geriatrics
(full days & home visits)
Urgent Care
(8 hour evening shifts)
Community & School-Based Health
(half-days)
Electives
(half-days)
Four-Week Blocks
Away | Inpatient Peds. | Peds. ER (1/2)
Peds. ER (1/2) | Away


Total Clinic Visits
700
600
500
400
300
200
100
0
2011-12
2016-17
R1
R2
R3
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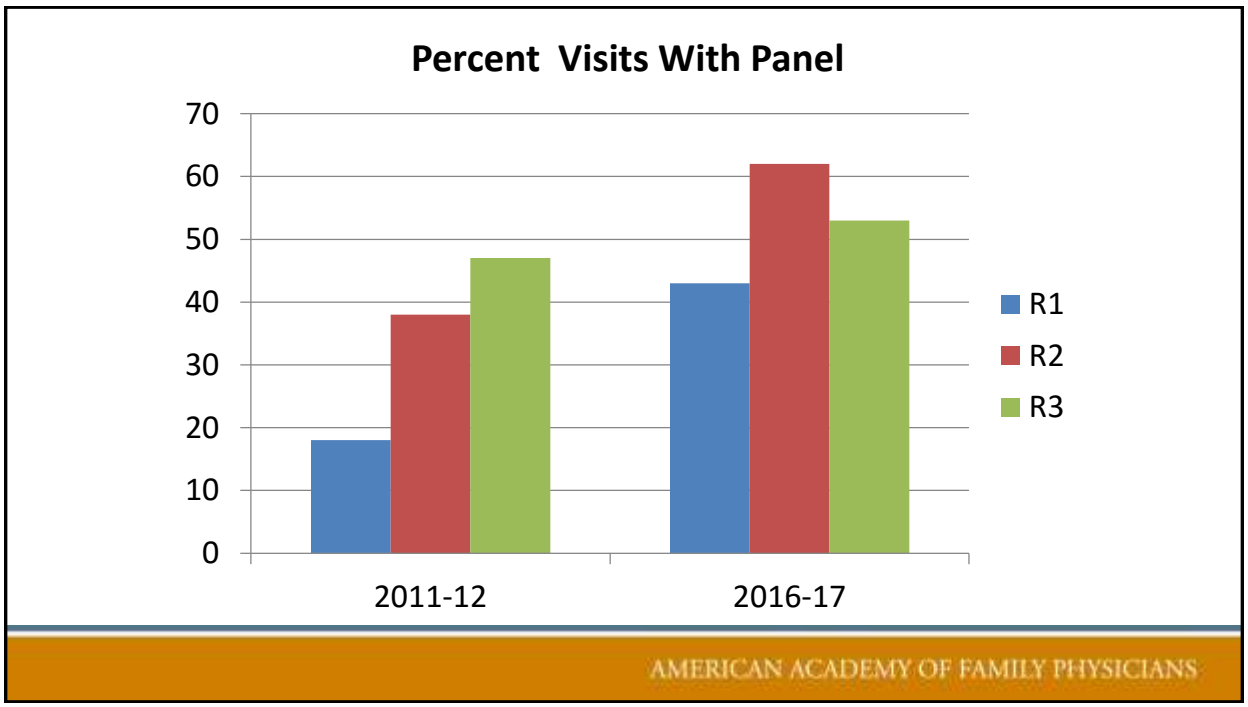
Percent Visits With Panel
70
60
50
40
30
20
10
0
2011-12
2016-17
R1
R2
R3
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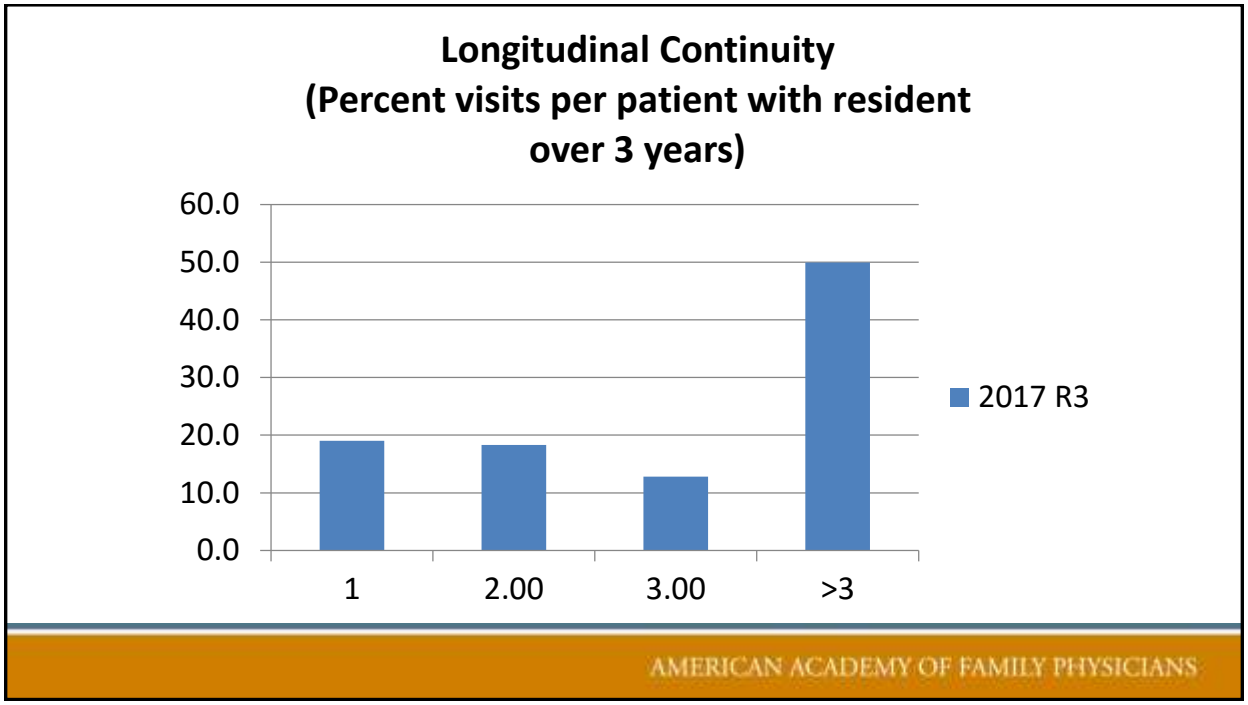

Outcomes

- **Residents are FPs**
  - **Learn like FPs**
  - **Know their panel**
  - **More confident and skilled in inpatient care**
  - **Think about wellness like a graduate**
  - **Experience continuity**

Discussion

- Discuss with the same or different partner:
  1) Do residents in your program regularly go from inpatient rotations in the morning to clinic in the afternoon?
  2) Does this cause stress for the residents?
  3) How might you change your scheduling so that residents do not go from inpatient rotations in the morning to clinic in the afternoon?
- Keep a few notes of good ideas coming from your discussion and e-mail them to margae.knox@ucsf.edu

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Crozer-Keystone Family Medicine Residency

Bill Warning, MD

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Crozer-Keystone FMR

- Three larger color teams (3 attendings, 2 MAs, 9-10 residents)
- 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

Team-based care

- Co-location
- Huddles
- Expanded team roles

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

Resident engagement

"**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

Discussion

- Discuss with the same or different partner:
  1) Do you try to pair residents with the same MA or small group of MAs every time the residents are in clinic?
  2) Would you like to have stable resident-MA pairings?
  3) How might you move in the direction of stable resident-MA pairings?

- Keep a few notes of good ideas coming from your discussion and e-mail them to margae.knox@ucsf.edu

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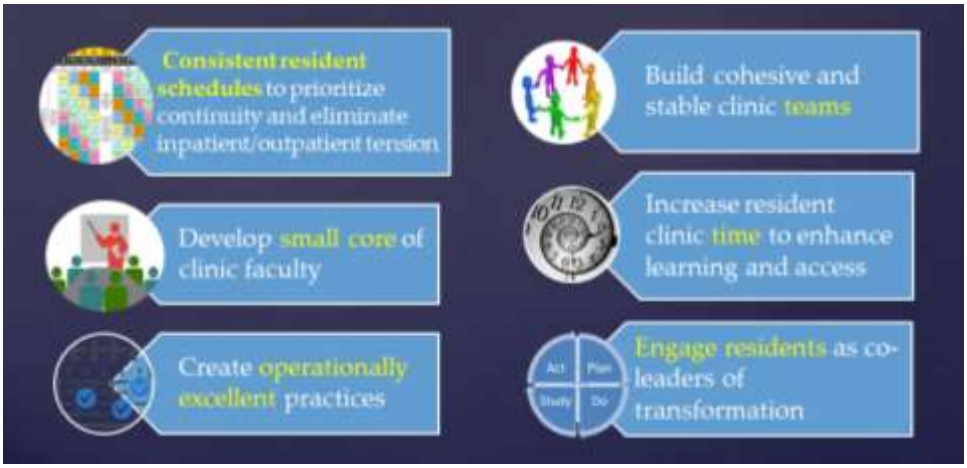


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