No More Blocks

Four-Year Experience with a Fully Longitudinal Curriculum

Kaiser Permanente Washington Family Medicine Residency
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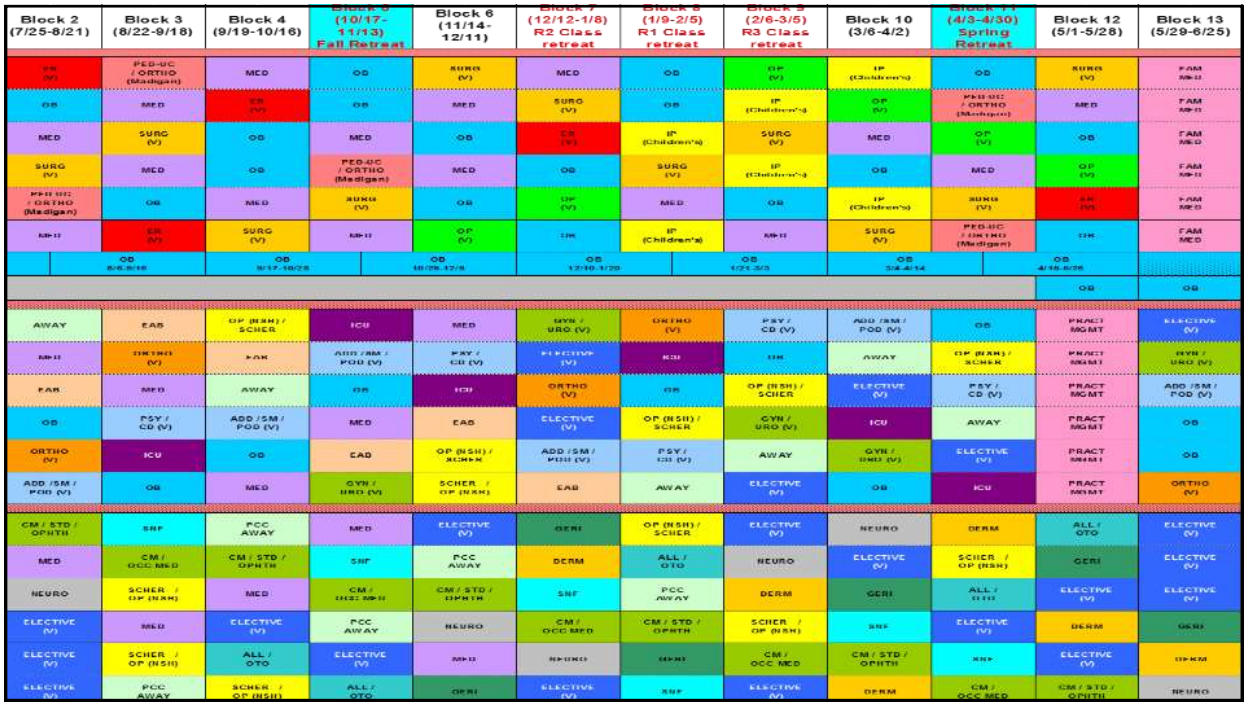
AMERICAN ACADEMY OF FAMILY PHYSICIANS

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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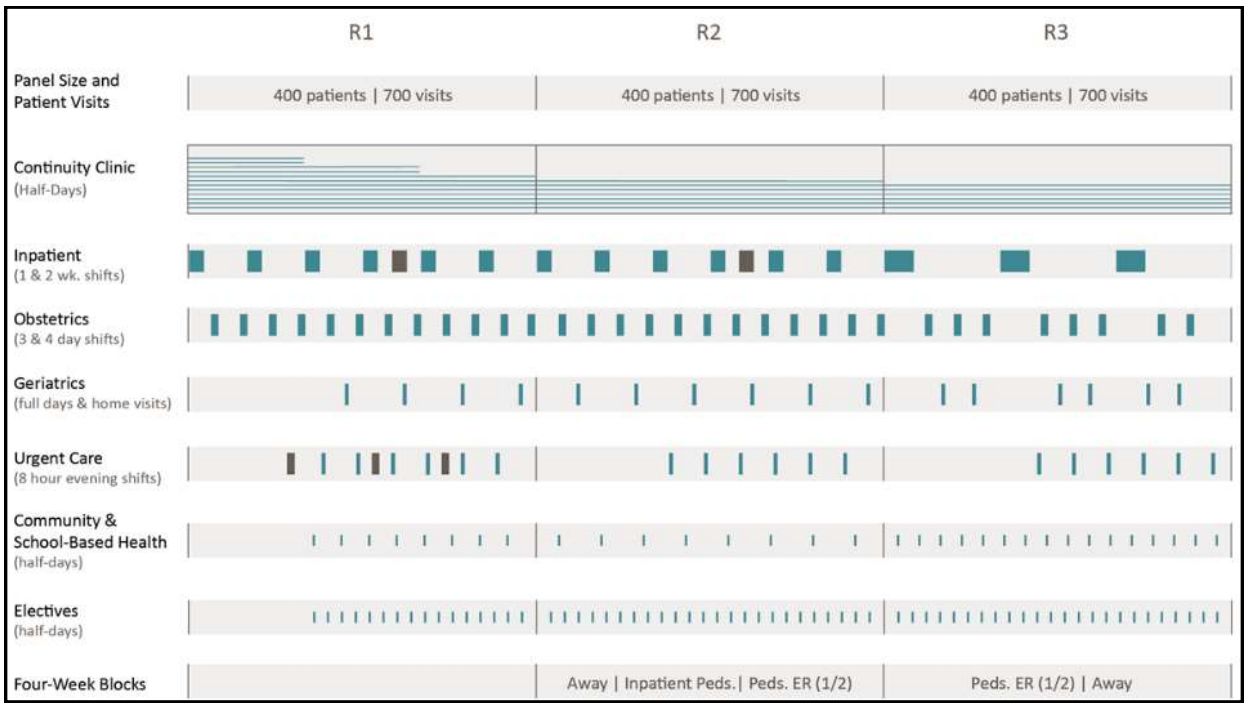
Block 3 (8/22-9/18)
Block 4 (9/19-10/16)
Block 5 (10/17-11/13) Fall Retreat
Block 6 (11/14-12/11)
Block 7 (12/12-1/8) R2 Class retreat
Block 8 (1/9-2/5) R1 Class retreat
Block 9 (2/6-3/5) R3 Class retreat
Block 10 (3/6-4/2)
Block 11 (4/3-4/30) Spring Retreat
Block 12 (5/1-5/28)
Block 13 (5/29-6/25)


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

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**

Agenda

- **Blocks vs longitudinal**
- **Empanelment**
- **Outcomes**
- **Scheduling Mechanics**
- **Discussion**

The basic structure of a family practice residency curriculum is familiar… First-year residents spend most of their time in hospital rotations, while devoting only 1 or 2 half days per week to continuity practice. During the second and third years of residency, the rotations continue, but they are focused in outpatient settings as well as inpatient settings, and the time in the outpatient settings increases. This format for residency training has been in place ever since the first family practice residency programs were established…

Barry D. Weiss, MD, Longitudinal Residency Training in Family Medicine: Not Ready for Prime Time, *Family Medicine*, 2001

What's a Block?

- 2-4 weeks
- 3-6 days per week focused on a specific learning area
- Often addresses an ACGME/RC defined curricular requirement
- Can vary in how regimented vs. fluid the educational experience is
- Most training programs consist of a total 39 blocks, with "split" blocks allowing for flexibility, particularly in the second and third years

Block Benefits

- Immersion in one type of learning
- Repetitive opportunities to develop, demonstrate, and document competency
- A sense of completion
- Generally predictable and manageable logistics

[Family practice]… was welcomed in the 1960s as a public response to to the apparent failing of multispecialty medicine to connect with people… and to help them with ill-defined, ambiguous problems… Our training programs' format was taken from the extension of the rotating internship with the addition of an ambulatory care clinic experience. It was assumed that by being in other specialty inpatient rotations, one could learn about medical problems and by spending scattered bits of time in the family practice center one could learn continuity relationships and their value. I believed back then and I believe now that we can train family physicians in a more appropriate model.

H.E. "Pat" Crowe, MD, Foreward (STFM Monograph), *Models of Innovation: Longitudinal Curriculum in Family Practice Residency Education*, 2001

Block Detriments

- Long periods without continuity outpatient care
- Long gaps in opportunity to practice skills
- Learning from specialists instead of family docs
- Rotation-based burnout

Longitudinal Curricula

“Essential Components”

Availability

- 1 half-day session every day or nearly every day
- Emphasis on residents being available to see paneled patients
- If patients require procedures, hospitalization, or other services within the scope of family practice, residents provide them

Barry D. Weiss, MD, Longitudinal Residency Training in Family Medicine: Not Ready for Prime Time, *Family Medicine*, 2001

“Essential Components”

Supervision and instruction

- Core topics… are learned through care of family practice center patients under supervision of family medicine faculty
- Family medicine faculty members provide the majority of teaching (both didactic instruction and clinical supervision)

Barry D. Weiss, MD, Longitudinal Residency Training in Family Medicine: Not Ready for Prime Time, *Family Medicine*, 2001

“Essential Components”

Rotations

- Time spent on rotations constitutes only a minority of the total time
- Rotations are used only to provide exposure to important clinical problems and procedures that are unavailable in the family practice continuity clinic and inpatient practice

Barry D. Weiss, MD, Longitudinal Residency Training in Family Medicine: Not Ready for Prime Time, *Family Medicine*, 2001

Our Goals at KPWA

- Start residents with a full continuity patient panel on day one
- Schedule residents so that they can provide appropriate access for their panel during every week of training
- Give residents the opportunity to practice core outpatient, inpatient, and obstetrical skills consistently throughout residency
- Strive for training that mirrors practice
- Establish residents’ identities as family physicians early on, locating the core of their practice in the outpatient clinic
- Establish continuity care as a source of rejuvenation and wellness

Poll Question

Which best describes your program's curriculum?

A. All or mostly rotational
B. Rotational in year one, longitudinal in years two and three
C. Mixed rotational and longitudinal, not specific to year of training
D. All or mostly longitudinal
E. None of the above

Longitudinal in 2001

- 477 programs surveyed, 320 responded
- 3.6% "mostly longitudinal"
- 14.2% "half block/half longitudinal

Carin E. Reust, MD, Longitudinal Residency Training: a Survey of Family Practice Programs, *Family Medicine*, 2001

Longitudinal in 2001

2001 STFM Monograph and Special Issue of *Family Medicine*

- Special focus on Sparrow FMR in Lansing, MI and Fairfax Family Medicine – both longitudinal since the early ’70s
- Recognition of Valley Family Medicine’s “clinic first” program
- Acknowledgement of no clear educational outcome measures

17 Years Later…

- 211 out of 566 programs surveyed; 27% “clinic first” and 68% want to be clinic first (Aaron Zeller, 2018 NIPPD Fellow)
- RPS/PDW & STFM talks – Community Hospital East FMR, Indianapolis
- Focus on “X+Y” scheduling in internal medicine (44% adoption)
- Canada’s “Triple C” residency redesign initiative
- *Building Blocks for Providing Excellent Care and Training* from the Center for Excellence in Primary Care (UCSF)
- Rising implementation and interest in our region (WWAMI)

…continuity is still key.

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Empanelment

Empanelment means linking each patient to a primary care clinician and, ideally, to a stable team. The basis for patient-clinician continuity, empanelment is the substrate for the longitudinal therapeutic relationship essential for good primary care. Clinicians know their patient panel, and patients know who their primary care clinician is.

High-Functioning Primary Care Residency Clinics, AAMC, 2016

Considerations

- Are tools available to track and manage empanelment?
- What is the total patient population of the family practice center?
- Can it grow if needed?
- What are the impacts of larger resident panels?
- What impacts would result from changing the panel transfer process?

Our Panel Mechanics

- Panels transferred intact from graduating R3 to new R1
- Residents paired with the same MA and RN throughout residency
- Goal of 400 paneled patients on day one of residency
- 400 patients = .22 of a full-time provider's panel at KP Washington
- A .22 provider should have ~16 (15.7) appointment slots per week*

*This takes into account full-time provider absences for vacation, CME, and holidays.

Clinic Mechanics

R1	16 weeks	4 patients	4 half-days/week
R1	20 weeks	5 patients	3-4 half-days/week
R1	16 weeks	6 patients	2-3 half-days/week
R2	52 weeks	7 patients	2-3 half-days/week
R3	26 weeks	7 patients	2-3 half-days/week
R3	26 weeks	8 patients	2 half-days/week

All years include 2 phone visits per clinic half-day and continuous inbox coverage when not on hospital services.

Outcomes

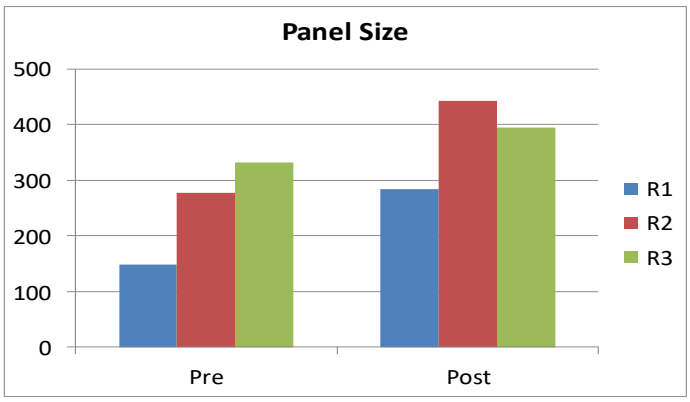
Outcomes

- Pre -> average of the three years prior to implementing longitudinal curriculum (2011–14)
- Post -> 2016-17 academic year

Panel Size

	R1	R2	R3
Pre	149	278	332
Post	285	443	395

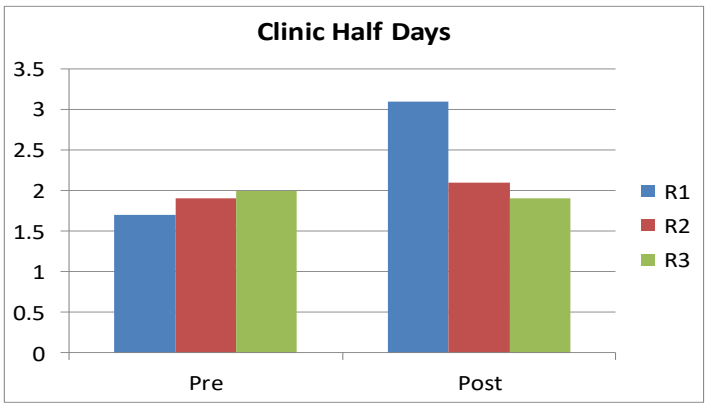
Panel Size



Clinic Half-Days Per Week

	R1	R2	R3
Pre	1.8	1.8	1.9
Post	3.1	2.1	1.9

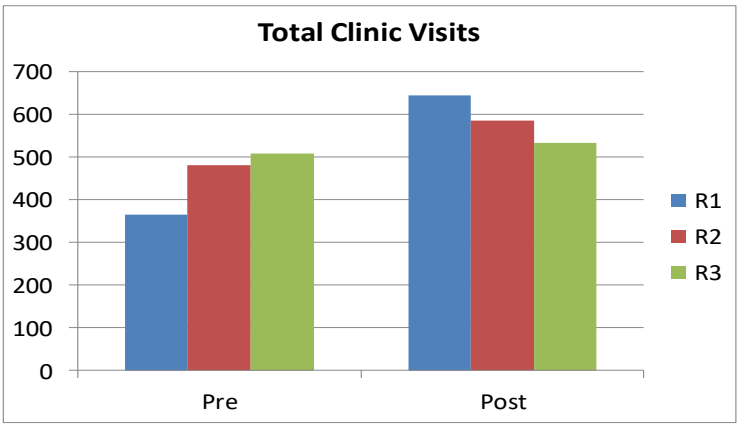
Clinic Half-Days Per Week



Total Patient Encounters

	R1	R2	R3
Pre	365	480	507
Post	644	586	534

Total Patient Encounters



Encounters per Week

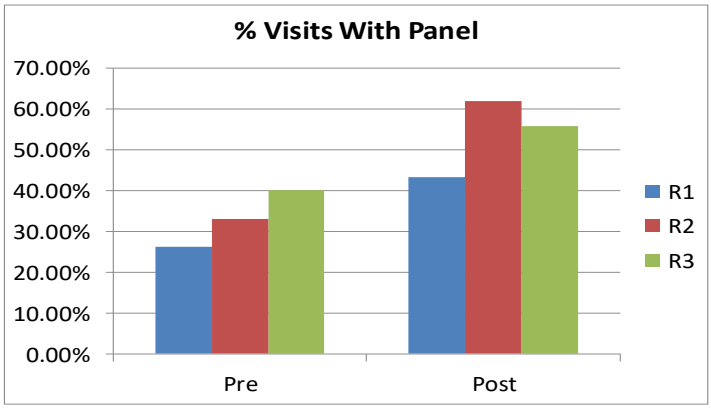
	R1	R2	R3
Pre	7	9.2	9.8
Post	12.2	11.1	9.8

Provider Continuity

	R1	R2	R3
Pre	26.2% (96)	33% (158)	40.2% (202)
Post	43.4% (279)	62% (363)	55.8% (298)

The percentages indicate the proportion of provider visits that were with paneled patients. The number in parentheses is the actual number of encounters with paneled patients.

Provider Continuity



Patient Continuity

	R1	R2	R3
Pre	46.5%	42.8%	44.1%
Post	51.3%	45.3%	45.8%

Scheduling

Scheduling residents to be in clinic predictably and without long absences increases continuity of care from both the patient and resident perspectives. Moreover, residents state that running between the hospital and clinic on the same day is highly stressful: it divides their attention and adulterates learning in both environments.

Reena Gupta, MD, et al., Clinic First: 6 Actions to Transform Ambulatory Residency Training, *JGME,* 2014

Demonstration Goals

- Illustrate how breaking up blocks can provide better clinic availability
- Illustrate how breaking up blocks can allow residents to practice a variety of skills more frequently
- Explain the choices we made in breaking up our blocks
- Demonstrate the steps we follow in creating longitudinal schedules
- Itemize considerations to take home

Demonstration Framework

- 6 R1s (demonstration focuses on one)
- 16 weeks
- 4 “blocks”
- 1/3 of the academic year (our first four weeks are a special “family medicine month”)
- End of R1 year, so a target of 2 to 3 clinic half-days per week (6 patients per half-day with a target of ~16 visits per week)
- Even though focused on one scheduling window, these principles and core experiences continue on through residency

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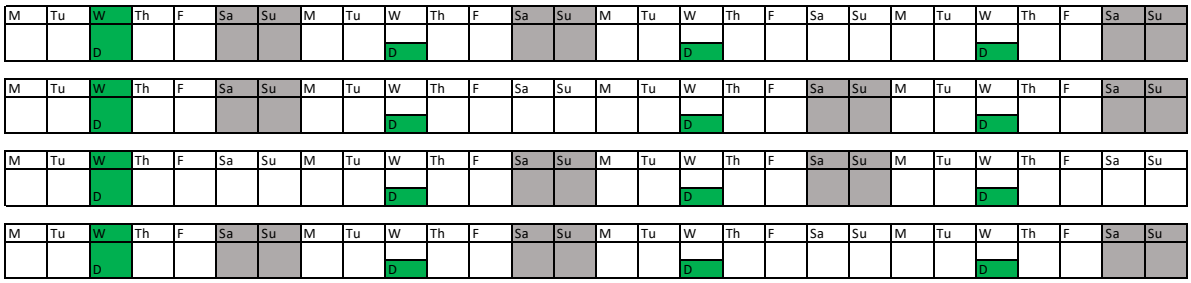


Poll Question

Which of the following should always be taught in a block (four-week intensive) format?

A. Inpatient Medicine
B. Obstetrics
C. ER/Urgent Care
D. None of the above
E. All of the above
F. A and B
G. A and C
H. B and C

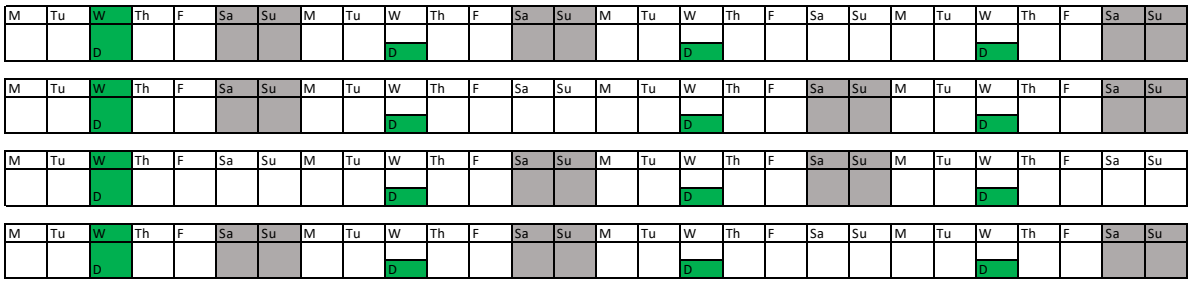
Breaking Hospital Blocks

Considerations:

- What level of coverage do residents need to provide?
- What rate of change is appropriate for hospital teams on different services?
- How long does a resident need to be on a service for good learning?
- Can night shifts and post-call days be arranged to avoid weeks without clinic?

Breaking Hospital Blocks

- 3 medicine blocks -> 6 one-week shifts (39 days to 42 days)
- 3 OB blocks ->12 three and four-day OB shifts (39 days to 42 days)
- ½ pediatric urgent care block -> 3 three-day pediatric urgent care shifts
- Inpatient pediatrics moved to the R2 year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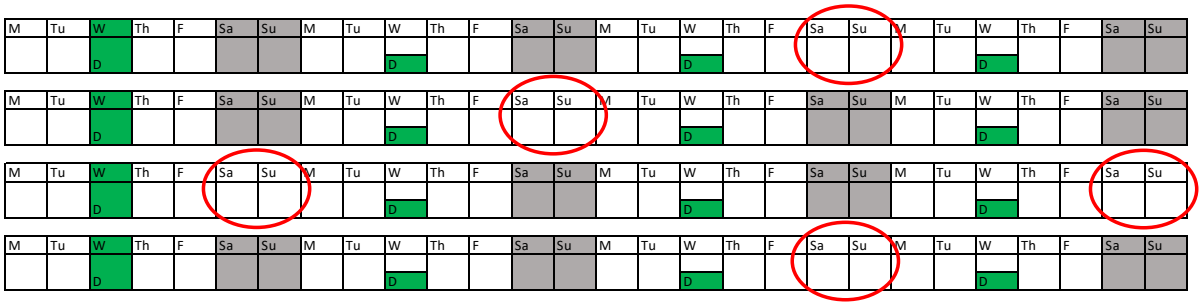
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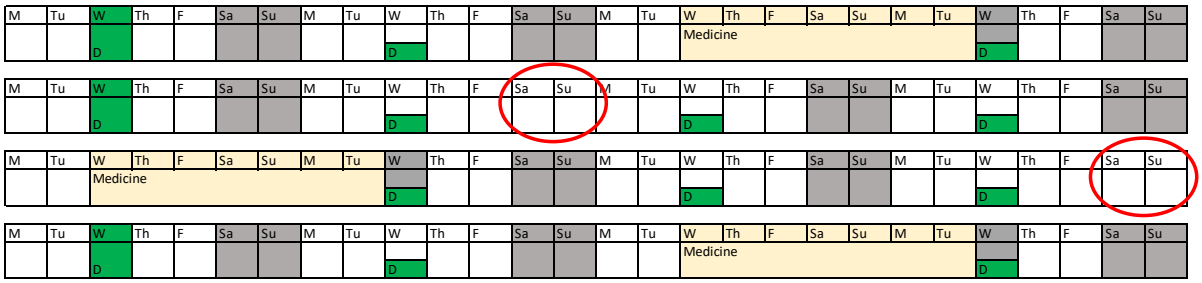

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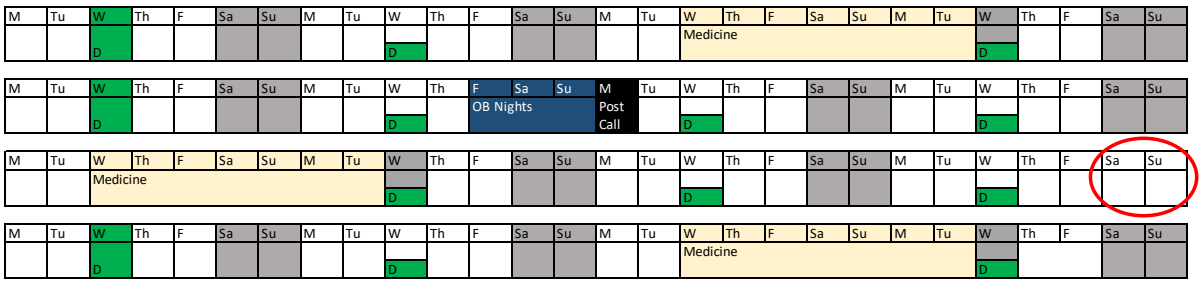

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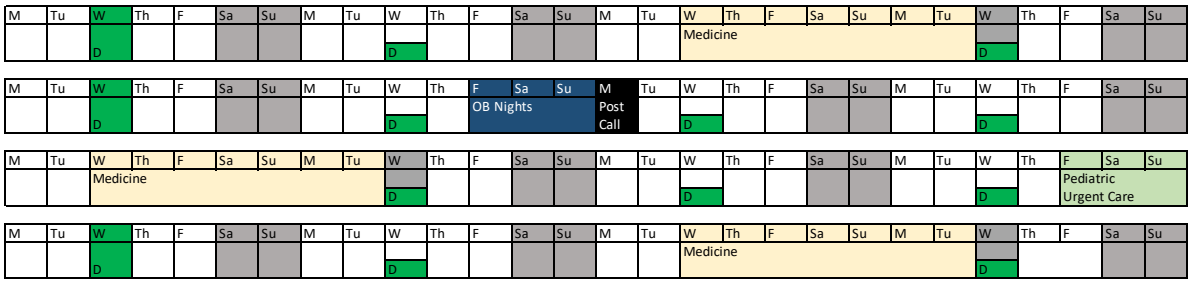
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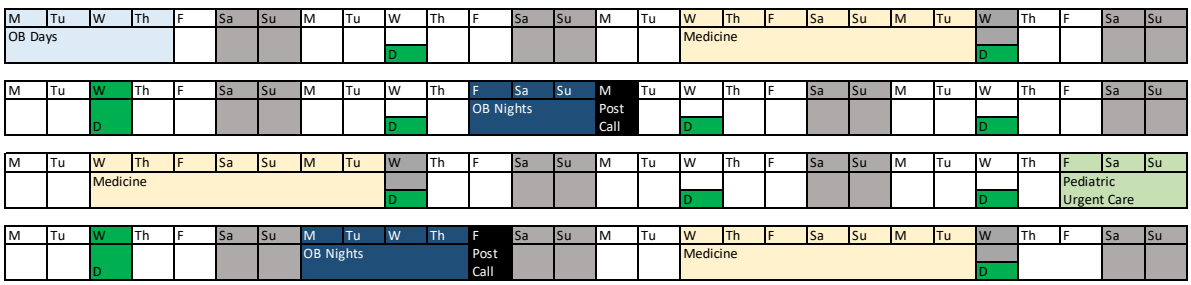
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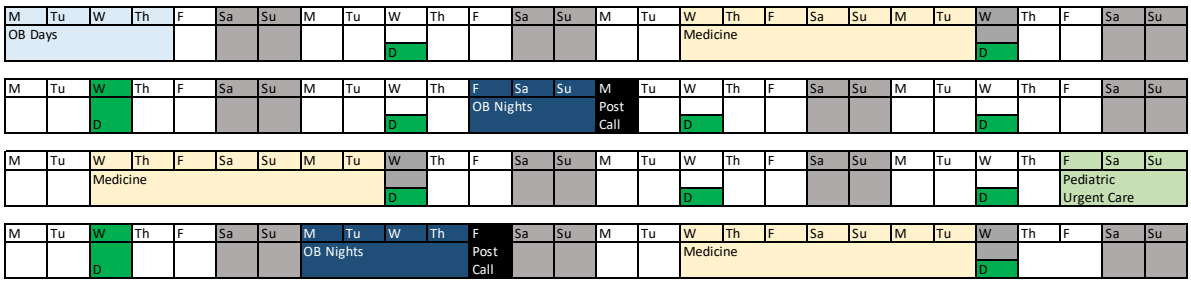
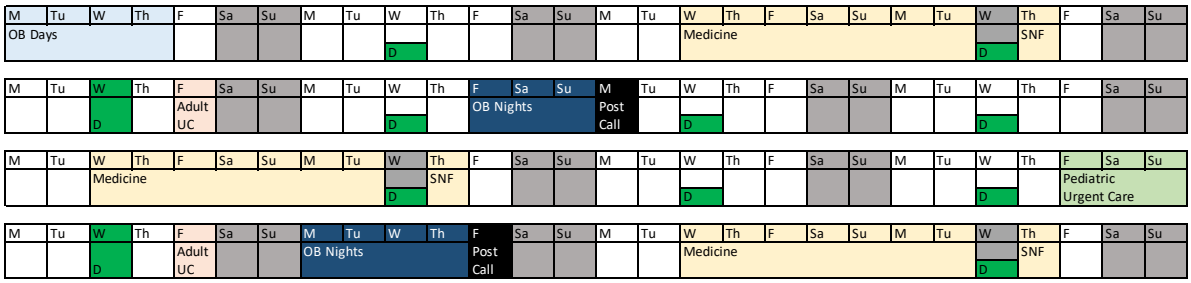
Core Specialties

- What level of frequency do specialist preceptors need to feel comfortable with a resident?
- At what point does a longitudinal experience become diluted and reduce a resident's opportunity to be involved in clinical work?

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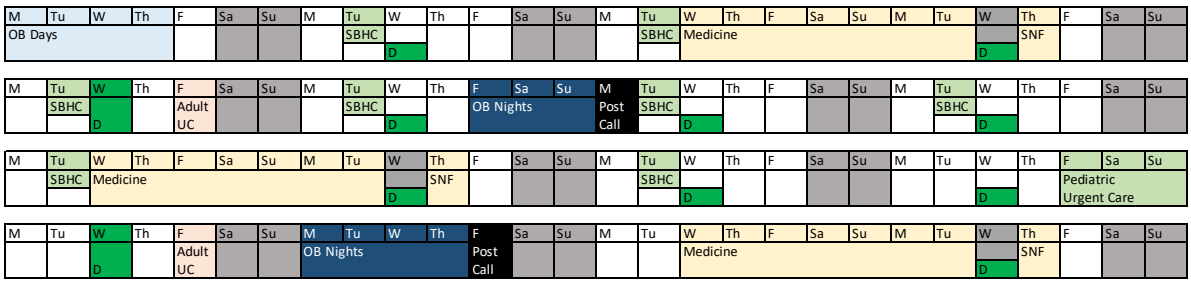
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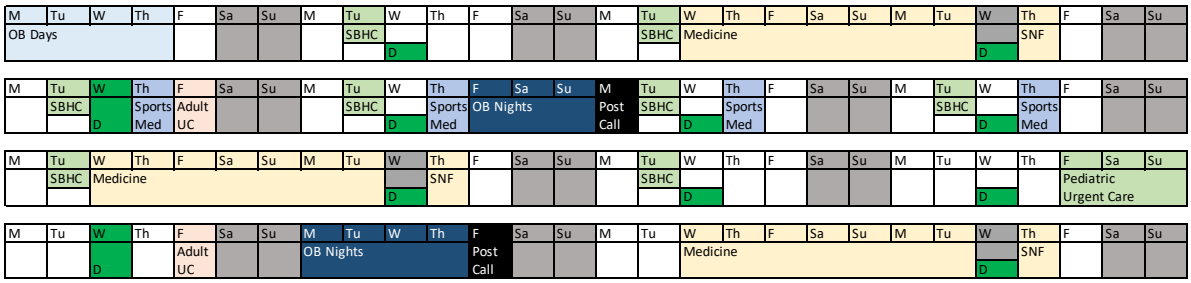

Isolate Clinic Half-Days

- Our goal for this point in training (end of R1 year) is 2 to 3 a week

Considerations:

- Can a predictable clinic schedule underlie multi-day and specialty experiences, providing minimal variance in a resident's clinic half-days?

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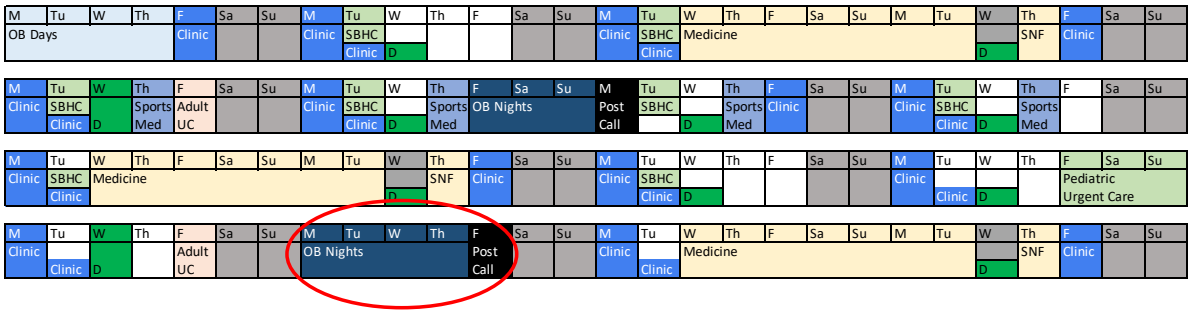

Electives and Other Specialties

- Self-designed elective study
- R1 orthopedics, addiction and behavioral medicine, hospice care

Considerations:

- Will residents have a better experience if they are able to cluster time with specialists?

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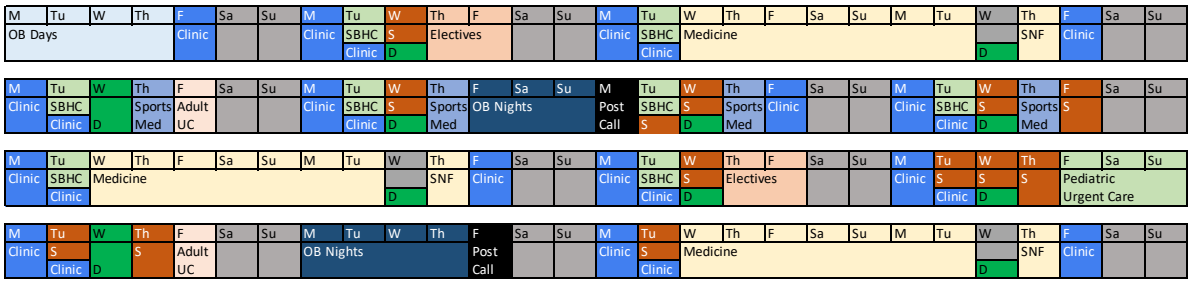
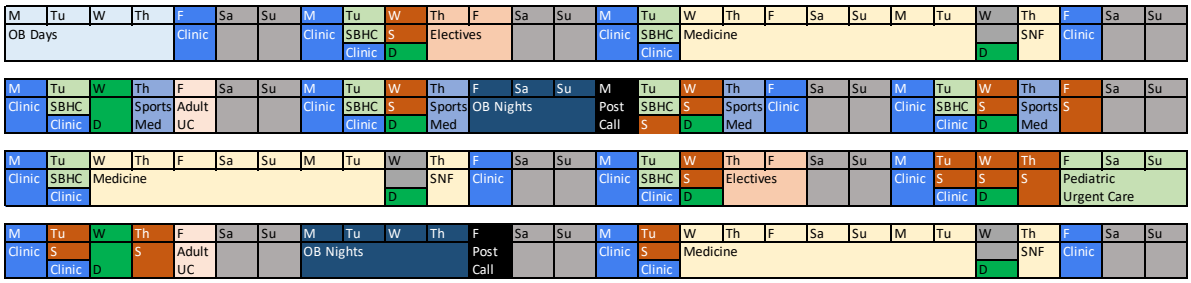


Accommodating More Clinic

- We used this example to illustrate the integration of elective and observational specialty experiences during the middle and end of the R1 year
- Early in the year, those experiences are minimized to accommodate the goal of four clinic half-days per week
- An even distribution of four half-days every week is still aspirational, particularly when trying to preserve core specialty experiences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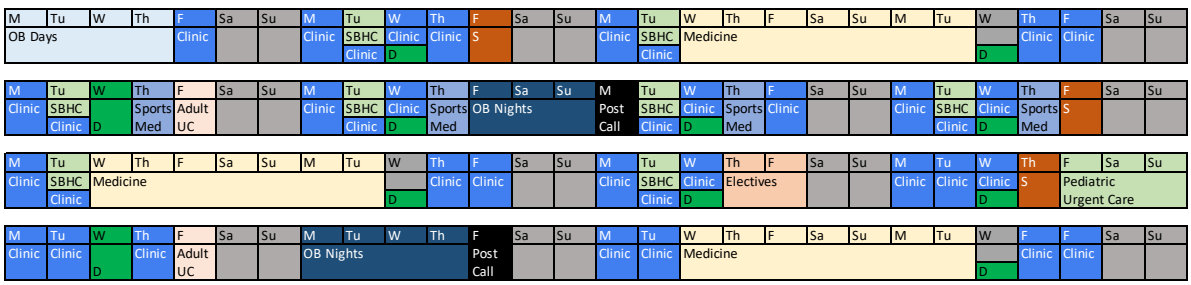
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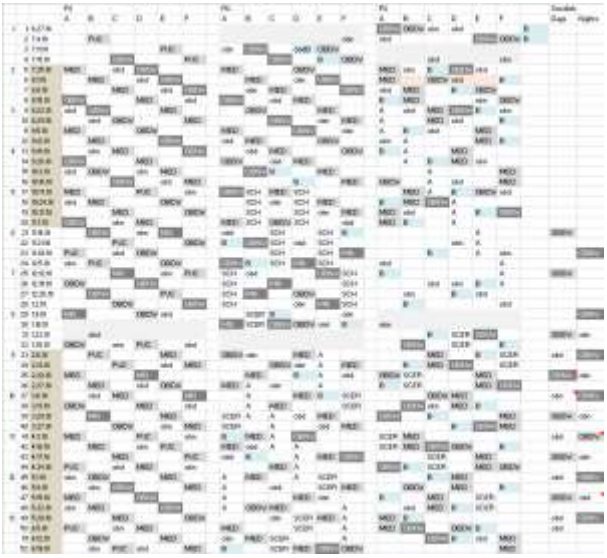
Beyond R1s

- The basic principles illustrated carry through the R2 and R3 years
- Residents do the same amount of medicine and roughly the same amount of OB in each year of training
- Some blocks remain in the R2 and R3 year: pediatric inpatient; pediatric ER; and away months
- R3s do medicine two weeks at a time to provide continuity for the service



Poll Question:

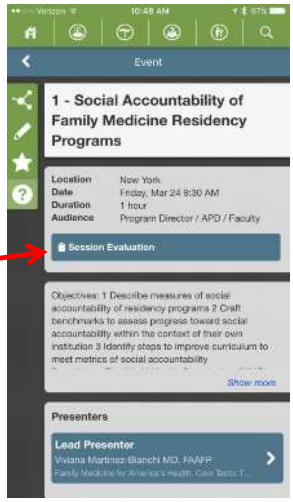
Enter your email address to be included in any follow-up communication from the presenter(s).

Social Q & A

Please…

Complete the session evaluation.

Thank you.



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