Implementation of Care Teams in a Resident Continuity Clinic: Innovations in Patient Continuity, Chronic Disease Management, and Outpatient Medical Education

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Background

- Traditional system led to poor resident physician continuity in clinic and between visits.
- Residents lacked ownership of their patients after the office visit and engagement in inter-visit care.
- Residents on “firm block” provided inter-visit care for thousands of patients with whom they had no prior relationship.
- No clearly identifiable attending who was ultimately responsible for any given patient.
- At end of academic year, patients were randomly assigned and in ad hoc fashion reassigned to incoming interns.
- Schedules of incoming interns could not be opened until mid-June. Above factors resulted in delayed care, lapses in chronic care management, lower attainment of standard goals for chronic diseases, and patient dissatisfaction.

Objectives

- To create small groups of patients.
- To transform resident clinic structure into patient care teams.
- To lower attainment of standard goals for chronic diseases.
- To improve care of patients and serve as a longitudinal educator for each resident.

Innovation

1. Creation of Patient Care Teams (PCTs)
   - In AY2016, the Internal Medicine Residency program switched to a block scheduling system of 6+2. This system design creates 4 cohorts of residents who rotate through clinic in predictable succession.
   - We assigned 4 residents, one from each cohort, to a longitudinal patient care team (PCT) to cover the daily needs of about 250-300 patients.
   - Each PCT was assigned an outpatient continuity attending who supervises the care of patients and serves as a longitudinal educator for each resident during 3 years of training.

2. Optimize Transitions of Care: Early Scheduling and Whole Panel Handoffs
   - At the end of AY2015, we reassigned entire panels of graduating residents.
   - The 6+2 structure & PCTs allowed us to know exactly how many interns we would have in clinic.
   - We led a massive effort to open schedules for AY2016 before end of academic year for residents and “dummy interns.”
   - When new academic year started, we changed the “dummy intern” schedules to the names of new interns.

3. Operationalize a Coverage System: Leveraging the EMR
   - Each provider has an EMR “inbox” where all patient calls, results, consultant notes, prescription requests, etc. are routed.
   - Access to individual inboxes were granted to all members of a PCT and their continuity attending.
   - Office staff, nurses, residents, and attendings were educated on new workflow that emphasized continuity and utilization of PCTs.

Results: Patient Scheduling

Our intervention dramatically increased the number of available appointments. This was correlated to a significant increase in Press Ganey patient access satisfaction scores.

Results: Inter-visit Care

We tracked the amount of time it took for an “inbox” message (patient call, result, refill request, etc.) to be completed. This typically reflects that a patient matter has been addressed to completion.

Results: Chronic Disease Metrics

We developed biannual report cards for residents & their PCT to track their performance with regards to chronic disease management.

Discussion

- Restructuring residency program scheduling to an X+Y block system provided an opportunity to reorganize and redefine patient care.
- Our large academic program successfully transitioned to a shared patient panel strategy.
- Whole-panel reassignments from outgoing senior residents to interns, along with other IT initiatives led to significant improvement in lapsed care around the end of year transition.
- Shifting the responsibility of inter-visit care to a “Patient Care Team” led to significant reductions in time to address patient issues.
- Measures of chronic disease care did not change 1 year after PCTs were implemented.

Next Steps

- Establishing a system for formal patient hand-offs between outgoing residents and incoming interns.
- Capitalizing on the PCT structure to create a population management curriculum for residents.
- Utilizing PCT data to identify and develop QI projects aimed at improving specific chronic disease metrics within each PCT.