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Innovations in Residency Training in Community Hospitals

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When someone thinks about residency training, the first image that comes to mind for most people is a large tertiary care center with patients rolling in every minute and beautiful doctors and nurses running around taking care of them, sometimes with a TV romance thrown in. The reality of family medicine residency training is that the majority of family physicians in our country are trained at community hospitals with a university affiliation. The affiliation with the university mainly means that the community hospital assists with training medical students from the university with little or no resources supplied by the university to the community hospital.

So, change the initial image of residency training to a small urban or rural hospital or to a federally qualified health center with affiliations to a community hospital. The beautiful people are still there but the patient demographic mix changes to what we actually see in our communities. I believe that the best family medicine training occurs out in the community where most of the patients live and work. The greatest opportunities to impact health care costs lie in the same communities. I was having a conversation last week with Dan Bair, the Trinity Mid-Atlantic Clinically Integrated Network and Accountable Care Organization executive director. He was evaluating a Medicaid program in Pennsylvania where 226 patients resulted in 46% of the spending for a panel of 7511 patients. Impacting the health and utilization patterns of those 226 patients is where the opportunity exists to have the greatest impact on both health care cost and quality. Health systems, insurance companies, the state and federal government, employers and patients can all benefit from creating models to better care for these high risk and high cost patients. I can think of no better place to develop innovative programs than in a community based family medicine residency.

While university hospitals may take the lead in research, community hospitals have opportunities to take the lead in developing quality improvement in population health. Seven years ago, a quality improvement program was developed at St. Francis Hospital with the residency program, care management, and a lead social worker titled, “From Home to Hospital and Back,” focused on improving transitions in care. This program predates when Medicare started to pay for transitional care management services. This example in innovation in population health laid the groundwork for success in Medicare programs such as the Bundled Payments for Care Improvement (BPCI) and the Delaware Care Collaboration (DCC) Medicare Shared Savings Plan. Our residents are trained in performing transitions of care visits in the office and in population health management for our highest risk patients. Many processes take years to develop and improve before they are successful, and I believe that part of the success of the Delaware Care Collaboration dates back to the formation of a care management team focused on keeping patients out of the hospital by providing them with appropriate resources.

Last year the DCC achieved a savings rate of 10% which resulted in a total reduction in Medicare spend of nearly 10 million dollars for less than 10,000 patients. This resulted in Medicare writing a check to the DCC for 4.9 million dollars. We are now beginning the process of approaching other insurance companies in Delaware to look at quality payment programs with an interest in looking at models with some accountable risk taken by the health system. The

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latest innovations we have added in population health include adding a community health worker to the team and focusing on behavioral health integration. Health systems with limited resources have to be creative to enhance behavioral health services. Some systems have made investments to employ behavioral health specialists such as psychologists and licensed clinical social workers (LCSWs) in the outpatient setting. We have a full time bilingual LCSW employed in the residency practice as well as a behaviorist, but two people cannot possibly manage the behavioral health needs of our patients. The process of behavioral health integration in our residency program has been more collaborative with community mental health practices. The practice has implemented universal screening for depression and a team of social work interns led by our behaviorist perform brief interventions and coordinate care both with our primary care physicians and with the behavioral health specialists at Mid-Atlantic Behavioral Health, with whom we have partnered to improve the access of care for our patients with high health disparities. The population of uncontrolled diabetics is currently being targeted for brief behavioral interventions as many social and behavioral factors are why their diabetes is not controlled.

Let's now shift gears to the emergency room setting where unfortunately many patients go as their only source of care. If you look at the definition of a primary care physician, an emergency room physician is not on the list. The story is often the same—another hospital admission that could be prevented and another discharged patient goes home but never follows up with any of the resources printed out on the computer discharge document containing pages of information ranging from diet to medications. To influence change in this process, our residency training program has led the way in population health innovation by developing an emergency room follow-up program. Patients who present to the emergency room who do not have a primary care provider and are interested in having one are scheduled for an appointment in the residency practice before the patient leaves the ER. The patient is scheduled for an appointment with a resident by a care coordinator in the ER who has access to the outpatient schedule. We have blocked 16 appointments per week for ER follow-up patients who have not been seen in our office previously. Recently a second outpatient community practice site was included in this program. Facilitating outpatient care can have huge implications as we all know that having a primary care provider can dramatically improve the quality of care and decrease cost. Targeting the ER patients who do not have a primary care provider has great potential to decrease the total cost of care for a high risk population. This program was not implemented without problems, mainly because the program did not initially add appropriate resources in the office to manage this extra volume. This population has a high no show rate which complicates office flow in a practice that already has a high no show rate. Data from the past year demonstrate a no show rate of 45% for ER follow-ups which exceeds the baseline no show rate of 20% in our urban residency practice. Office flow communication for managing these patients was probably one of the largest stressors in the outpatient setting for our residents as the appointment times were adjusted to account for the high no show rate which doesn't work on a single day if everyone shows up. It took about a year before the processes were streamlined to make this program successful without negatively impacting resident wellness.

The experience residents have in training shapes their practices for the remainder of their career. Community hospitals are in a position to lead the way in training our residents for the quality based payment programs that are developing in our health system. Residents have the opportunity to be at the forefront of creating and developing innovative models of care. Medicine in the past several decades has valued innovation and development of surgical and

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pharmaceutical programs. The future successes in our health systems need these innovations, but more importantly, we need to work to improve the health of our populations. We need to invest in our care managers and in our social workers and in physicians who work with them. Outstanding case managers and social workers work in our community hospitals and in our federally qualified health centers as these places attract smart and energetic people who want to make a difference. Residency training working closely with diverse health care teams is instrumental in developing our future physician leaders.

Innovations in graduate medical education that are supported by quality payment and risk-based models have the potential to improve our health systems and diversify the financial support for residency training in primary care. There are more changes happening in medicine now than ever before and we are in a position to influence these changes especially if we involve our residents and students.

Resources

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