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BEST PRACTICES: PART II

Transforming Primary Care in an Academic Safety Net Hospital: Steps to Take

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Transforming primary care at a large, academic, safety-net institution can be a challenging task due to the competing needs of patients, residents, and the clinic itself. This article describes the general approach to practice transformation and the specific steps taken to improve the primary care practice at the J. Willis Hurst Internal Medicine Residency Program at Emory University. The practice consists of 150 residents, all of whom have their continuity clinics at Grady Memorial Hospital, Atlanta's public, safety-net primary hospital. Grady's Primary Care Center provides approximately 55,000 outpatient visits per year to a diverse patient population.

We focused our practice transformation efforts on "building blocks" (blocks A, B, and C: resident clinic scheduling, resident engagement, and enhanced work-life balance, respectively) derived from site visits to other transformative academic primary care centers.[1] Each block was incorporated within our practice around ongoing plan-do-study-act (PDSA) cycles and required engagement and feedback from residents, faculty, and staff for continual improvements, as well as ongoing discussion and communication with a supportive administrative and IT team.

Our practice recently promoted better resident clinic scheduling (Block A) and enhanced work life balance (Block C) by moving from a half-day to a full-day clinic model.[2] This new structure allowed for residents to focus exclusively on outpatient needs during their full-day clinic session, without the pressure of having to return to the inpatient environment once clinic was complete. We also created administrative days on time-intensive rotations (such as MICU) during which residents have protected time for inbasket management. These changes allowed for scheduled time where resident efforts are fully focused on ambulatory care delivery, thereby preventing clinic duties from spilling into other rotations and/or personal time, and vice versa.

To enhance resident engagement (Block B), we implemented curricula addressing systems-based practice and population health. Topics included hands-on demonstrations on laptops of real-time inbasket management and enhanced EHR efficiency in the outpatient setting, as well as round table discussions on various primary care policies within our practice (e.g., chronic pain management, problem-based charting, and depression screening / management). We identified clinic-based QI projects (such as improvement of the health maintenance tab in the EHR, and updating of smartset orders), recruited interested residents, and created task forces by which residents could provide suggestions for improvement, and directly participate in tests of change and follow-up.

To begin the work of improving empanelment, we first defined goal panel sizes for each PGY level. We chose panel sizes based on the number of patients each resident was expected to see in a half day clinic session, multiplied by the average number of weeks before that patient would be expected to return. By the end of the academic year, interns should have a panel of 60-80 patients, PGY-2s 80-100 patients, and PGY-3s 100-110 patients. Our IT team created panel reports for each resident PCP to identify over- and under-empaneled residents. In the future, we hope to (1) work with an "empanelment coordinator" to monitor the panel sizes of our residents and reassign patients as needed, (2) engage senior residents to review their panels prior to graduation and identify high-risk patients suitable for warm handoffs to rising PGY-2s and PGY-3s, and (3) implement automated panel transfers through the EHR so that graduating PGY-3's panels are automatically reassigned to incoming interns.

Achieving continuity within our practice has become more difficult, as we recently moved to an open-access scheduling model. Our templates now open 60 days in advance, essentially requiring every patient to call back to schedule their next 3-month appointment. We have built in 2-4 "reserved" slots on each residents' template, to allow for scheduling of high-risk patients when the resident is concerned they will not call back for an appointment. Our open-access model has created opportunities for patients lost to follow-up (e.g., with a graduated PCP) to re-access the system, though some-

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times at the expense of empaneled patients who are then unable to see their PCP. To that end, we have engaged our IT team around implementing automated panel transfers through the EHR, and hope to analyze whether the automatic conversion of graduated PGY-3's names to incoming intern names will improve continuity scheduling with an active and current PCP.

Because our ambulatory scheduling does not follow the x+y model, there are times when a resident may be out of clinic for 4-8 weeks.[2] We therefore created teams within our clinic, to provide team-based continuity when the resident PCP is not in clinic. Each team, or "trio," consists of a PGY-1, PGY-2, and PGY-3, with an assigned trio attending. When a patient's PCP is not available, every effort is made to schedule the patient with another member of the PCP's team. The teams have been built into the software used to schedule patients, under the support of our IT department and administrative team. We have also reinforced the team concept by creating door signs that display the names and faces of all physicians within a trio team, allowing patients to see their team when being roomed. Each team is also assigned a nurse and CMA in order to allow staff members and residents to get to know each other over time.

As we continue to optimize our staffing ratios, we hope to further implement team-based care using (1) huddle time for review of the team's daily patient panels, (2) pre-visit planning in preparation for the clinic day, (3) processes for outreach to no-show patients, (4) methods for closing care gaps through referral tracking of high risk patients, and (5) population health panel reporting to identify and reach out to patients within a PCP's panel. Future initiatives requiring a redesign of our ambulatory care space may be aimed at co-location of team members to further improve team communication and rapport-building, as well as incorporating the team nurse and CMA onto the team door signs.

Transforming primary care is a challenge for any practice. Transforming primary care in a hospital-based, safety-net, resident practice adds numerous additional hurdles that require creative solutions. By working to improve the resident experience in clinic, collaborating with other members of our larger clinic team, and creating additional structures within each clinic to support residents and patients, we are taking important steps towards achieving our goal of innovative primary care transformation—one that promotes patient-doctor relationships through continuity of care, and that develops team-based solutions for delivering safe and quality medical care in a patient-centered fashion. We also hope that with the implementation of the above initiatives, we will see an improvement in resident self-assessment results as it relates to our practice. We plan to reassess again in the 2019 academic year.

Our program will always remember Dr. Alanna Stone for her tireless contributions to transforming primary care delivery at Emory. We would also like to acknowledge Dr. Reena Gupta and Margae Knox for their efforts visiting our practice as a Transforming Teaching Practices project site visit. We are appreciative to the Grady Memorial Hospital administrative and IT team in providing systems change and innovations through the EHR at our site.

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