Utilizing a Value-Based Care Resident Rotation to Improve Quality of Care and Resident Recruitment

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Introduction

Increasing educational activities for primary care residents is important given the evolving primary care landscape. The movement from a system mainly dependent on fee-for-service primary care delivery to one where value-based care (VBC) delivery plays a key role in structure, culture, and even compensation is one that needs intentional training experiences, education, and mentorship.

Many medical residency programs lack a pathway to learn VBC (1). In 2010, the Medicare Payment Advisory Commission proposed to reallocate over one-third of current $9.5 billion of Medicare funding towards graduate medical education as performance-based payments, rewarding residency programs that educate physicians on the basis of: integration of community-based care with inpatient care, practice-based learning and improvement, and systems-based practice.

Residents start with inadequate ideas of medical practice (2). The percentage of students reporting "appropriate" training was 90% to 92% for clinical decision making, 80% to 82% for clinical care, and 40% to 50% for the practice of medicine. In addition, it has recently been proposed that providing high-value, cost-conscious care become a new core competency for training physicians

Many residency programs teach VBC in the context of ongoing activities, including during clinical teaching and journal clubs. Many programs attempt to bring Choosing Wisely ideals to current rotations. The American College of Physicians (3) sponsors a 6-hour curriculum, The High Value Care Curriculum, that was jointly developed by ACP and the Alliance for Academic Internal Medicine to train physicians to be good stewards of limited health care resources.

Our quality improvement (QI) project assessed the impact of a VBC residency curriculum on the number of residents who stay to work at our primary care practice.

Abstract

Purpose: This project aims to increase the number of residents hired into an outpatient primary care faculty position at an academic medical center.

Study Design: Pre and post assessment of knowledge of VBC knowledge and assessment of % residents who remained with the institution following residency.

Setting: An academic medical center in San Antonio, TX. The primary care practice is a service line within the practice plan, which employs family medicine, internal medicine, pediatrics, geriatrics, and psychologists.

Intervention: Implementing a VBC-focused curriculum for 3rd year residents during a month-long rotation

Participants: Third-year family medicine residents and third-year internal medicine residents who were selected for an Ambulatory Care Track.

Measures: The main measure was recruitment of residents for outpatient primary care positions after residency graduation.

Materials and Methods

- Resident Rotation:
  - Components
    - Longitudinal QI Project
    - Self-Reflection
    - Journal Club
    - Practice Leadership Meetings (with clinical leaders, including Chief Medical Officer, Chief Quality Officer, Chief Medical Information Officer, Director of Primary Care Center, Finance Director, and accountable care organization leadership)
  - Deliverables
    - Self-Reflection
    - QI Project
    - Group Presentation

Health Improvement Systems Elective

Target Population: Family Medicine and Internal Medicine Residents

Learning Objectives:
- Differentiate different models of primary care delivery, including the model at UT Health Physicians Primary Care Center (PCC).
- Describe the components of the Triple Aim.
- Define value-based care.
- Identify clinical and population health-related tasks associated with team-based care.
- Given a clinical metric, discuss how it relates to quality, population health, and stewardship.
- Describe the care delivery model of an accountable care organization.
- Discuss how health information technology is used as a tool to enhance care delivery workflows and manage the health of patient populations.
- Discuss one example of a quality improvement tool and how it can be applied to improve a quality metric.
- Create a current state and an ideal state process map of a clinical workflow tied to a quality metric.

Curriculum:

Experiential: The resident will schedule meetings with clinical and operational leaders to learn about the principles of and components necessary for a high-functioning health system. The resident will also visit multiple primary care practice locations in order to meet with faculty and staff who are developing and implementing the UT Health model of care.

Project: The resident will create current state and ideal state process maps of a clinical workflow and present them to UT Health Physicians leadership in a 60 minute session (45 minute presentation with 15 minutes for questions and discussion).

Reflection: On the final Thursday day of the rotation by 5:00 PM the resident will submit a reflection paper to Dr. Cancino via email on:
1) The lessons learned from rotating with UT Health Physicians faculty and staff,
2) The answers to the items below,
3) The information learned from the required readings, and
4) What, if any, lessons learned during this rotation will change clinical practice or thoughts on health care systems design.

Week 1 (QUALITY)
Project Goal: Brainstorm QI Project.

Meeting (resident will schedule): Primary Care Center (PCC) Director, UT Health Physicians
- What are the objectives of this rotation?
- What is expected from each participant?
- What are the expected deliverables?
- What do you want to learn from this rotation?
- What is the definition of high-value care?
- What needs to happen to move from fee-for-service to value-based care?
- What is the difference between commercial, Medicare, Medicaid, and Medicare Advantage?
- What is an accountable care organization?

Site Visit (Residents will schedule): Hill Country Primary Care

Meeting (resident will schedule): Chief Health Informatics Officer, UT Health Physicians
- What does a Chief Health Informatics Officer do at UT Health Physicians?
- How is quality measured and tracked in a primary care practice?
- What are the unique challenges to understanding utilization metrics?
- Why is it sometimes challenging to aggregate quality metrics and produce reports for physicians to use?
- How are practices incentivized to practice high value care?

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Results

Residents. From 2018-2020, 45 3rd year residents took part in the rotation. 34 residents were family medicine. 11 were internal medicine.

Self-Reflection. 100% of residents submitted self-reflections. Themes from self-reflections included: increased knowledge of value-based care (including impact of cost), importance of billing and coding (including HCC coding), increased knowledge of pathways to leadership positions for primary care physicians, and increased recognition of the importance of physician leadership.

QI Projects. 100% of residents were part of QI projects. The QI project topics included: immunization improvement, colon cancer screening process improvement, patient check-in process improvement.

Group Presentations. 100% of residents gave the required group presentation. Group presentations included an overview of the month's QI project as well as a description of the lessons learned during the month-long rotation.

Resident Conversion to Faculty. Of the 34 family medicine residents, 12 interviewed for positions and 7 were hired. Of the 11 internal medicine Ambulatory Track residents, 4 were interviewed and 2 were hired. Of note, one resident returned to become faculty following an out-of-network fellowship.

Discussion

This 3rd year family medicine and internal medicine resident rotation resulted in multiple QI projects, increased VBC knowledge, and increased recruitment of residents to stay and remain primary care faculty.

Prior to the implementation of this rotation, few family medicine and even fewer internal medicine residents remained on as primary care (ambulatory-only) faculty. Based on feedback from residents, one reason for this was that, while the residency programs did well training residents on their clinical skills for both inpatient and outpatient work, they did little to give residents insight into the job market they will be entering. Furthermore, while resident rotations provide context for outpatient primary care, the resident experiences were limited to rotation locations, which did not often include private practice-type care models.

The resident rotation needed residency and practice plan leadership buy-in. In order to align the resident 3rd year schedule with the activities of the rotation, it was important to provide the residents flexibility during the month to schedule at times when clinical leaders were free to meet with them. Furthermore, residency leadership in family medicine and internal medicine had to align resident schedules so that they could attend sessions together.

Clinical leaders thoroughly enjoyed helping with this rotation and did so without reimbursement. Clinical leaders understood the importance of developing a culture of high-value care and were happy to devote one-hour per month to speak to residents about their paths to medicine. Importantly, residents typically cited Physician Leadership as an important component of this rotation.

Conclusions

Based on the results of this project, a physician-led multi-disciplinary VBC resident rotation resulted in increased resident conversion to faculty and increased QI projects at this academic medical center.

Future research will be done on continued recruitment as well as faculty job satisfaction and retention.

References

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2. Patel, Mitesh, MD, MBA, Lypson, Monica, Davis, Matthew, MD, MAPP. Medical Student Perceptions of Education in Health Care Systems. Acad Med. 2009;84(9):1301-1306. doi:10.1097/ACM.0b013e3181b17e3e.
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