

Residency Training Focuses on Improving Chronic Care

—By Elissa Fuchs

With diabetes afflicting 7 percent of the U.S. population and other chronic conditions like hypertension on the rise, providing optimal, longitudinal care for such individuals has emerged as a health care priority. With this in mind, several teaching hospitals are exploring new ways of preparing tomorrow's doctors to manage patients with long-term chronic illnesses, and prevent others from developing these conditions in the first place.

In 2005, the AAMC created the Chronic Care Collaborative, for which 22 institutions redesigned their education models to incorporate the six key components of the Wagner Chronic Care Model—clinical information systems, the health care organization, community, decision support via guidelines, patient self-management, and delivery system design. The model is named for Edward H. Wagner, M.D., M.P.H., and is widely recognized as the foundation for any approach to chronic care. Since then, these facilities have continued to add components of the model to their chronic care curricula in hopes of improving resident education and patient treatment.

Suboptimal care of chronically ill patients motivated officials with the internal medicine residency program at the University of Cincinnati and University Hospital to boost its educational efforts on long-term care.

"Patient outcomes were the driving force," said Eric J. Warm, M.D., associate program director of the internal medicine residency program. "If those need improving, you can surmise that resident education could also be better."

In order to expose residents to more patients with chronic conditions, Cincinnati—which is also a participant in the Accreditation Council for Graduate Medical Education's Education Innovation Project (EIP), in which institutions redesign GME programs—completely redesigned its curriculum, adding a year-long block of clinic experience in 2006. For three half-day cycles a week, each resident left the hospital to train in the Hoxworth Clinic, which had a high percentage of chronically ill patients. (Cincinnati's EIP participation allowed the facility to have guidelines preventing such extended clinic time waived.)

Residents met with a multidisciplinary care team weekly to discuss the status of patients. They learned to teach patients to manage their illnesses, use registries to keep track of people with certain conditions like diabetes, and adhere to the recommendations of disease-related literature provided by medical staff.

As a result of this approach, prevention and treatment outcomes improved. Warm's research indicate that pap smears went up by 212 percent among women over age 21 from Dec. 2006 to Oct. 2007. Men ages 50-70 had a 109 percent increase in prostate cancer screenings, and diabetic patients designated as in control of their cholesterol and blood pressure jumped 111 percent. Research also found an improvement in a less quantifiable but

no less important area—residents' satisfaction of their knowledge of chronic care.

"What patients said about their doctors' care went way up," Warm said. "It outscored the other measures. All of these statistics are incredibly heartening. We felt like something really worked here.

Cincinnati's process is by no means complete, Warm said. Officials plan to unveil an electronic medical record system this spring, and continue tweaking how it teaches chronic care.

At University of Minnesota Medical Center, Smiley's Family Residency Program Director Jennifer Welsh, M.D., and her colleagues have been incorporating chronic care into the curriculum since 2003.

Seven Most Common Chronic Conditions:

- cancer
- stroke
- hypertension
- pulmonary conditions
- heart disease
- mental disorders
- diabetes

Total annual impact on U.S. economy: \$1.3 trillion

Source: "An Unhealthy America: The Economic Burden of Chronic Disease," the Milken Institute

"We have been using the framework of the Wagner care model to really get the learner thinking about what is going on for the chronically ill patient," Welsh said. "We want our training experience to include walking in that patient's shoes."

A two-month clinic block had been a standard for several years, but Welsh said that faculty tailored this training period to chronic care in 2006. Trainees attended quality improvement sessions on women's health, diabetes, asthma, or pediatric preventive medicine and learned to use the evidence base to follow guidelines. Meeting with other members of the care team (e.g., patient advocates, financial counselors) and learning how they contribute to the patient's well-being was also incorporated.

This July, the facility is taking things a step further as it fully implements the chronic care curriculum. Among these changes are monthly, two-hour self-reflection sessions where groups of first- and third-year residents talk with a faculty member facilitator about chronic care delivery.

"This is a chance for residents to reflect on the Wagner model, focus on a particular aspect each month, and learn and practice some new skills," Welsh said.

All these efforts, Welsh said, were made in the hope of standardizing care as much as possible.

"As physicians, we cannot be automatons, of course, but we should have knowledge of the guidelines, follow them, and know when it is appropriate to deviate," Welsh said. "Guidelines are a way of us saying 'What are the goals, and how can I help my patient get to those goals?'"

Both Cincinnati and Minnesota incorporate a component where residents instruct medical students on chronic care.

The Louis Stokes Cleveland Veteran's Affairs (VA) Medical Center, in conjunction with Case Western Reserve University, will unroll its first chronic care management track for six internal medical residents in July 2008. This pilot program was made possible by a VA innovation award.

Program Director Susan R. Kirsh, M.D., hopes this track will motivate residents in what can be a challenging field.

"Chronic illness is not a 'quick fix,' so to speak," Kirsh said. "Doctors like to see that they've made a difference, and that's not so easy to do with chronically ill patients, where change can take months or even years. Working in this environment can be frustrating if you aren't trained properly."

As part of the program, residents will partake in a clinical research course that emphasizes epidemiology, biostatistics, quality improvement, and patient safety. They can practice their skills in simulated chronic care situations.

More time on ambulatory block rotations will give trainees optimal continuity with patients. These rotations include shared medical appointments with nurses, faculty, and allied health professionals.

"The group redesign is extremely important, because people aren't working in isolation anymore. You have back-up," Kirsh said. "Each member of the health care team brings different perspectives, and it's by building on these different strengths that patients get the best care."

Patients, after all, are at the heart of why Kirsh believes in teaching about chronic care.

"A larger and larger portion of patients are coming in with chronic conditions. If we really want to improve their treatment, education is something we need to invest in."