Merging the Health System and Education Silos to Better Educate Future Physicians

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The Affordable Care Act (ACA) is shifting physician reimbursement from volume to value. Academic medical centers (AMCs) are responsible for educating future physicians so that they will acquire the skills to practice value-based care. However, the linkages between the leaders of health systems and leaders of residency education may be tenuous, primarily because these leaders exist in separate silos in AMCs.

Even though the American College of Physicians, Institute for Healthcare Improvement, Veteran Affairs Centers of Excellence, and others have created curricula to teach residents principles of value-based care and population health, the practice models that residents are immersed in result in powerful imprinting on future decision making and practice. If residents observe attending physicians frequently order unnecessary computed tomography scans due to perverse financial incentives, residents may be more likely to adopt this practice. Similarly, regional spending patterns in which physicians train are associated with their future spending patterns in practice. In this Viewpoint, we outline 3 steps AMCs can use to accomplish their dual missions of delivering high-quality care and preparing the next generation of physicians for new models of value-based care and population health.

Supporting Leaders Who Bridge the Health Care Delivery and Education Silos

The first step is to support physician leaders to serve as the institutional bridge between graduate medical education and the health system. Several institutions, including the University of Pennsylvania and the University of California, San Francisco, have dedicated institutional leadership positions bridging residency education and the health system to promote quality, safety, and value. The creation of such positions is being further catalyzed by the new Accreditation Council for Graduate Medical Education (ACGME) Clinical Learning Environment Review program. Bridging leaders can develop new training pathways and collaborate with local quality directors to promote resident and faculty coaching to reduce unnecessary practice variation. They can also restructure existing residency curricula to promote value-based care and population health by incorporating relative costs and quality of relevant therapeutic options, care coordination, and strategies to promote health of specific patient populations.

Bridging leaders can also take responsibility for ensuring that the clinical learning environment creates an “imprinting” of these principles. This is critical because many institutions are at the crossroads of adopting new models of care while receiving a high proportion of fee-for-service payments, which incentivize doing more rather than providing high-value care. Therefore, exposing residents to new alternative care models is important. Currently, the internal medicine and family medicine residency programs at the University of Washington, Virginia Mason, Swedish Medical Center, and Group Health are jointly developing an elective that integrates residents into high-performing practice teams to achieve high-value care outcomes; it will use population health innovations like health coaches, LEAN (Lean Education Academic Network), and alternative payment models.

Ideally, bridging leaders will not only have a working knowledge of the health system’s goals but also can access institutional support in health information technology (IT) and quality to facilitate aligning resident practice with institutional goals. These leaders also can interface with the entire health care team, including nurses and other health professionals, so residents receive consistent messages and role modeling in interprofessional teams.

Academic medical centers can also invest in cultivating medical student and residency trainees who may ultimately fill these bridging leadership roles. The Dell Medical School at the University of Texas at Austin and Duke University residency programs have developed leadership and management education pathways for trainees to obtain extra skills in value-based medicine. Postresidency fellowships, such as the National Clinical Scholars Program, can also foster the development of physician leaders trained in understanding health systems, health policy, implementation, and evaluation of health system innovations. Although new educational pathways to promote high-value care have not yet been evaluated rigorously, combining curricula and immersion in emerging care models could help inform how to influence imprinting.

Academic institutions can also learn from each other’s experiences. Recently, the Costs of Care and American Board of Internal Medicine (ABIM) Foundation launched the online Teaching Value in Healthcare Learning Network, an e-learning community to facilitate sharing lessons and tools to catalyze spread in
training value-based care. Organizations such as the ACGME and Association of American Medical Colleges can also convene bridging leaders to share experiences.

Engaging the Frontlines

The second step to promoting value-based care and population health in AMCs is having bridging leaders directly engage residents who provide much direct patient care. Bridging leaders will need to identify and work with enthusiastic residents to understand workflow redesign, role restructuring, feasible integration of IT, and meaningful incentives for residents. Several institutions, including Cornell University, have created house staff quality safety councils, which directly link health system leaders to residents to improve care. Bridging leaders can also interact with residents in direct care settings to better understand their experiences and identify strategies to improve care and workflow. Some institutions are using crowd-sourcing innovations to engage residents. The University of California, San Francisco, sponsors awards up to $50 000 for groups with the best ideas to reduce inefficiencies and health care costs, such as reducing unwarranted use of nebulizers, blood transfusions, and intravenous medications. Although programs that directly link residents to institutional leaders could promote rapid innovation and ultimately culture change, sustaining efforts like these require ongoing investment from engaged leaders. Moreover, whether linking bridging leaders with residents results in trainees who practice high-value care is unknown.

Going for Win-Win Outcomes

As a third step, to ensure success, bridging leaders should engage residents in projects that are likely to result in wins for both the health system and residency education. Projects ideally should be under the resident purview, align with health system goals, and improve quality and efficiency of patient care. It is also vital to share outcomes of such projects with trainees and faculty to sustain successes and close the learning loop. At the University of Chicago, graduating residents were asked upon signing out clinic panels to risk stratify their patients, a principle of population management. Residents received coaching on how to implement an enhanced clinic handoff process, which included system redesign to prioritize scheduling high-risk patients. After 2 years, there were fewer resident clinic patients lost to follow-up, and acute care visits in the emergency department within 3 months of the handoff decreased from 26% to 16%. Similarly, residents at New York Methodist Hospital engaged in a blood transfusion reduction initiative that was associated with reduced transfusion-related complications and cost savings for the medical center. Although residents likely engage in numerous improvement efforts in their programs, aligning them to meet education and health system goals is key to success.

Through these successes, educators can offer residents firsthand experience for health system improvement, track how clinical decisions affect patients over time, and meet ACGME requirements. Health systems benefit by improving quality, reducing costs, building a skilled workforce, and fostering their mission for value-based care and population health.

Conclusions

As the US health system continues to undergo reform, the approach of AMCs to graduate medical education should also evolve. Aligning efforts between leaders of health systems and medical education is vital to produce physicians skilled in value-based care and population health. This three-step approach could foster an environment conducive to training physicians for the future health care system. The next steps should involve rapidly evaluating and scaling interventions that have the most potential to achieve these goals.

ARTICLE INFORMATION

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REFERENCES


