



Residencies as a high leverage policy target: Learnings from the I³ and I³ PCMH Collaboratives

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Key Points



- Residencies are an ideal target for policy, in terms of number and vulnerability of patients, residents' future practices and the role of faculty in their communities
- It is possible to significantly improve quality of care in academic settings
- Investment in faculty development, learning networks and some direct costs is necessary and extremely cost effective



Building Quality into Residencies



- Quality chasm across continuum of care
- “Orders of Magnitude” more difficult to improve quality in academic settings
- Quality collaboratives promising...



I³ Rationale



- A collaborative limited to residencies
- Regional setting allows face to face meetings and local knowledge
- Priority was *practice redesign*, but also addressed teaching/curriculum
- I³= *Impact* to the power of three—current patients, residents' practices, community practices faculty consult with



Timeline and Methods

Capstone 1

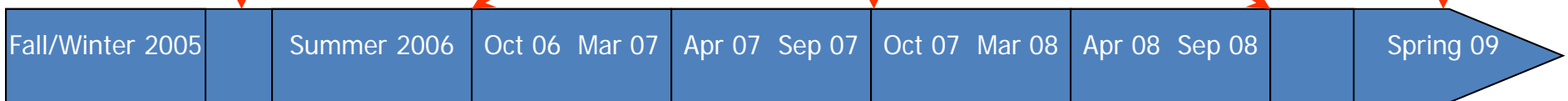
- Leadership
- Change Model
- Collaboratives

Learning Sessions

- Sharing data & improvement plans
- Training in practice redesign
- Sharing educational ideas & improvement plans

Capstone 2

- Other residencies
- Other specialties



Application

Startup

- Site visits
- Baseline data
- Charter

Collaborative Periods 1 – 4

Incentives: • academic collaborative • 2 year duration • 10K pay for participation
 • MOC IV credit • staff and resident development



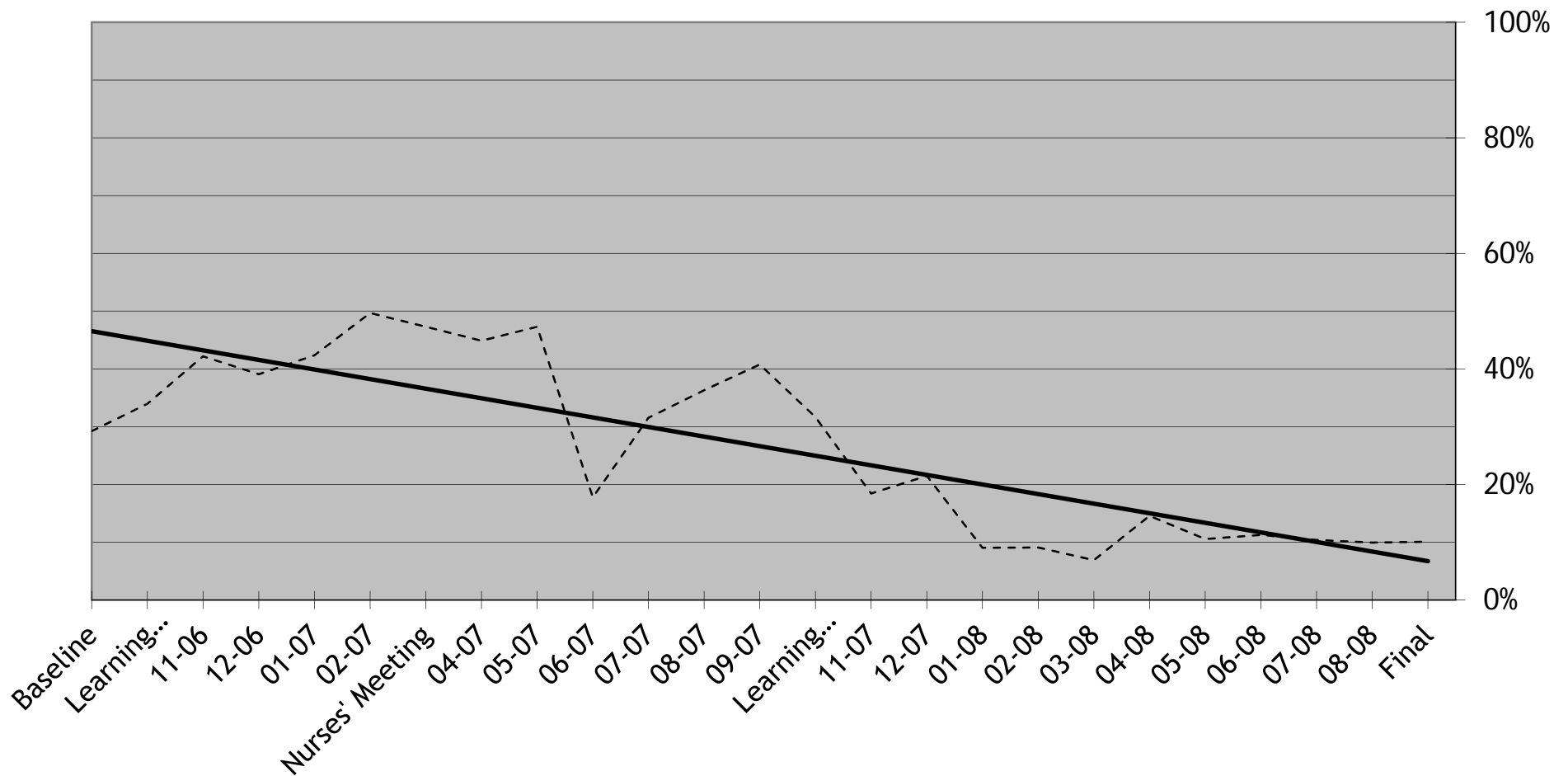
I³ Results

- 10 NC and SC Family Medicine Residencies, with 140,000 patients with 400,000 patient visits/year; 252 residents, 93 faculty
- Diabetes—significant improvement in quality of care in testing, exam, foot exam, blood pressure control, self management
- CHF- significant improvement in use of Beta-blockers, ACE inhibitors, self management, *38% drop in hospitalizations*

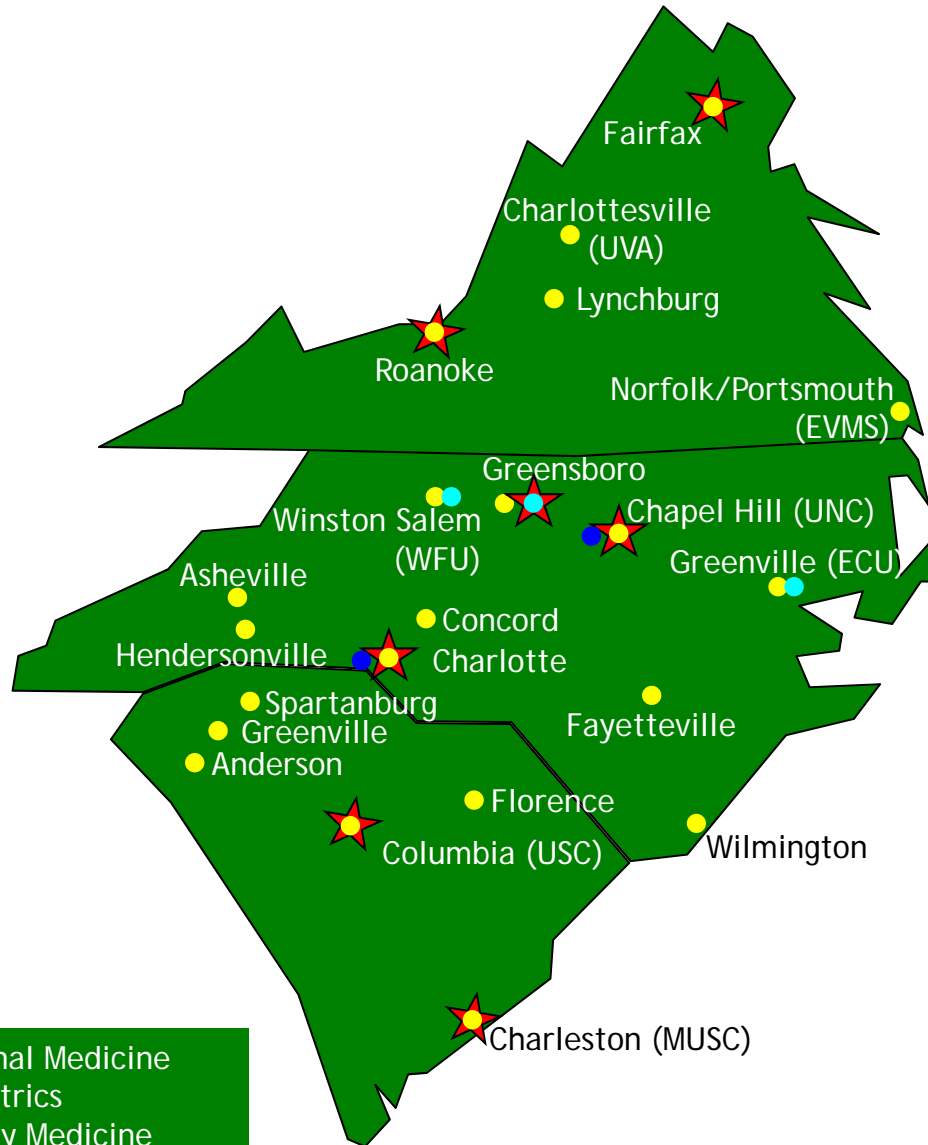


CHF Outcomes of I3

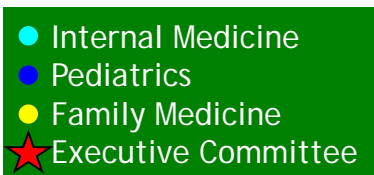
Percent of patients sampled admitted to hospital in the previous 12 months



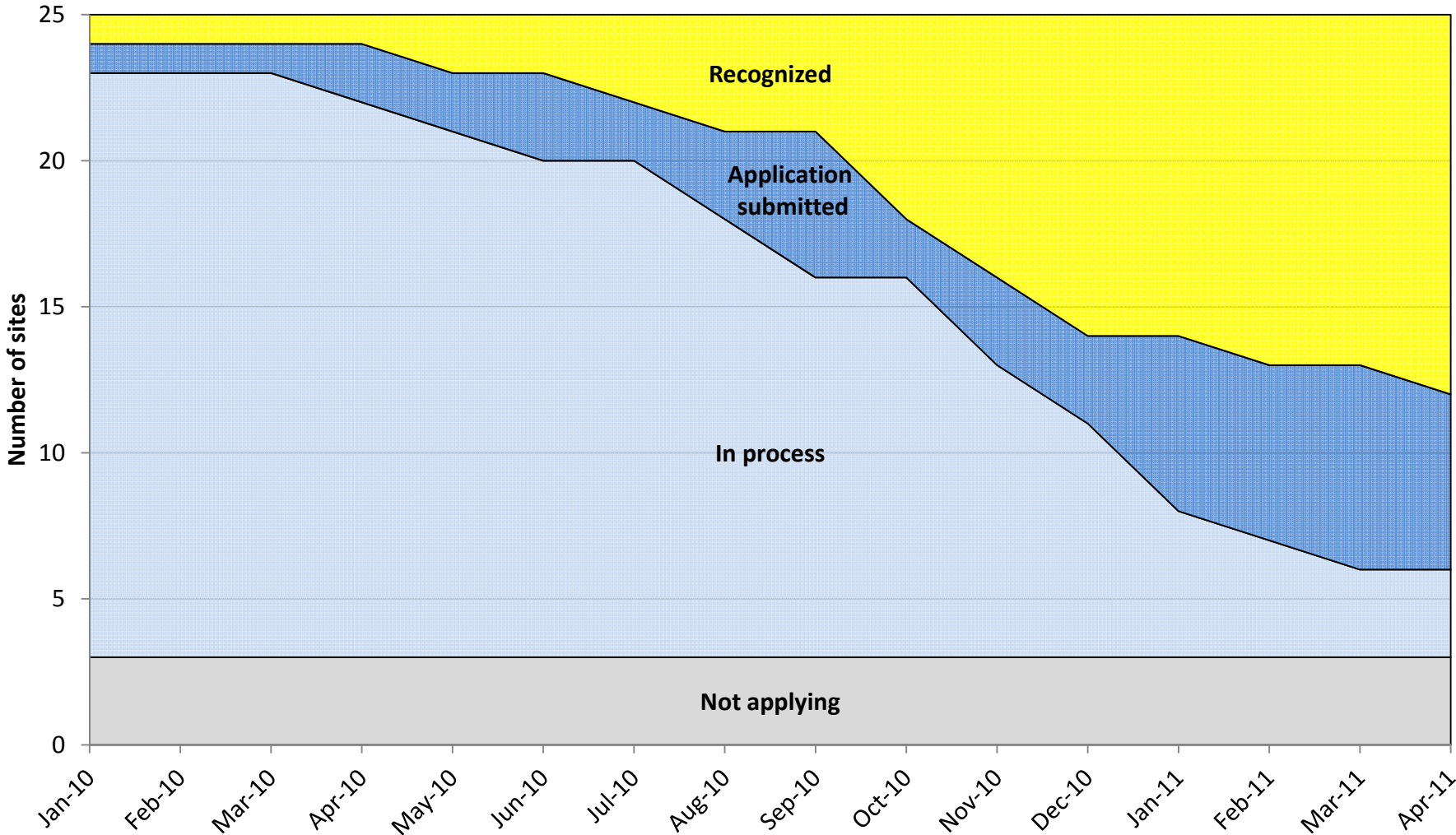
I³ PCMH Collaborative



- **880,000 visits annually**
- **55% minority**
- **Medicare 30%, Medicaid 31%, Uninsured 30%**
- **295 Attendings, 793 residents**



Progress toward NCQA PCMH recognition from the collaborative mid-point forward



I³ Cost Effectiveness

- I³: \$1.2M over four years led to significant improvement in quality of care for DM and CHF for 440k patient visits/year; 38% drop in hospitalizations, estimated \$13.5M savings
- I³ PCMH: \$300K over 2.5 years, PCMH applications for 22/25 residencies with 880K visits per year
- Indirect impact (residents' future practices, community practices seeking help from faculty)

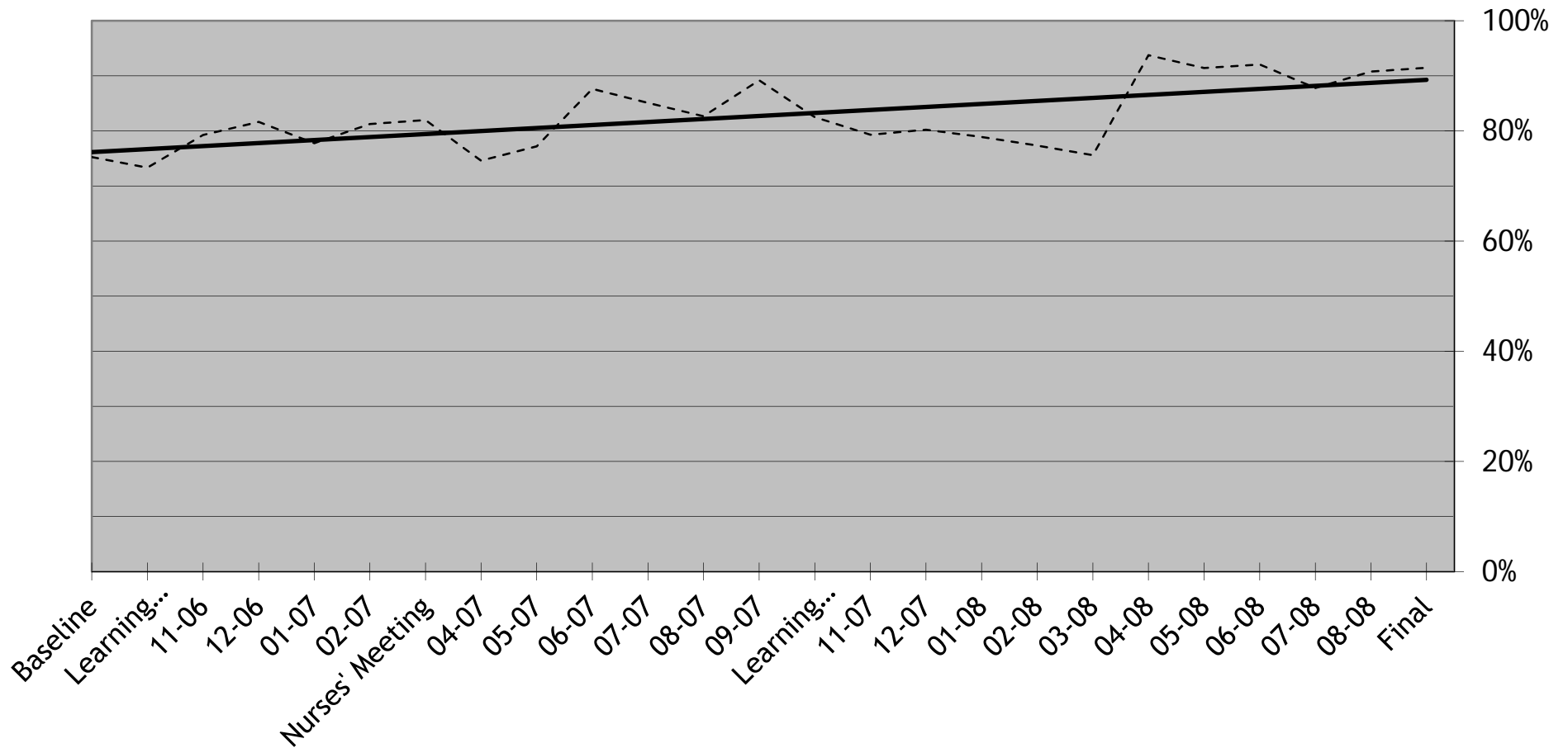
Proposed Next Step: I³ ACO

- Focus: managing populations, improving patient experience, reducing ED, CT/MRI use, and readmissions and coordinating care
- 25 primary care residencies
- Methods: Regional collaborative, face to face meetings +monthly data submission and call/webinar; residents/students participate
- Academic collaborative for dissemination
- Incentives: MOC IV credit, payment for data collection, staff/resident development



CHF Outcomes of I3

Percent of patients sampled with EF \leq 40% on Beta-blocker therapy





CHF Outcomes of I3

Percent of patients sampled with EF \leq 40% on ACEI or ARB therapy

