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

Incentives:
- academic collaborative
- 2 year duration
- 10K pay for participation
- MOC IV credit
- staff and resident development
I$^3$ 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
$I^3$ 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

![Chart showing the progress of sites towards NCQA PCMH recognition from January 2010 to April 2011. The chart indicates the number of sites recognized, in process, and not applying over time.](chart.png)
I$^3$ Cost Effectiveness

- $I^3$: $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
- $I^3$ 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: \( I^3 \) 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 ≤ 40% on Beta-blocker therapy
CHF Outcomes of I3

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