Quality Improvement Initiative Assessing and Improving Continuity of Care Utilizing Care Teams within a Family Medicine Residency Clinic

Tarek Chahine MD, Cortney Cole MD, Dana Achmar MD, Tess McCready DO, Elizabeth Towner PhD

Wayne State University Family Medicine Residency Program

Ascension Providence Rochester Hospital

Introduction

- Continuity of care (C of C) leads to quality care in which the patient and a physician-led care team (CT) are cooperatively involved in ongoing health care management.
- Goal is for seamless patient hand-offs between providers, this then leads to effective continuity of care.
- Minor challenges to providing follow-up care in a resident-led clinic consist of variability in rotation schedules and lack of care team knowledge.

Previous PDSA Cycles

- In 2019, a quality improvement initiative was performed to increase the concept of C of C by improving usage of EMR follow-up function frequency.
- The follow-up function usage increased from 65% to 94%.

EMR Care Team Feature

- Clinic has been using EMR system (Athena) since July, 2018.
- Includes “CT’” feature in patient information drop down window; lists all physicians caring for patient including PCP and specialists
- Residency CT consists of a PGY3, PGY2, and PGY1 residents, facilitating continuity of care by informing front desk which resident is familiar with patient in the event their regular resident PCP is out of office
- Residents received information about the feature during an initial orientation but were not using consistently

PDSA CYCLE 1

Plan

- Gather baseline data of resident use of CT feature in the month prior using EMR system
- Increase resident documentation of PCP within CT to 80%
- Create CT poster to remind residents of assigned CT

Do

- Hang posters reminding all providers of their CT assignment
- Educate residents how to input PCP into CT of patient
- Daily reminders prior to clinic start to use CT function for 1 month

Study

- CT PCP was documented 73.7% of time for chronic care patients
- CT utilized 80.8% of time when scheduling follow-up appointments
- CT PCP was seen 96.6% of time for follow-up while continuity CT used 3.4% of time

Act

- Adopt: Posters hanging in clinic to remind residents of CT assignments and to serve as a reminder to utilize CT
- Adapt: Identify and test strategies for increasing front desk use of CT assignments

PDSA CYCLE 2

Plan

- Intervention: educate ancillary office staff on CT and ask them to document reason(s) if patient not scheduled within their CT
- Aims: increase resident use of CT function >80% and scheduling of chronic care follow-up visits within resident CT >80%
- Measured use of CT and if follow up visits were scheduled in CT

Do

- For 1 month residents were reminded daily at the morning staff huddle to continue adding PCP to CT
- Front desk tracked scheduling of follow-up appointments within CT, and scheduled patients within their assigned CT to best of their ability

Study

- CT PCP was documented 73% of time for chronic care patients
- CT utilized 71.3% when scheduling follow-up appointments
- Barriers identified: temporary ancillary staff not educated on CT utilization, lack of CT member in clinic every day

Act

- Adopt: Daily reminders to residents and staff to utilize CT for appts.
- Adapt: Explore methods of scheduling residents within a CT on separate days of the week in clinic

CONCLUSIONS

- Utilizing CT feature increased chronic care patient scheduling with their resident PCP
- Education and visual cues appear effective for increasing use of Care Team feature
- Future PDSA cycles should examine impact of staggered clinic days for residents within assigned CT