

Does “Quality Time” Improve the Quality of Care?

KARIN NELSON, MD, MSHS
STEPHAN D. FIHN, MD, MPH

To improve residents' ambulatory care clinic experience and attract more of them to a primary care career, as well as to fulfill Residency Review Committee requirements, internal medicine programs have adopted a variety of scheduling strategies for resident continuity clinics. In 2009, the Residency Review Committee required internal medicine residents to have 130 ambulatory, half-day sessions over 3 years, an increase from the 108 sessions required in 2004, and a scheduling approach that reduces conflict between ambulatory and inpatient responsibilities.¹ In response, residency programs have developed block models to better separate inpatient from ambulatory care.

Whether such changes in scheduling are associated with improved patient satisfaction, an important measure of quality of care,^{2,3} have received limited attention, although previous studies have reported that heavy inpatient workload was associated with lower patient satisfaction in resident continuity clinics.⁴

In this issue of the *Journal of Graduate Medical Education*, Francis and colleagues report on patient satisfaction with continuity clinic from a multi-institutional, cross-sectional study that included 569 internal medicine residents from 11 geographically dispersed programs.⁵ The study was performed with a widely used instrument (the Consumer Assessment of Healthcare Providers and Systems survey) to measure patient experience and satisfaction. They set out to determine whether patient satisfaction in traditional models of weekly continuity clinic differed from that for patients seeing residents in 2 new clinic models: a block model and a combination of the traditional model and the block schedule. The authors compared results from multiple clinics across the country by type of continuity clinic schedule. They found small, but statistically significant, lower patient satisfaction scores in the combination clinic model. Importantly, they did not observe any

differences between the traditional and the block model in patient satisfaction.

The notable finding of this study was the essential lack of difference in patient satisfaction between the types of clinic blocks. There is no theoretical basis to expect a traditional model to produce better patient satisfaction than a combination model. The differences observed may be attributable to the lack of adjustment for patient or provider characteristics or, perhaps, to how the clinic schedules were implemented. Patient characteristics associated with satisfaction included demographic factors, socioeconomic status, and general health status. The authors were not able to adjust for those patient-level variables or for differences in physician-specific factors, such as language concordance. Moreover, continuity is a major determinant of patients' satisfaction with care, and measured continuity between the scheduling models did not differ much. This suggests that the patients' experience of continuity may have been similar across the different clinic models. An additional problem is that the Consumer Assessment of Healthcare Providers and Systems survey is relatively insensitive to important aspects of primary care, particularly those related to the patient-centered medical home.⁶ Finally, the differences that were observed were fairly small and unlikely to have been meaningful.

Should one conclude from those findings that resident schedules do not matter to patients? The answer is yes, if changes in schedules are relatively limited and do not provide a way for trainees to meaningfully enhance continuity with patients and engage more fully with primary care teams. Perhaps akin to parenting, it is not clear that carving out “quality time” equates to being meaningfully present and engaged. Brief, intense training experiences are well-suited to the tempo of inpatient care, but care for chronic conditions in the outpatient setting typically evolves over time, as do the therapeutic relationships that facilitate that care. If the dominant component of training remains heavily focused on inpatient care, residents may not have opportunities to interact with patients longitudinally in a manner that enables them to understand how patients experience and cope with illness. In addition, residents may not develop competencies in a full range of outpatient skills, including virtual modalities. Thus, it is probably unreasonable to expect that altering schedules as the sole intervention will

All authors are at the University of Washington and the Veterans Affairs Puget Sound Health Care System. **Karin Nelson, MD, MSHS**, is Associate Professor, Department of Medicine, and Adjunct Associate Professor, Department of Health Services; and **Stephan D. Fihn, MD, MPH**, is Director, Office of Analytics and Business Intelligence, Veterans Health Administration, Professor, Departments of Medicine and Health Service, and Division Head, General Internal Medicine.

Corresponding author: Karin Nelson, MD, MSHS, Veterans Affairs Puget Sound Health Care System, 1100 Olive Way, Suite 1400, Seattle, WA 98108, 206.277.4507, karin.nelson@va.gov

DOI: <http://dx.doi.org/10.4300/JGME-D-14-00346.1>

result in major changes in the experiences of patients or, perhaps, trainees.

References

- 1 Peccoralo LA, Tackett S, Ward L, Federman A, Helenius I, Christmas C, et al. Resident satisfaction with continuity clinic and career choice in general internal medicine. *J Gen Intern Med.* 2013;28(8):1020–1027.
- 2 Browne K, Roseman D, Shaller D, Edgman-Levitan S. Analysis & commentary: measuring patient experience as a strategy for improving primary care. *Health Aff (Millwood).* 2010;29(5):921–925.
- 3 Hochman ME, Asch S, Jibilian A, Chaudry B, Ben-Ari R, Hsieh E, et al. Patient-centered medical home intervention at an internal medicine resident safety-net clinic. *JAMA Intern Med.* 2013;173(18):1694–1701.
- 4 Feddock CA, Hoellein AR, Griffith CH, Wilson JF, Becker NS, Bowerman JL, et al. Are continuity clinic patients less satisfied when residents have a heavy inpatient workload? *Eval Health Prof.* 2005;28(4):390–399.
- 5 Francis MD, Warm E, Julian KA, Rosenblum M, Thomas K, Drake S, et al. Determinants of patient satisfaction in internal medicine resident continuity clinics: findings of the Educational Innovations Project Ambulatory Collaborative. *J Grad Med Educ.* 2014;6(3):470–477.
- 6 Scholle SH, Vuong O, Ding L, Fry S, Gallagher P, Brown JA, et al. Development of and field test results for the CAHPS PCMH Survey. *Med Care.* 2012;suppl 50:2–10.