

Innovative Practices Congruent With the First Goal of the IOM 2014 Report on Graduate Medical Education

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Editor's Note: The ACGME News and Views section of JGME includes data reports, updates, and perspectives from the ACGME and its review committees. The decision to publish the article is made by the ACGME.

In a News and Views piece entitled “ACGME Initiatives in Concert With Institute of Medicine Recommendations” in this issue of the *Journal of Graduate Medical Education*, Dr. Nasca lays out the current initiatives by the Accreditation Council for Graduate Medical Education (ACGME) in keeping with the aims of the Institute of Medicine (IOM) 2014 report entitled *Graduate Medical Education That Meets the Nation's Health Needs*.¹ This brief companion article offers examples of existing initiatives in accredited programs that are in furtherance of the first goal in the IOM report, which is to “encourage production of a physician workforce better prepared to work in, help lead, and continually improve an evolving health care delivery system that can provide better individual care, better population health, and lower cost.”

The IOM committee's remaining goals provide recommendations for changing the financing and oversight of GME to better meet this first goal. The first goal explicitly references the Institute for Healthcare Improvement's Triple Aim framework for optimizing health system performance to focus on quality, safety, and value. The Triple Aim framework calls for the design of the health system to:

1. Improve the patient experience of care (including quality and satisfaction);
2. Improve the health of populations; and
3. Reduce the per capita cost of health care.²

The IOM report provides general information on the types of projects the committee considered in keeping with the aims of the report (Box S-3, page 14). It does not include any concrete examples, noting that little work has been done to date to develop and test innovative

approaches for organizing and deploying physicians in new models of care delivery, to encourage physicians trainees to enter the specialties and practice locations with the greatest need, and to provide residents with the skills set most relevant for their practice after graduation. The report notes the committee viewed the recommended GME innovation fund as a critical tool in promoting broader development and testing of these approaches.

The examples in furtherance of the IOM's goal highlighted here are provided to show what is already feasible and being done in accredited programs, and to offer other programs ideas to consider for adoption or adaptation. The examples selected focus on readily implementable approaches that would benefit from further testing and assessment to begin the development of an evidence-based innovation in GME.

Existing Program Level-Initiatives in Furtherance of the “Triple Aim”

Use of a Team Care Model in a Resident Clinic to Improve Continuity and Outpatient Care Efficiency

Use of “patient care management teams” in a family medicine residency resulted in significant improvements in perceptions of continuity of patient care, office efficiency, and team communication, with improvement reported by trainees and in results for patient satisfaction.

Reported as Hern T, Talen M, Babiuch C, Durazo-Arvizu R. Patient care management teams: improving continuity, office efficiency, and teamwork in a residency clinic. J Grad Med Educ. 2009;1(1):67–72.

Geriatric Interprofessional Care Immersion Training for Chief Residents

A program to educate chief residents about value-based care also linked the chief residents to key interprofessional staff members to promote team-based care. This resulted in chief residents being better prepared to teach medical students and residents about the use of a team-based, patient-centered approach for the care of older adults.

Reported as Mohler J, D'Huyvetter K, O'Neill L, Clemens C, Waer A, Began V, et al. Development of an

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enhanced Interprofessional Chief Resident Immersion Training (IP-CRIT) program. Gerontol Geriatr Educ. 2014;35(4):354–368.

A “Virtual Practice” to Teach Skills for Going Into Practice

Use of a virtual practice in a resident continuity clinic addressed perceived gaps in knowledge about practice after completing residency, including ambulatory practice management, clinic operations, insurance, quality improvement, and financing.

Reported as Perez JA Jr, Faust C, Kenyon A. The virtual practice: using the residents’ continuity clinic to teach practice management and systems-based practice. J Grad Med Educ. 2009;1(1):104–108.

Family Medicine Training in a Clinic Serving an Urban Underserved Population

An urban family medicine track was used to recruit minority students and promote their future practice in urban, underserved areas of Milwaukee. The program met the goal of training more minority physicians in Milwaukee, with 50% of residents in the urban-track site from minority groups. The urban track also increased the number of physicians practicing in underserved areas after graduation.

Reported as Bade E, Baumgardner D, Brill J. The central city site: an urban underserved family medicine training track. Fam Med. 2009;41(1):34–38.

Better Management of Psychosocial Problems for Low-Income Children

A randomized controlled trial tested a self-report psychosocial screening instrument, with pediatrics residents/parents randomly assigned to either the intervention or control group. Compared with the control group, parents in the intervention group discussed a significantly greater number of family psychosocial topics (2.9 versus 1.8) with their resident provider and had fewer unmet desires for discussion (0.46 versus 1.41). The intervention showed that brief family psychosocial screening is feasible and may lead to greater use of community support resources by parents.

Reported as Garg A, Butz AM, Dworkin PH, Lewis RA, Thompson RE, Serwint JR. Improving the management of family psychosocial problems at low-income children’s well-child care visits: the WE CARE Project. Pediatrics. 2007;120(3):547–558.

A Dedicated Program to Teach High-Value Care

A high-value care program co-led by a physician and an administrator used financial and clinical data to identify areas with clear evidence of waste in the hospital. The initiative promoted evidence-based interventions that im-

prove both quality of care and value, and paired interventions with evidence-based cost awareness education to drive culture change. The team included hospitalists, residents, and pharmacists. Preliminary data showed significant reductions in some care processes along with associated savings.

Reported as Moriates C, Mourad M, Noveler M, Wachter RM. Development of a hospital-based program focused on improving healthcare value. J Hosp Med. 2014;9(10):671–677.

An Innovative Cancer Prevention and Control Track in a Traditionally African-American Institution

Development of a physician with enhanced training in cancer prevention and control in minority patients through a dedicated track with longitudinal community-based activities, cancer-focused academic experiences, and practicum rotations.

Reported as Taylor BD, Buckner AV, Walker CD, Azonobi I. Training residents to address cancer health disparities. J Grad Med Educ. 2012;4(1):72–75.

Integrating Community Health Into Internal Medicine Training

A dedicated community health elective rotation to enhance internal medicine residents’ community and public health competence. The curriculum included public health segments and clinical experiences at health centers targeting medically underserved populations. Outcomes included significantly enhanced self-perceived competence for discharging patients with follow-up at a community health sites.

Reported as Catalanotti J, Popiel D, Johansson P, Talib Z. A pilot curriculum to integrate community health into internal medicine residency training. J Grad Med Educ. 2013;5(4):674–677.

The limited examples above do not constitute a comprehensive list of current initiatives in furtherance of the IOM’s aim, but rather are intended to show what is currently being done and reported in the literature. The list likely omits other equally relevant initiatives that have not, or not yet, been reported. In addition, the examples are physician-focused and do not include interventions that address innovative care delivery models using other health professionals. Finally, a likely consequence of the focus on physicians and on health “care” is that 1 aspect of the Triple Aim, initiatives to improve the nation’s health status,³ is underrepresented.

Despite these limitations, the examples presented here and others such as a dermatology service learning project with a homeless population in Boston described in this issue of the *Journal*,⁴ make it apparent that some of the efforts recommended by the IOM report have already been started in programs and their sponsoring institutions despite the absence of funding for this type of innovative approach to clinical education.

References

- 1 Nasca TJ. ACGME Initiatives in concert with Institute of Medicine recommendations. *J Grad Med Educ.* 2014;6(4):809–810.
- 2 Institute for Healthcare Improvement. Triple Aim: The Best Care for the Whole Population at the Lowest Cost. <http://www.ihl.org/offering/Initiatives/TripleAim/Pages/default.aspx>. Accessed October 17, 2014.
- 3 Anderson GF, Squires DA. Measuring the US health care system: a cross-national comparison. *Issue Brief (Commonw Fund).* 2010;90:1–10.
- 4 Sheu J, Gonzalez E, Gaeta JM, Bharel M, Tan JK. Boston Health Care for the Homeless Program—Harvard Dermatology Collaboration: a service-learning model providing care for an underserved population. *J Grad Med Educ.* 2014;6(4):789–790.