At a Crossroads: The Future of Primary Care Education and Practice
Rebecca S. Brienza, MD, MPH

Abstract
Academic medical centers are under increasing scrutiny to provide both timely, high-quality primary care (PC) and health professional education. The complexity of these issues will require innovative multipronged solutions aimed at academic ambulatory PC training programs. In this issue, Serrao and Orlander describe one model that may address some of these issues: the Ambulatory Diagnostic and Treatment Center (ADTC) in the Veterans Affairs Boston Healthcare System. The ADTC model offers primary care providers (PCPs) the opportunity to refer an especially complex patient to a team of PC faculty and trainees who are not familiar with the patient but who have more time and resources to dedicate to her or his care. The ADTC is one model that may mitigate some of the tension between patient care and education in PC settings. Another model is the West Haven Veterans Affairs Center of Excellence in Primary Care Education program, in which interprofessional teams of faculty and trainees are assigned to care for a panel of patients. Creative solutions to overcoming the barriers to providing timely, high-quality care as well as a commitment to providing sufficient time and quality in PC education are essential. These solutions must include models of education and care that (1) preserve PCP–patient continuity, (2) allow more time for complex patient visits, and (3) integrate interprofessional teams to support PCPs. These models will afford patients, providers, and trainees sufficient time for patient care, continuous relationships, learning, and reflection, resulting in improved satisfaction and more meaningful work.

Editor’s Note: This is a Commentary on Serrao RA, Orlander JD. The Ambulatory Diagnostic and Treatment Center: A unique model for educating medical trainees and providing expedited care. Acad Med. 2016;91:XXX–XXX.

A
cademic medical centers are under increasing scrutiny to provide timely and high-quality care to patients. Recently, the Veterans Affairs (VA) system, in particular, has received negative publicity for a lack of timely access to care for veterans, which has resulted in the passage of the Veterans Access, Choice and Accountability Act of 2014. Throughout the nation, all VA medical centers are now required to ensure that all veterans have timely access to care. In addition, the VA has a statutory mission prioritizing health professional education and trains the largest number of health care providers of any single institution. Is it possible for the current model of primary care (PC) training in the United States to meet these competing priorities of providing access to high-quality care as well as meaningful education, while allowing providers and trainees to maintain relationships with their patients?

Selecting a PC Career
Much has been written about the shrinking pool of trainees selecting careers in PC.1–4 The reasons for this trend are multifactorial but mostly relate to trainees reporting a decreased number of PC faculty role models who are satisfied with, and who find meaning in, their work. Trainees see primary care physicians (PCPs) struggling with limited time to care for complex patients, overwhelming administrative and documentation burdens, and having to answer phone calls and secure e-mails on top of an already-full workday. Mostly, however, PCPs report a loss of control and lack of meaning in their work due to the increasing complexity of their patients’ cases and inadequate time for patient visits.5,6

An Innovative Model for PC Training and Patient Care
In this issue, Serrao and Orlander7 describe one model that may address some of these issues: the Ambulatory Diagnostic and Treatment Center (ADTC) in the VA Boston Healthcare System. The goal of the ADTC is to offer providers, including PCPs and emergency department physicians, the option of referring complex patients who require additional time and resources than are typically available in an ambulatory PC setting to a clinic that can meet those needs. The clinic is intentionally limited to a modest patient volume that allows for extended visits with patients (described as “VIP-level access for all patients”). In addition, postgraduate year 2 and 3 residents and fourth-year medical students have the option to rotate through the ADTC, they are supervised by rotating attending physicians. The structure of the rotation includes ample time for learning, including a pre-review of patients, didactics, and team-based case discussion. The authors describe the rotation as a way to mitigate the tension between patient care and training in academic medical centers, improving the educational experience for trainees while allowing for the comprehensive assessment of complex patients. In addition, they suggest that the model may enhance access to ambulatory PC and potentially reduce unnecessary hospitalizations.

For both patients and PCPs, continuity is desirable.5,8 In addition, PCPs’ knowledge of patients’ preferences, values, and
goals of care is critical, especially with complex patients. I believe that we need to develop new models of PC training and patient care that address the provision of accessible, high-quality care while allowing for the preservation of continuous relationships between patients and PCPs. Achieving this goal will require a change from a “one-size-fits-all model” to one that allows PCPs more time with their complex patients. In addition, building models of interprofessional team care within the established PC patient-centered medical home (PCMH) model will offer PCPs support in caring for their patients and allow them to focus their time more effectively. To reverse shrinking interest in PC careers, we must restructure the frenzied environment of the PC setting and allow providers adequate time and support to address the needs of complex patients.

The ADTC model allows PCPs to refer an especially complex patient to a team of providers who are not familiar with the patient but who have more time and resources to dedicate to her or his care. This model addresses some of the competing demands in the academic PC training environment. However, I believe that it may have the unintended consequence of further eroding the PCP–patient relationship, as well as increasing PCPs’ dissatisfaction with their work. Why can’t we instead restructure existing PC clinics to afford PCPs a reasonable amount of time to address the needs of their complex patients within the PCMH, which is rooted in the maintenance of meaningful and continuous relationships with patients? I believe that this change would contribute to increased satisfaction for PCPs, patients, and trainees.

**Ambulatory PC Training and Patient Care: It’s Time for a Change**

Serio and Orlander7 suggest that the ADTC model is “an outpatient clinic with an inpatient mind-set.” As a PCP and educator, I believe that we need to change ambulatory education and patient care to afford it the same status, time commitment, and importance that we do inpatient education and care. Historically, internal medicine trainees and faculty have completely immersed themselves in the inpatient setting during a ward month. During this time, the demands of the inpatient service take priority over most other work. We need new models of education and care that similarly prioritize dedicated and adequate time in ambulatory settings; such models should be focused and allow for the integration of learning, reflection, and application to clinical care.

**Interprofessional Team Learning and Patient Care**

A potential solution to many of the problems facing academic PC is building interprofessional teams of faculty and trainees (e.g., physicians, nurse practitioners, psychologists, pharmacists, physical therapists, social workers) who learn together and provide collaborative care for a panel of patients. This team care model includes full integration and understanding of all team members’ training, roles, and scopes of practice so that each may practice at the top of her or his license. In addition, this model provides support for PCPs to work with other health professional team members to collaboratively care for patients.

To integrate health professional trainees into patient-centered PC delivery models, the VA has funded seven Centers of Excellence in Primary Care Education (CoEPCEs). The main goal of these centers is to develop and test innovative structural and curricular models that foster transformation to interprofessional, team-based education and care delivery systems. At the West Haven VA CoEPCE, we have developed and implemented such a system.9 Our model includes interprofessional teams of faculty and trainees assigned to care for a panel of patients. The faculty and trainees are organized into practice partnerships to provide timely access to care and team continuity for patients. In this model, a nurse practitioner may see an internal medicine resident’s patient if her or his practice partner (the internal medicine resident) is unavailable, and vice versa. This team structure and the fact that our teams are in close communication to ensure safe transitions of care are made explicit to patients. Other health professional trainees and faculty (e.g., psychologists, pharmacists, physical therapists, social workers) are embedded into our PCMH model and provide additional services to patients. We have observed that our patients have an increased adherence to appointments when introduced to these providers by their PC team.

During CoEPCE rotations, trainees spend 100% of their time at the VA with their team. Approximately half of that time is spent in learning sessions, team meetings, or reflection, and the other half is spent in direct patient care with their continuity panel. They have weekly team meetings, which include their “teamlet” members (e.g., RNs, medical assistants). These meetings focus on team building, systems issues, and working on performance improvement projects together. This model allows time for pre-review and team discussion of complex cases. In addition, our teams have biweekly interdisciplinary meetings where trainees select one or two of their most complex patients for discussion and development of an action plan.10

Development of the CoEPCE structure required substantially changing faculty and trainee models of learning and care to allow faculty more time for supervising, mentoring, evaluating, and providing feedback to trainees during their CoEPCE rotations. We describe these immersion blocks as “reverse ward months” because they require the same level of intensity for faculty as an inpatient supervisory month. Implementing this structure required not only leadership support but also cultural change and buy-in from both faculty and trainees. As the whole team shares the care of patients in this model, it has actually resulted in increased patient access and allowed trainees and teams to take ownership and accountability for patients. Although the development and implementation of the CoEPCE model is grant funded, the expectation is that the local medical centers and academic affiliates will sustain the centers after the funding period ends.

In summary, the ADTC model addresses only some of the issues related to the complex and competing priorities facing PC delivery and training environments. Creative solutions to overcoming the barriers to providing timely, high-quality care as well as a commitment to providing sufficient time and quality in PC education are essential. These solutions must include models of education and care that (1) preserve PCP–patient continuity, (2) allow more time for complex patient visits, and
(3) integrate interprofessional teams to support PCPs. These models will afford patients, providers, and trainees sufficient time for patient care, continuous relationships, learning, and reflection, resulting in improved satisfaction and more meaningful work.

Acknowledgments: The author thanks Dr. Anna Reisman and Dr. Emily Meyer for their review and comments on this article.

Funding/Support: The Centers of Excellence in Primary Care Education are funded by the Office of Academic Affiliations, Veterans Health Administration, U.S. Department of Veterans Affairs.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

References