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Former family medicine residents have established innovative micro-practices throughout Rhode Island or have joined group practices that incorporate FCC principles such as enhanced access and group visits for patients with chronic conditions.

“Sick today, seen today.” One of the key principles of an exemplary primary care practice is having a provider accessible to the patient when needed. At Memorial Hospital of Rhode Island’s Family Care Center (which serves as the primary continuity clinic for the Alpert Medical School of Brown University family medicine residents and core faculty), the introduction of enhanced access in 2004 means, patients are seen the same day they call for an appointment. Enhanced provider accessibility does not end once an appointment is scheduled. The Family Care Center (FCC) has developed innovative methods of communication that have directly improved practice performance and quality.

The FCC is home to Brown University’s Center for Primary Care and Prevention, a collaborative effort with Memorial Hospital of RI. The Primary Care Center unites patient care, medical education, and research, serving as an interdisciplinary training site for family medicine, general internal medicine, pharmacy, and mental health. Rhode Island is fast becoming a living laboratory for the patient centered medical home as a result of the state Office of the Health Insurance Commissioner’s Rhode Island Chronic Care Sustainability Initiative (CSI-RI). This multi-stakeholder program was designed to align quality improvement goals and financial incentives to make primary care more effective for patients and more appealing to physicians through enhanced payment to primary care providers. Through this program, participating practices like the FCC receive a modest per-member-per-month fee for providing additional services not otherwise reimbursable under Medicare fee-for-service. Additionally, each practice is provided with a nurse care manager to provide patient care management services. In return, the FCC must agree to study three chronic conditions that have the greatest impact on their community: diabetes, coronary artery disease, and depression. According to Dr. Jeffrey Borkan, Family Medicine Department Chair, Rhode Island now contains one of the highest patient-centered medical home practices per capita of any state.

Before 2004, open access scheduling had rarely if ever been implemented in an underserved, teaching environment in Rhode Island. Since its introduction in 2004, no-show rates have declined and both patient satisfaction and continuity measures have improved. FCC staff schedule each patient with a personal clinician for continuity of care purposes. Residents are included in the schedule. Resident physicians experience approximately 75 percent continuity with patients for non-acute visits and over 80 percent with attending physicians. Over 98 percent of patient visits are set within the immediate care team. Two blocks of time – one in the morning, one in the afternoon - are set aside in each physician’s schedule. Patients are able to reserve a time up to 5 days in advance. This “adds flexibility to the scheduling of residents on rotation.” Acting as the primary resident training site, Family Medicine leadership saw the importance of using the FCC to model new delivery models to trainees. Dr. Borkan notes that “residents have been both partners in and part of the push in advancing the patient-centered attributes utilized at the Family Care Center.”

Training in an innovative environment has impacted the way former residents practice once they are in community settings. Taking what was learned during their residency training at the FCC, former family medicine residents have established innovative micro-practices throughout Rhode Island or have joined group practices that incorporate FCC principles such as enhanced access and group visits for patients with chronic conditions. Such results affirm family medicine faculty intentions, but do not

necessarily come as surprising considering the impact they play in helping expose trainees to such elements throughout their continuity experience at the FCC.

In 2003, the FCC began offering interdisciplinary group medical visits to patients with diabetes. Faculty quickly realized the power of these forums for the patient and expanded offerings to include other chronic conditions. Recognizing the educational value in these visits, residents routinely participate in the sessions and are required to lead a group visit as part of their continuity rotation. Nutritionists and physical therapists that offer particular expertise are often invited to help lead focused discussions. During these visits, several patients meet with their care provider to review recent lab results and discuss self-management goals. Patients are coached using motivational interviewing techniques at the sessions, and providers note patients in turn routinely employ similar techniques amongst one another. At the end of the visit, patients are provided with a summary sheet of their visit which details a self-management regimen to follow between group sessions.

In 2009, team members began an experimental program testing a personal health record (PHR) for patients with certain chronic conditions. Accessible through a patient Web portal, the PHR is an untethered interactive health record for patient-provider communication and provides self-management education modules for patients with diabetes, hypertension, chronic obstructive pulmonary disease (COPD), and coronary artery disease (CAD)

Group visits are just one of several vehicles implemented at the FCC that empower patients with the information and self-management tools necessary to make better informed care decisions. Having a fully implemented EHR at the FCC for nearly 10 years, faculty and staff are adept at using the system to capture clinical data and manage patients on both individual and population-based levels. In 2009, team members began an experimental program testing a personal health record (PHR) for patients with certain chronic conditions. Accessible through a patient Web portal, the PHR is an untethered interactive health record for patient-provider communication and provides self-management education modules for patients with diabetes, hypertension, chronic obstructive pulmonary disease (COPD), and coronary artery disease (CAD). Providers are able to monitor patient “engagement” by capturing the number of times a patient views the site and clicks on informational buttons. To assist patients with limited computer proficiency, as part of this trial, the FCC has begun utilizing “patient Web navigators.” The patient Web navigators, while not from clinical backgrounds, are trained in the fundamentals of motivational interviewing and receive basic instruction on chronic medical conditions like hypertension prior to working with PHR patients. Once a navigator, these new members of the care team provide basic case management assistance through electronic monitoring of patients and can schedule follow-up visits with their personal clinician. Though still in its experimental phase, the program has proven so successful there are plans to expand to 70 affiliated practices in the future.

Providing accessible, patient-engaged care is crucial to developing an exemplary primary care practice. At the FCC, members of the Family Medicine team have embraced practice innovation for more than 10 years while training medical residents to incorporate similar models once practicing in the community. Nearly two thirds of the family physicians in Rhode Island were trained at this one program over the past 35 years. Though the need for primary care physicians is rising dramatically, it is hoped that with more than 50 percent of Family Medicine graduates practicing within one hour of Brown University, the State will be spared a shortage of 21st century primary care leaders.