

From: Smith CS (1995). The impact of an ambulatory firm system on quality and continuity of care. *Med Care*; 33(3):221-6.

### **Resident Group Practice**

While firm teams provide continuity, they do not provide a state-of-the-art group practice experience. During the 2006-2007 academic year, we converted the resident clinic experience to a resident group practice. Our goals were to 1) improve faculty-resident supervision in clinic and 2) provide cross-cover opportunities that would lead to more concise, informative noting and sensitivity to practice style differences. A new firm with a small defined group of supervising faculty was dedicated to resident teaching and training. A hand-picked group consisting of a nurse, a clerk, and two medical assistants was selected to support this team. These staff triage all phone calls and drop-in requests, forwarding them to the primary provider or to 'urgent care' as necessary. One resident from each afternoon clinic has a light schedule and is designated to cover the urgent care for the group that day. Pharmacy residents work together with the Internal Medicine residents in clinic. We plan to measure several outcomes from this change, and resident response to date is very enthusiastic.

### **Firm Systems for Resident Practice**

As the Boise VA expanded and became more complex this intimate connection between clinic staff and providers decayed. For this reason, an interdisciplinary team spent nine months in 1991 restructuring the ambulatory and urgent care clinic system into firm teams. These teams, consisting of eight clinical services, cared for a stable subset of patients. Because of this continuity and smaller size, teams got to know their patients, staff got to know their providers, and patients got to know their health care team. Without adding additional personnel, simply by restructuring the way we did business, we were able to improve patient and staff satisfaction, decrease the average length of an outpatient visit, and increase continuity. The concept of resident firm teams has since been expanded to the Roosevelt clinic, Harborview, and VA sites in Seattle.

### **Process Outcomes**

Nationwide, graduate medical education has changed its evaluation focus from content and structure to process outcomes. Key process outcomes for ambulatory care are identified as system-based practice, practice-based learning, communication, and professionalism. The Boise VA has been measuring these process outcomes using a standardized evaluation instrument with a 9-point, Likert-style element for each. We are planning significant additions to the measurement fidelity of each of these outcomes as described below.

The Boise VA is ideally placed to offer innovative practice-based learning opportunities and measure their outcomes. Through the VA's existing electronic medical record and quality improvement initiatives, a tremendous amount of outpatient clinical data is currently captured and available in the regional CHIPS database. This includes data on all recommended preventive health measures and performance measures on established clinical practice guidelines. Next year, we are planning several quality improvement initiatives with residents. First, we will provide a 'full-denominator' individualized monthly report to residents on their preventive and performance measures. This will include a list of all patients that fell outside of goals. Second, we will create a 'performance' bulletin board that will track key team-level performance. Finally, each fall we will select a single outcome that we would like to address as a team and redesign processes in order to improve that outcome. This will be a key indicator on the performance board.

Measurement of systems based practice (SBP) and professionalism are in their formative stages. 'Patient advocacy' and 'understanding one's own system' (sub-competencies of SBP), as well as

professionalism, are time consuming and expensive to measure using the suggested 'gold standard' of 360o feedback. Furthermore, there are potential conceptual problems with 360o feedback. Data collection instruments are sponsored by the executive leadership and reflect their particular goals and values. These instruments may simply not contain questions about important goals or values of other stakeholders. Data collection instruments for 360o feedback are usually composed of Likert-style questions aimed at evaluating one element at a time. By evaluating each element in isolation, they may not reflect true resource constraint decisions faced by residents in a way that a forced-choice data collection method would. Cultural Consensus Analysis (CCA) is a standard anthropological technique that determines whether groups hold shared or conflicting preferences and values. A research team at the Boise VA has created a CCA tool that has been shown to predict operational problems and patient satisfaction in teaching clinics. This technique avoids both of these conceptual problems, requires only small sample sizes, and is very efficient. For all of these reasons, we will be testing it as an ideal candidate to function as an improved outcome measure for professionalism and these SBP sub-competencies.