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;91:669–672.

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. It is 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.5,6 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

Serrao and Orlander’ 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. 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.

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

622  Academic Medicine, Vol. 91, No. 5 / May 2016
Copyright © by the Association of American Medical Colleges. Unauthorized reproduction of this article is prohibited.
(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