LETTERS

An Evaluation of Continuity Clinic Redesign

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To the Editor: We read with great interest the article by Wieland and colleagues regarding the redesign of their residency program to a 50/50 alternating ambulatory–inpatient schedule.[1] Interestingly, patient continuity decreased from both a provider and patient perspective, and there was no change in resident or faculty satisfaction with the clinic restructuring.

We implemented a similar system in the last academic year (AY 2012–2013). We intended to add a stronger emphasis on ambulatory care. We were also addressing what we felt was a common problem in the traditional model of residency—that staffing residents to cover inpatient needs with restricted duty hours occurred at the expense of canceling or changing continuity clinic days. This led to a steady increase in patient cancellations and rescheduling.

Based on survey and clinic data, our experience with the transition to a 50/50 block schedule mostly mirrors the experience described by Wieland et al. Our residents did note an overall higher satisfaction with the new system. They noted less of a burden of continuity clinic compared to the traditional model, a more positive ambulatory experience, and felt more engaged in their inpatient rotations. Additionally, our rescheduling rate was reduced by 33 %, our clinic no-show rate declined by 10 %, and overall we had an increase in patient visits by 38 %. Like Wieland et al., we also observed a perceived drop in continuity of care.

Another aspect of restructuring to a block model is the ability to implement longitudinal curriculum. This allowed us to implement a longitudinal quality and safety curriculum culminating in residents developing improvement projects in both the inpatient and outpatient setting. Whether incorporating residents into improvement initiatives will have a positive impact on patient outcomes is unknown, but certainly is a point of emphasis for the ACGME's Next Accreditation System.[2]

Although we feel we have had an overall positive experience transitioning to a block model, the question remains whether this is an effective way to train internists, or simply a reaction to restrictions in resident duty hours. It would be interesting to see research comparing the relative merits of different models of block scheduling (50/50, 4:1 week or 4:2 week) to the traditional model of training. Nonetheless, the work by Wieland et al. is the start of a systemic look at the restructuring of residencies to enhance educational and clinical opportunities for the internal medicine resident.

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REFERENCES

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