Engaging Students in New Models of Care

Breanna Johnson, BA; Beat D. Steiner, MD, MPH

(Fam Med. 2018;50(7):554-5.)
doi: 10.22454/FamMed.2018.666218

He greeted me with a smile. It was our first visit. "I am here for a checkup but I am fine," he said.

"What is the bandage around your hand?" I asked.

"Oh I was hit by a car," he said.

When I slowly opened his hand clutching a dirty, tattered bandage, I saw external fixation pins protruding from his knuckles. When I looked further, I noticed a heavily scabbed scar line, stitches still in place, along the entire length of his left leg. It turns out that almost 4 months ago, he was walking when he was hit by a car. He suffered open fractures of his tibia, fibula, and metacarpals. Tibia intramedullary nailing and external fixation of his fourth and fifth metatarsals stabilized the fracture. But after discharge he was "lost to follow-up." We spent the rest of the afternoon cleaning his wounds, removing his stiches and his external fixation pins. Our nurse noticed that his toenails needed trimming so she did that also! Mr Thomas (not his real name) is a homeless man with schizophrenia who was seeking care at our office. Our office provides an enhanced primary care model for patients with serious mental illness (SMI).

I write this column to shine the spotlight on one of the most vulnerable populations in our country. People with SMI are often stigmatized and marginalized, and die on average 25 years earlier than the general population.[1] This is a shocking statistic and a reminder of how badly our current system is failing people with these illnesses. While the reason for these pronounced disparities is multifactorial, the cause of death is often related to illnesses we care for as family physicians. These patients die early because their chronic illnesses like diabetes and hypertension are not well managed and because they do not receive the recommended preventive screening tests.

But I write this column with hope. I share with you one new model of primary care that can help to close this gap. And in a departure from prior presidents' columns, I am cowriting this one with a student. When we engage our learners in new models of care, we show them the power and creativity of our discipline.

Enhanced Primary Care: A Faculty Perspective

Many patients with SMI do not do well in current primary care settings. At WakeBrook Primary Care, a University of North Carolina Health Care System (UNC-HCS) practice, we have developed an alternate model of enhanced primary care that is showing powerful early results. We have built a patient-centered medical home (PCMH)[2] model with three additional components:

1. We allow for longer and more frequent visits to establish trust with patients who have often suffered past trauma. Our panel size for one family doctor caps at 750 patients.
2. Our multidisciplinary team has the skills to provide effective primary care but also has the training and heart to take care of patients with SMI.
3. We comanage all of our patients with behavioral health teams. We meet monthly with the behavioral health teams and are in touch by phone daily.

This enhanced primary care model allows us to take care of patients like Mr Thomas. We have the time in our schedule and the skills to address his infected wounds. We have the

heart to care deeply for a man whose smell and behavior might repel others. And we have the relationships with our behavioral health colleagues to reconnect him to care for his mental illness. After 2 years, our outcomes are impressive. Patients report being highly satisfied with their care. Wait times are short, usually less than 15 minutes. And patients with acute illnesses can usually be seen the same day. Once a patient establishes care at WakeBrook Primary Care, emergency department (ED) utilization often falls dramatically. One patient was seen twice a week in EDs for years. Since joining our practice in 2016, he has had only one ED visit! However, perhaps most important is the improvement in quality metrics, as we seek to narrow the mortality gap in patients with SMI. Many of our quality metrics now exceed the metrics in other UNC HCS practices. Cervical and colon cancer screening rates doubled! We are now in negotiation with our county and our state to develop a value-based payment model and expand to other sites. As a faculty member, it has been exhilarating to help develop this model. Learners were involved at all stages. They helped us write the SAMHSA-PBHCI grant that helped fund the clinic. They help care for our patients, and they offer creative ideas on how to improve our practice through their quality improvement projects.

Enhanced Primary Care: A Student Perspective

Mr Thomas provided just one of the countless enlightening patient encounters I have had working in this new model practice. The routine follow-up, lengthened appointment times, and scheduling flexibility we are able to offer our patients through the enhanced primary care model have allowed me to develop reciprocal relationships that I might not have been able to build in a different practice. My medical and bedside skills have been shaped by true continuity of patient care, and my patients have found a medical home because of our focus on continuity.

As an MD/MBA student interested in systems of care, WakeBrook has given me the reassurance that creativity and flexibility can be part of my career. I have initiated a quality improvement project that focuses on increasing cervical and breast cancer screening rates in our clinic. I have organized a Women's Wellness Day and am working with assertive community treatment teams, social workers, psychiatrists, and local businesses to offer Pap smears, mammograms, nutrition and exercise tools, and tobacco cessation to our female patients. I have discovered integration among a variety of specialties is necessary to effectively reach our patients.

WakeBrook has also taught me powerful lessons about people living with SMI. I have a deeper understanding of the issues facing patients with SMI and ways to earn the trust of patients who are often marginalized in our system. I have seen the importance of integrating primary care with psychiatry to improve the care of this group of patients. I am excited to continue my medical school training with a greater appreciation and commitment to delivering patient-centered care to this vulnerable group of patients. I will strive to meet the needs of patients with SMI with the same level of enthusiasm and dedication as my preceptors.

Conclusion and Future Direction

Many vulnerable groups continue to face grave health inequities. People with serious mental illness are among the most vulnerable. As family physicians we have the training and creativity to develop new models of care to right these injustices. As family medicine educators we have the opportunity to influence our learners to join us in this fight. I believe there is hope.

CORRESPONDENCE: Address correspondence to Dr Steiner, University of North Carolina School of Medicine FMR, 590 Manning Dr, Campus Box 7595, Chapel Hill, NC 27599. 919-966-3711. Fax: 919-966-6125. beat_steiner@med.unc.edu.

References

1. Parks J, Svendsen D, Singer P, Foti ME. Mortality and morbidity in people with serious mental Illness. Alexandria, VA: National Association of State Mental Health Program Directors; 2006.
2. Jackson GL, Powers BJ, Chatterjee R, et al. Improving patient care. The patient centered medical home. A Systematic Review. Ann Intern Med. 2013;158(3):169-178.