Clinic First at Stanford-O’Connor: Changes, Challenges, and Collaboration

The Stanford Healthcare- O’Connor Hospital Family Medicine Residency Program has truly benefited from this year with the Clinic First Collaborative. We came to the conference with some of our own ideas for improvements to make in our clinic. Through the collaborative, we got helpful suggestions for implementing those ideas, and we’ve also been inspired by new ideas we hadn’t thought of!

2+2 model
Our first and biggest change was moving from a monthly rotation schedule to a 2+2 model. We obtained an ACGME waiver to allow this. The new model separates outpatient from inpatient days on most inpatient rotations, and also created a new intern “Clinic” rotation during intern year.

Separating outpatient from inpatient days has resulted in improved resident satisfaction and decreased resident stress. Residents are very happy with the change and highlight it to our applicants on interview days. Residents solved the workflow issues that arose, for instance by having clinic team members or the “doctor of the day” cover urgent paperwork that comes in during residents’ two-week blocks away from clinic.

The Clinic rotation is a new intern rotation of two 2-week blocks early in intern year. During this time interns are introduced to quality improvement and to our clinic’s population health software, culminating in a QI project of their choice. Interns also dive into continuity clinic, familiarizing themselves with the EMR and clinic workflow early in their first year. Previously interns didn’t spend extended time in clinic until R2 year, so this early clinic exposure has helped interns become more comfortable in clinic early on. Overall feedback has been positive.

Access and continuity
Before the CFC, our clinic had same day access through two half-day acute clinics. However, individual residents often had poor same-day access, since continuity appointments were booked up to several months in advance. In August 2018 we dropped one half-day acute clinic and instead blocked two visits in every R2 and R3 clinic session for acute visits that open 48 hours in advance. The total number of acute slots in the clinic per day stayed approximately the same.

We hit a barrier because the acute slots were not held; they got booked more than 48 hours in advance, leading to inadequate same-day clinic access. Our EMR does not provide a way to truly block visits. Phones staff gave us feedback that they had booked the appointments more in advance to increase continuity with the PCP. Staff also noticed that sometimes the held slots weren’t getting filled. We will try again holding the slots till 48 hours and see how it goes. We will then analyze access and continuity measures under the new system.

Co-location
We had not considered co-location before the CFC conference. However, we were excited by this idea and returned from the conference wanting to try it. We had strong buy-in from our MA’s at the outset, as they thought it would help with huddling and communication. We anticipated more resistance from residents, so we spent time trying to perfect the plans before rolling it out. Two residents did QI and FCM projects in preparation for the roll-out, which led to
helpful suggestions. However, in this case we spent too much time planning. In those 2-3 months, we had a large turnover of MA staff. New staff were reluctant to try co-location, so our plans to roll it out stalled.

However, recently our new RN hire and clinic manager have built support among the MA’s by delving deeper into what their concerns are and addressing them. Co-location will be logistically complex in our clinic residents and MA’s may sit in different locations every day, and seats will need to be assigned on a daily basis. But we tried rolling it out last week and so far it seems to be working. We will solicit feedback from staff and residents at our clinic meeting next week.

**Change to 20/40 appointment lengths**

In the fall of 2017, a resident did a flow study in our clinic. The study revealed that despite our 15/30 minute visit times, every visit type took an average of at least 19 minutes. The resident also found that many 30 minute visit types took less than 30 minutes. Residents had long expressed interest in changing to 20/40 minute appointments. After obtaining approval from clinic system leadership on the condition that productivity be maintained, we began a pilot of 20/40 minute visits in November. All 15 minute visits became 20’s. Thirty minute visits were changed to 20’s or 40’s based on findings from the flow study and on consensus from residents, the clinic director, MA’s, and the front desk. Seniors were limited to one 40 min visit per half day, whereas previously there had been no limit on 30 minute visits. We will soon evaluate productivity under the change, and will seek feedback from staff and residents on what they think of the new schedule.

**Hopes for a discharge clinic**

Inspired by the presentation in the CFC webinar, we hope to start a multidisciplinary discharge clinic two half days per month for our recently hospitalized continuity patients. Our social worker has agreed to participate, but we lack a pharmacist. Pharmacy students currently rotate on our inpatient service. We met with the director of the pharmacy school rotation, who is very interested in collaborating. We are currently working with our FQHC leadership to navigate regulatory requirements. If we are successful, we hope to roll out the clinic in early 2019.

**Resident engagement in clinic improvement initiatives**

Our residency program has a rich history of resident involvement in QI projects, under the leadership of our program director Dr. Yu. Over the past year resident engagement has continued, and the new Clinic rotation has allowed interns to undertake additional projects. Some resident projects from the past year include:

- Creating a postpartum visit scheduling algorithm to increase the number of patients who receive LARCs at their postpartum visit
- In July, interns on the Clinic rotation trained our MA’s to perform diabetic foot exams, and developed standardized training instructions so MA’s at all sites can be trained.
- Improving medication reconciliation: Interns led a successful effort to change our system-wide automated telephone reminder to instruct patients to bring their medication bottles to their appointment. Also, an intern placed new red “medications” bins in exam rooms where patients place their bottles for review.
- Identifying pediatric patients with elevated blood pressure: Under an intern’s leadership, and through physician-staff discussion and collaboration, we have just changed our workflow to more consistently flag pediatric patients with elevated blood pressures. The
intern also updated the reference BP values to the new 2017 guidelines. The reference will be updated system-wide.