A Golden Opportunity: The Coevolution of Medical and Education Homes

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Suboptimal public health is an intrinsic (if unintentional) feature of the American health care system. Because of the reactive nature of patients and providers to illness, conditions that could be managed successfully in outpatient settings often deteriorate before patients receive care. That care, typically provided in emergency rooms and hospitals, then becomes far more expensive than proactive outpatient management would have been. As a result, the system is unintentionally prone to generate the “worst of both worlds”—poor health and high costs.

Traditional approaches to clinical education reinforce these features, as most training remains rooted in reactive, inpatient-oriented systems. In many fields, short, high-acuity hospitalizations decrease the educational value of inpatient training and raise questions of the relevance to trainees’ ultimate practice, as many specialties are increasingly practiced in ambulatory settings. This gap between training experiences and practice needs as well as the Flexner centennial in 2010 have contributed to a crescendo of calls for medical education reform.

But the reform of both health care delivery and medical education faces a “catch-22.” Although educational modernization seems a logical route to improving the health care system, teaching innovative delivery models in the classroom will produce little change if students are then trained in traditional clinical settings. Alternately, if trainees do not learn about new practice models during their formal education, their ability to function effectively in such systems and to serve as change agents will be diminished.

The next few years provide an opportunity to escape this quandary, with health care delivery undergoing transition and medical education primed to do so as well. Academic health centers (AHCs) can upgrade both their clinical and education missions by nurturing the coevolution of medical homes for patients as education homes for trainees. An education home is envisioned here as an ambulatory site with a stable practice staff and patient population where a student or resident receives the bulk of his or her clinical training over several years.

Although political and judicial uncertainties prevent full clarity, two pending changes in the health care system loom large. First, an expected influx of newly insured patients in 2014 will require increased capacity that AHCs can meet through new outpatient delivery models, which strategically incorporate practitioners and trainees from a variety of health professions under the supervision of faculty physicians. Second, as payment models transition from a fee-for-service structure to one that rewards efficiency and quality rather than volume, delivery systems that reduce costs-per-patient-served and emphasize chronic disease management and after-hours care to avoid emergency treatment will lower expenses and improve outcomes.

A medical and education home model structured as an interprofessional, multitrainee outpatient center—in which patients have 24/7 access and each team member’s role requires the routine use of his or her most advanced competencies—will instill the values and skills of teamwork in learners while reducing health care costs.

Competency assessment provides a conceptual framework for including all students as members of a functional clinic team, with early learners participating in clinic operations and progressing to patient evaluations, presentations, differential diagnoses, and management. As learners acquire competencies, they teach junior colleagues, solidifying their own mastery. Beyond feedback from faculty and team members, clinic operational and outcome metrics would increasingly reflect trainees’ efforts and contributions as their responsibilities grow. More important, trainees would form their professional identities in a native habitat focused on patient-centeredness, interprofessional teamwork, quality, and efficiency. Additional educational benefits include longitudinal mentoring by a small, clinic-based faculty team and opportunities for students to form long-term relationships with patients and observe the progression of illness. Service in after-hours clinics would provide experience in acute diagnosis, around-the-clock access for patients, and demonstration of commitment to patient-centered care by AHCs.

Achieving these benefits will require a substantial change in the nature of clinical education. To align trainees’ experiences with new practice models, their education homes should serve as the backbone of clinical training throughout medical school and/or residency, supplemented by appropriate outpatient and inpatient specialty experiences. Inpatient education under academic hospitalists will allow trainees to learn and practice efficiency and quality improvement from experts in inpatient medicine.

The coevolution of medical homes for patients as education homes for trainees can cost-effectively increase outpatient capacity, decrease high-cost emergency and inpatient care, and emphasize proactive prevention and chronic disease management—all while educating trainees in new models of health care delivery and providing them abundant clinical experience. It will be a significant challenge to overcome the inertia of teacher-centered education and doctor-centered clinical care. This may be a once-in-a-century opportunity, and we must take advantage of it.

References

