EDITORIALS

Time for Leadership in Teaching About Care of Chronic Illness

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In this issue of JGIM, authors report on an exciting multi-institutional quality-improvement initiative designed to teach residents how to care for patients with chronic disease using the Chronic Care Model (CCM). The residency programs report on a variety of different approaches to educating residents who are providing care in their longitudinal out patient clinics in teaching hospitals. Innovative approaches include; the "Teamlet Model" using health coaches,¹ a motivational interviewing curriculum,² a novel nutrition and exercise curriculum,³ and others. It was inspiring to read about these creative programs implemented in longitudinal clinics to teach about and improve chronic care. However, I also must admit to feeling a bit disheartened by the articles. How is it possible that we are only now, in 2010, observing small experiments in education change, when we have recognized the compelling need for so long? Why is teaching the CCM still in early stages rather than well established?

In fact, implementing the CCM and teaching residents how to improve chronic care in academic ambulatory practices represents a culture change. Academic medical centers and community teaching hospitals have for decades been designed to care for acutely ill patients, to provide sophisticated new diagnostic technologies and to deliver cutting edge therapies. The clinician faculty members have been predominantly subspecialists with relatively few generalists who practice and teach in the outpatient clinics. Reimbursement systems have rewarded the delivery of this inpatient high tech care. Health care systems, hospitals, and academic leaders have focused their attention on improving the quality of care in the inpatient delivery system; clinics for out patients with chronic illness have been lower priority.

But, if the articles in this issue motivate others, times may be changing and leaders will need to step forward to reconsider traditional models. MedPAC has reported to Congress that the present training of physicians is falling short in ensuring that graduates have the knowledge and skills to meet the present day needs of our society. In particular MedPAC notes that training is less than adequate in teaching several key competencies including: a focus on population health and disease prevention; quality improvement; multidisciplinary teamwork; patient-centered care; and chronic disease management.⁴ They particularly point out the need for increased education in ambulatory care settings. MedPAC has recommended to

Congress that funding to hospitals for graduate medical education be modified to provide incentives to teach these competencies. To make the sweeping changes required to meet the needs of our society, realignment of incentives to support care of patients with chronic illnesses and to teach students and residents how to do this will be a necessary requirement.

The most important requirement for change is leadership. Not long ago, I told a senior academic leader about the MedPAC report. I indicated that we needed to make major changes in our teaching settings to demonstrate that we are training physicians to provide the care our society needs. He said, "Wendy, tell them we teach science". Sadly, this attitude reflects the difficulty we face in making major changes. Leaders must recognize and embrace the need for fundamental change in a system to train physicians who are very different from us. We cannot train physicians to replicate ourselves: many of us don't have the skills necessary to provide longitudinal care for patients with multiple chronic conditions and we don't practice in clinics that are designed to deliver this care.

This issue of JGIM shows us that at the front lines of resident education, change to teach the CCM is feasible and effective programs can increase learners' knowledge and skills. But teaching programs like these cannot sustain these kinds of fledgling experiments without leaders in their organizations fully recognizing the imperative to change and resetting the priorities of the institution. Leaders in these institutions need to provide infrastructure and human resources to build well organized, IT-enabled outpatient clinics and to support the faculty and other health professionals on the team. For example, the implementation of a CCM for patients with diabetes in the San Jose-O'Connor Family Medicine Clinic required the implementation of a diabetes registry in the electronic medical record and financial resources to invest in changing the processes of care. Authors specifically point out that one of the keys to success was the commitment of the leadership to change.⁵ I am sure this is true for all the programs.

So it is inspiring to see these programs teaching the CCM and improving care. Society needs many more physicians and healthcare systems to develop new approaches to care of chronic illness. Residency programs need to prepare graduates to participate in and lead these redesigned healthcare systems. To accomplish these changes transformation is required. Leaders please step forward.

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REFERENCES

1. Chen EH, Thom DH, Hessler DM, Phengrasamy L, Hammer H, Saba G, Bodenheimer T. Using the teamlet model to improve chronic care in an academic primary care practice. *J Gen Intern Med.* 2010; XX:xxxx-xxxx.
2. Abramowitz SA, Flattery D, Franses K, Berry L. Linking a Motivational Interviewing Curriculum to the Chronic Care Model. *J Gen Intern Med.* 2010; XX: xxxx-xxxx.
3. Fluker SA, Whalen U, Schneider J, et al. Incorporating Performance Improvement Methods into a Needs Assessment: Experience with a Nutrition and Exercise Curriculum. *J Gen Intern Med.* 2010; XX:xxxx-xxxx.
4. MedPac. Medical Education in the United States: Supporting Long-Term Delivery System Reforms. June 2009. Accessed June 17, 2010 at http://www.medpac.gov/chapters/Jun09_Ch01.pdf. Pgs. 3-6.
5. Yu GC, Beresford R. Implementation of a chronic illness model for diabetes care in a Family Medicine residency program. *J Gen Intern Med.* 2010; XX:xxxx-xxxx