

Continuity of Care

Teaching and Learning Through Continuity of Care Experiences

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Libby's Story

DG

DG was an African American woman in her 40's. We met early in the year when she was admitted to the ICU for a complication associated with dental extraction. On my pager flashed, "DG ICU admission". She was still intubated and I introduced myself to her family and learned of what happened. It was a very stressful time for everyone and luckily she was extubated the next day and soon discharged home after diuresis.



DG

Soon after, DG underwent mitral valve repair for her worsening regurgitation. I saw her post-op for that and got to know her better during her primary care visits that fall.

During a home visit I met her three sons and learned the story of her husband who had passed away of AIDS. DG disclosed to me she also contracted HIV from using. When he died of AIDS she decided it was time to get her life together. She stopped using and worked hard to get her kids back in her life. She started working for an organization, Cambridge Cares About AIDS, and found a lot of reward and enjoyment in her job.

We discussed her worsening depression and together worked to find an ARV regimen that would make her feel better, in conjunction with yoga classes she was taking at the local Y and acupuncture classes.



DG

About that same time, during the long and cold Boston winter, her unremitting cough began to concern us. DG had given up smoking after undergoing the mitral valve surgery. She was very proud of her long road to recovery.

Unfortunately DG's cough turned out to be lung cancer. I sat in the pathologist's office and looked at the biopsy slides under the microscope. She was quizzing me on the different types of lung cancer, helping me to come to a diagnosis, and all I could think about was the ways in which this was going to change DG's life forever.



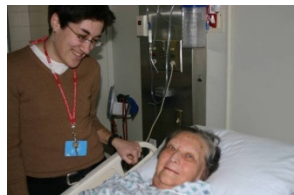
DG

My preceptor broke the news to DG and I accompanied her on visits to discuss prognosis and treatment with the oncologist and cardiothoracic surgeon. Her cancer was inoperable and treatment mainly palliative. I knew that DG could count on me when she told her friend (who was nervously pacing the room and wringing her hands) that we (she and I) would be ok, she could wait for us in the waiting room if she preferred and we would tell her what the doctor said.

I never had another chance to thank DG for all that she taught me and let her know how much she had influenced me. I started out medical school thinking I wanted to only work with children, but through this experience and many others in my third year CIC program, I realized I wanted to take care of entire families, both adults and children and try my best to help them lead healthy lives.

Continuity of Care

- What is it?
- Why do it?
- What do students and preceptors get from teaching and learning through longitudinal care?





Continuity of Care

Why do it?

- “Ecological” case
 - Primary care
 - Paradox of specialists’ vs generalists’ care
 - Special populations
 - Discontinuities of care
- “Relational” case
 - Patients’ perspectives
 - Providers’ perspectives

The Ecological Case

Health Better Where More PCPs

- U.S. states with higher ratios of PCPs/10,000 (corrected for SES, ethnicity, lifestyle factors) have:
 - Lower overall mortality
 - Lower infant mortality
 - Lower mortality from heart disease, cancer, stroke
 - Lower rates of self-reported poor health
 - Lower smoking rates
 - Less obesity
 - Higher seatbelt use
 - UK: each 15 to 20 percent increase in GP/10,000 significantly associated with:
 - decrease in hospital admission rates of 14/100,000 for acute illnesses
 - decrease in hospital admission rates of 11 per 100,000 for chronic illnesses
 - a 6 percent decrease in mortality
 - even after controlling for social deprivation, social class, ethnicity, and limiting long-term illness
- **Across studies: increase of one PCP/10,000 (12.6 percent increase) resulted in 5.3% average improvement in mortality.**
- **As many as 127,617 deaths/year in the U. S. could be averted by increase in # PCPs.**



The Ecological Case

Is this just better access?

- Greater supply of specialists is associated with higher mortality
- Supply does not necessarily = access to needed care

The Ecological Case

Countries Emphasizing Primary Care Have Healthier Citizens

- Each country's primary care rated according to:
 - first-contact care
 - person-focused care over time
 - comprehensive care
 - coordinated care
- The stronger the country's primary care orientation was, the lower the rates were of all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from asthma and bronchitis, emphysema and pneumonia, cardiovascular disease, and heart disease.
- controlled for GDP per capita, total physicians per 1,000 population, percentage of elderly people and population characteristics, including the average number of ambulatory care visits, per capita income, alcohol consumption, and tobacco consumption.



The Ecological Case

Primary Care Associated With Decreased Health Disparities

- U.S.: decreased disparity in low birth weight rates between African-American and white patients receiving prenatal care in Community Health Centers
- Controlled for SES, black patients in UK do not have higher rates of lower extremity amputation than white patients whereas in the US they do.
- In the U.S., rates of hospitalization for ambulatory-care sensitive conditions are strongly associated with socioeconomic deprivation. In Spain, they are not associated with socioeconomic characteristics.

The “Paradox of Primary Care”

Specialists May Be Better at Some Things

- Severe Single Illness Care
 - HIV
 - Acute myocardial infarction, acute coronary syndrome, CHF
 - 30-day mortality after hospitalization in CHF (RR 1.07 for internists, 1.25 for FPs)
 - Chronic liver disease
 - Diabetes
 - Medical Outcomes Study—no difference in outcomes in DM or HPTN except fewer foot ulcers in specialists’ care

Stange KC, Ferrer RL. The paradox of primary care. *Ann Fam Med*. 2009;293-299

Foody JM, Rathore SS, Wang YF, et al. Physician specialty and mortality among elderly patients hospitalized with heart failure. *Am J Med*. 2005;118(10):1120-1125

Smetana GW, Landon BE, Bindman AB, et al. A comparison of outcomes resulting from generalist vs specialist care for a single discrete medical condition: a systematic review and methodologic critique. *Arch Intern Med*. 2007;167(1):10-20.

Greenfield S, Rogers W, Mangotich M, Carney MF, Tarlov AR. Outcomes of patients with hypertension and non-insulin dependent diabetes mellitus treated by different systems and specialties. Results from the medical outcomes study. *JAMA*. 1995;274(18):1436-1444.



Continuity of Care Better Outcomes

Why?

Access

Specific to having a PCP



Patients With PCPs Receive More Appropriate Preventative Interventions

- Each of the primary care attributes is significantly associated with patients' being up to date on screening, immunization, health habit–counseling services.
 - first-contact care
 - person-focused care over time
 - comprehensive care
 - coordinated care

Ettner SL. The timing of preventive services for women and children: the effect of having a usual source of care. *Am J Public Health*.1996;86:1748-1754

Flocke, S.A., K.C. Stange, and S.J. Zyzanski. 1998. The Association of Attributes of Primary Care with the Delivery of Clinical Preventive Services. *Medical Care* 36:AS21–30.



Patients with PCPs Greater Focus on Prevention

- Having a PCP results in fewer preventable hospitalizations
- Analysis of preventable deaths in the 42 countries accounting for 90 percent of child deaths worldwide:
 - 63 percent could have been prevented by the full implementation of primary care.
 - Interventions : integrated care addressing diarrhea, pneumonia, measles, malaria, HIV/AIDS, preterm delivery, neonatal tetanus, and neonatal sepsis



Continuity of Care

Better Outcomes

Access

Specific to having a PCP

Specific to receiving care with defining characteristics of primary care

Prevention



Moses's Story

SP

SP was a patient introduced to me by my medicine preceptor. He's a heavy drinker, former crack/cocaine and IV drug user, he's got AIDS, Hep B and C, cirrhosis, and ITP. I followed SP over time, going to his infectious disease and hematology appointments. A little confused—all those years of drug and alcohol abuse had taken their toll—non-English speaking, and illiterate to boot, but really a sweet guy.



SP

After his first admission I paid a visit to him at home and met his family here—his brother and sister-in-law and their children. They were a very educated family and ran a Portuguese-language newspaper dealing with issues relevant to the local Brazilian community. They helped give me a window into his life. He was born on a farm in rural Minas Gerais. He only completed second grade before dropping out of school to work on the farm. There wasn't a lot to do in rural Minas Gerais, and at the age of 12 he started sniffing glue and abusing over-the-counter, alcohol-containing cold syrup. Eventually he graduated to harder drugs and liquor.

He succeeded in entering the U.S. through Mexico by paying a coyote \$5000 to help smuggle him over the border. The \$5000 was given to him by his brother and sister-in-law here in the U.S. They wanted him to come because they thought there would be more opportunities for him here, and they thought they could help him to improve his life.

SP

After SP's second admission in as many months for thrombocytopenia,, his hematologist decided he should consult with surgery for a possible splenectomy. Arranging for SP to be evaluated for the splenectomy, and then later making the arrangements for it to actually happen, would not have been possible without his family for support and me to help coordinate. SP could not remember what each doctor had told him, and his family could justifiably not always be counted on to keep track of which doctor he was supposed to be seeing on which day, and arranging transportation for him. SP had to get evaluated by the surgeon, then get three separate vaccinations before having his spleen removed. But his hematologist was new to the CHA system and did not know how to arrange for these vaccinations. It was his ID doc who gave him two of the vaccinations—not that the surgeon had requested it of her but rather that I had told her they were having trouble arranging it so she did it. SP himself could usually not remember what had happened at each appointment and it was I who answered all the medical questions his doctors had.

Communication broke down between the doctors themselves often. The surgeon wanted the hematologist, ID doc and gastroenterology on board that the splenectomy was the best thing, and it was I who checked in with all of them and informed him that they were indeed all on board.



SP

Without me I can confidently say this illiterate, non-English speaking patient, even with his very supportive and involved family, would have fallen through the cracks. The number of appointments and communications and miscommunications would have been so numerous, and it would have taken so long, that he probably would have just stopped showing up.

It was so great to have been a part of this from beginning to end and to understand really how much had gone into actually getting him on the operating table



Continuity of Care Better Outcomes

Why?

- Access
- Specific to having a PCP
- Specific to receiving care with the defining characteristics of primary care
 - Prevention
 - Coordination of Care



Continuity of Care

What Do We Know About Longitudinal Care and Clinical Reasoning?



- Gaps in communication
 - Information
 - Flow of diagnostic reasoning
 - Personal knowledge that is relevant
- Vs stale thinking



Continuity of Care Better Outcomes

Why?

- Access
- Specific to having a PCP
- Specific to receiving care with the defining characteristics of primary care
 - Prevention
 - Coordination of Care
 - Integrity of Clinical Reasoning

Sarah's Story

Ms. L

When I first met Ms. L, she was curled up in a chair, shielding herself with one knee tucked under her chin. As I entered the exam room, her eyes darted toward the exit.

Instinctively, I used my quietest voice to ask her questions about her past medical history and why she was in the surgery clinic today. Ms. L told me details of times that she had been ill, what medications she was taking, that she had come to have her first colonoscopy. Then, in the same tone in which she had described a past elbow injury, she disclosed how she had been raped by a man 10 years ago. At the time, the medical system had been unhelpful, actually hindering her from successfully going to trial against her attacker. As a result, Ms. L desperately avoided going to the doctor, and only through the patience of a local PCP was she able to allow herself back into the medical system. His gentle and non-aggressive manner had enabled him to earn her trust-- so much so that she agreed to undergo this procedure.

After taking her history, I returned with my preceptor and her future surgeon-- a middle-aged, commanding man who may have reminded her of her attacker. She shrank away from his offered handshake, trembling just perceptibly.

Ms L

Because of the longitudinal nature of my clerkship, I was able to attend her pre-operative appointments. I watched as a well-meaning nurse grabbed her arm to measure her blood pressure, causing Ms. L to jerk away from the sudden contact. I saw the terror in her eyes as the anesthesiologist described the sedation procedure, thinking of how the idea of sedation was threatening enough for the average person, let alone for someone who had been brutally disempowered. Yet I could tell that she was beginning to trust me-- and trust the doctors who took the time explain in detail what would happen.

The day of the procedure I stood by her head while the sedatives took effect, in her line of vision until her eyes closed. The procedure went well, and there were no findings on colonoscopy.

I accompanied Ms. L to the post-operative holding area, where she slowly regained consciousness. I knew immediately what I should do from observing her reactions and how the best-caregivers had responded to her-- I described in detail what had taken place in the OR and reassured her that nothing inappropriate had occurred. She relaxed visibly and was able to sleep. I saw her again at follow-up visits, at which time she described to me in further detail what had happened to her and how she had resurfaced from the trauma.



Ms L

Ms. L later described to me how this invasive procedure, in which she was asleep and helpless in front of others, had paradoxically empowered her. Through the careful work of her PCP and some of her caregivers during the procedure, she had witnessed her own strength and found renewed trust in a system that had initially left her disenfranchised.

Ms. L was the first patient I met with PTSD and the first patient whom I felt actually benefitted from the presence of a medical student . As a student, I was initially an observer, and this role enabled me to interpret both her caregivers' actions and her responses from an objective perspective. I saw immediately how she could be lost in the system or even hurt by well-meaning individuals who were not aware of her needs

Lastly, I realized that had I not been there to make sure people were especially sensitive to respecting her boundaries, she may have experienced even more trauma. This knowledge provided me with the impetus to directly involve myself in her care by talking to the doctors and staff about her needs. It made me realize that as a doctor caring for disempowered people, I needed to be powerful -- to use whatever assets I had to improve her care.

Continuity of Care Better Outcomes

Relational

- Relational continuity
 - To whom does it matter?
 - Trust—effects on care outcomes
 - Concordance about the nature of the problem

Patients' Connection With PCPs

- US
 - 76% of 35,383 patients reported seeing same MD most of the time in 2005
 - Patients who see own physician all or most of the time have higher satisfaction scores

Fan VS, Burman M, McDonell MB, Fihn SD. Continuity of care and other determinants of patient satisfaction with primary care. *J GenIntern Med.* 2005;20(3):226-233

Franks P, Fiscella K, Shields CG, et al. Are patients' ratings of their physicians related to health outcomes? *Ann Fam Med.* 2005;3(3):229-234.

Continuity of Care

To Whom Does It Matter and When?

- Netherlands study-2000
 - 644 patients/35 GPs rated importance of seeing their own GP for various scenarios
- Results
 - For most of the scenarios, >75% considered “important” or “very Important” to see their own GP
 - Minority felt it was important for minor events (splinter, sprained ankle)
 - Patient characteristics correlated with perception of increased importance of continuity:
 - having children
 - Having had a serious life event in past 5 years
 - Not with age, gender, marital status, health status

Continuity of Care

To Whom Does It Matter and When?

- Research study: Direct Observation of Primary Care-1994
 - 84 practices in Ohio, 3283 patient visits of 184 family physicians
 - Assessed
 - Patients' health status
 - Perceived value of continuity of care
 - Perception of the adequacy of the visit
 - Perception of their physician's key primary care components:
 - Accumulated knowledge of patient
 - Coordination of care
 - Interpersonal communication
- Patient characteristics associated with higher valuing of continuity
 - Age: parents of children 0-6 and patients >40 yo
 - Poorer health status except dysfunction associated with emotional problems
 - Female
 - Less educated
 - Medicare or Medicaid coverage



Patients With PCPs

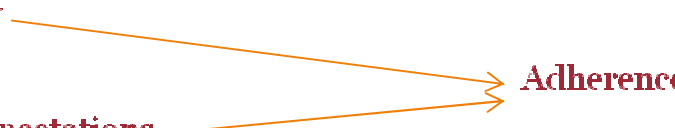
Improved Adherence, Increased Trust

- Appointment compliance better for patients seeing their personal provider in pediatrics and in prenatal care.
- Medication compliance higher in patients seeing their own provider as opposed to their provider's partner in completing strep treatment
- Mothers are more likely to disclose behavioral problems to their child's longitudinal provider than to another provider

Trust

- **Texas 2005**
 - 869 respondents majority female, white, college-educated, middle class
 - Trust in PCP correlated w/ MD's knowledge of pt, competence, support for autonomy
 - Trust in PCP correlated w/ patient's commitment to Pt-MD relationship
 - Commitment correlated w/ adherence to medications and with healthy eating behaviors

Trust

- 480 patients with Type II Diabetes in Taiwan
- Measures:
 - Trust
 - Self-efficacy
 - Outcome expectations
 - Adherence
 - Objective outcome measures (A1C, BMI, diabetic complications)
- Result: Mediators for effect of trust in physician on health outcomes are:
 - Self-efficacy
 - Outcome expectations

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graph LR; A[Self-efficacy] --> C[Adherence]; B[Outcome expectations] --> C;
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Physician-Patient Concordance

In 14 randomly selected practices in Auckland: 220 patients (61%) received a prescription, and 79% of these patients were taking the medication at follow-up

Measures significantly related to compliance:

- Trust
- Questions on concordance:
 - “To what extent do you think the doctor understands why you came in today?”
 - “To what extent did you and the doctor agree about the main problem or need today?”
 - “To what extent do you and the doctor agree on what part you play in making decisions about health?”

Continuity of Care Better Outcomes

Relational

- Relational continuity
 - Matters to most, but not equally and with some contextual differences.
 - Trust—effects care outcomes via self-efficacy, concordance of understanding and expectations, adherence

Continuity of Care

Definition(s)

- Continuity of information
 - a process of seamless communication through the whole illness: from problem identification and diagnosis through treatment.
- Continuity of relationship to a trusted healer
 - an attitudinal contract in which patient looks to provider for health care and provider, in turn, takes that responsibility.
- Continuity of access to needed services and medicines
 - a commitment to advocate for patient's needs to resolve barriers to care
- Continuously evolving understanding
 - a dynamic, evolving intellectual and relational interaction over the course of an illness

Dietrich AJ, Marton KI. Does continuous care from a physician make a difference? J Fam Pract.1982;15:929-37

Banahan BF Jr, Banahan BF. Continuity as an attitudinal contract. J Fam Pract.1981;12:767


Buelow SA. Towards a new understanding of provider continuity. Ann Fam Med.2004;2:509-11

Bor,D. Personal communication



Teaching and Learning Through Longitudinal Care

- What do students say?
- What do preceptors say?



Continuity of Care

Student Themes

- Creating a dynamic integrated learning environment
- Providing a broader understanding of all aspects of illness:
- Permitting a deeper connection with patients
- Improving care
- Transforming the student's role
- Inspiring commitment, advocacy and idealism

Thoughts on Continuity 3 Months In Simeon

Every patient I approach, I hope I'll get to see them again because I develop a different degree of curiosity about them both medically and personally the second time. The first visit I just try to get my bearings to understand the question at hand, but the second time I'm able to think more deeply. I start to try to understand every abnormal lab value, exam finding, or strange mannerism instead of just the narrow question at hand. I start to hope that I'll get to visit their home, be there for a birth, or their death. I start to feel ownership and responsibility.

And when they come into the hospital, that responsibility and knowledge gives me the confidence to be more assertive with the primary team--to ask questions about the things I don't understand, to push to get prompt and respectful treatment for the patient, and to fill the team in on the history they may not have elicited otherwise. When this happens, it disturbs the hierarchy in the hospital.

One patient's daughter paged me over the weekend when she was unhappy with the ICU team's treatment of her dying father. At the same time, the ICU asked me to be present so that I could help them negotiate with the daughter. The fact that for any patient, the patient, family, and team may view me as crucial to the care of the patient changes the way I approach every patient. Without this longitudinally, this positive feedback cycle would be impossible.



Themes from Preceptors

- Students bring better care
 - Bridge gaps in care
 - Fresh set of eyes
 - Drive deeper research and consultation into diagnosis
 - Provide comfort to patients
- Students motivate professional renewal
 - Intellectual renewal (keeping up with the students, learning from them)
 - Renewal of empathy
 - Renewal of motivation to provide excellent relational care
- Students drive creation of a learning/caring community
 - Improved communication among physician members of a care team
 - Promote self-reflection and open discussion of uncertainty, error

Y's Story

A Preceptor's View

When my student let me know she had picked up my patient, YM, in Gyn clinic, with a history of unexplained post-menopausal bleeding, my simultaneous first 2 thoughts were: terrific patient to learn from and, why does another person, and my student, to boot, have to see my error in judgment which nearly killed my patient?

YM is a 58 year-old, very sweet, minimally- English-proficient woman from Haiti whom I'd cared for intermittently over at least 10 years. She'd come with her own rhythm for pap smears, and typically on no medicines, despite my attempts to win her over to the importance of controlling her severe hypertension. A massive myocardial infarction, requiring 3-vessel CABG, complicated by atrial fibrillation and multiple cerebral emboli had finally engaged her in treatment, where I had been unable. And while I had always felt she liked me and trusted me as much as she could trust a modern medical provider, I had felt I had established a stronger connection with her and her husband over the preceding 2 years, as her heart regained its strength and she was able to go back to her work as a housekeeper in a hospital .



Y's Story

A Preceptor's View

YM came for a follow-up visit right before a planned trip to Haiti to take her elderly mother to an important family occasion. She felt fine, but asked if she could stop taking her coumadin, because it was making her bleed. Although she'd been seeing me regularly, she hadn't mentioned to me, nor to her husband, that she'd been having irregular "periods" again for at least 6 months, after a 2 year lapse. I told her this was worrisome. When her hematocrit came back very low, I called her and her husband and again encouraged her to postpone travel, but when she indicated she felt fine and was determined to go, I told her it was critical she take iron pills, counseled her that if she began bleeding again, she absolutely must go straight to a hospital. A week later she caught an emergency flight back to Boston and was admitted to our ICU with a hematocrit of 17.

This is the point when my student became involved. She has been able to follow YM through the management of severe anemia in a patient with coronary artery disease with all the clinical judgments (and mis-judgments). She has been able to follow the diagnosis of post-menopausal bleeding through to the identification of YM's advanced endometrial cancer. And she has become a source of support to YM and her husband as they undergo difficult, extensive surgery and chemotherapy. It has been a powerful learning experience.



Y's Story

A Preceptor's View

For me, the experience has underscored the beauty and some of the terror of working with a longitudinal integrated clerkship student. In retrospect, I wish that I had sat YM and her husband down before her trip to Haiti and said, “You must not go. Your blood count is so low that you could have another heart attack and die. You have to go into the hospital and be transfused and find out why you are bleeding!” But I didn’t. With reflective hindsight, I know that I minimized the extent of her coronary artery disease through having watched her excellent improvement over the years. I also believed that she would go anyway, no matter what I said, because she still put little stock in modern medicine, her mind was made up, and I was reluctant to be heavy-handed with her for fear of driving her once again from care. So I let her nearly die without at least putting up a fight.

And now, not only do I have to live with my own misjudgment, but I also have to expose my own imperfections to my preceptee. While I understand that reflecting together on my mistakes can also be a powerful learning experience for the student, it’s easy to talk about teaching students that we are only human, but not that easy to do.



Doña Olga

Late one November afternoon, our medicine preceptor urged us to go to the hospital to admit a delightful woman presenting with one month of unexplained fever, soaking night sweats, diminished appetite, and a weight loss of greater than 20 lbs.

Entering the room speaking our then still broken Spanish, we were greeted by a roaring welcome “the angels that my doctor sends to me!” What a privilege, as a student, to be integrated into this caring patient-doctor relationship. Longitudinal precepting provides modelling about relationships with patients

Despite her worrisome symptoms, Doña Olga’s smile beamed from her precisely made-up face as she conveyed her recent medical history peppered by tales of her interest in poetry, her career as a lawyer in Costa Rica, and her excitement about her young grandchildren.



Doña Olga

She attributed her own symptoms to a virus, picked up from some friends at a Halloween party. We worried about the broad differential diagnosis for unexplained fever—lymphoma, TB, abscesses, and more. After imaging and pathologic studies were complete, she received the unusual diagnosis of multiple pyogenic abscesses seeded by septic pyelophlebitis of the portal veins. Joanna and I delved into the literature to better understand this unfamiliar entity, taught each other, and were actually able to take a significant role in assisting with the patient's workup.

Doña Olga

Yet later, after months of broad-spectrum antibiotics, Doña Olga continues to experience a rocky course. The integrated clerkship has allowed us to follow her care through different institutions; to visit her in a cross-town hospital and to admit her with fevers and anemia. Through Doña Olga we have learned about issues ranging from abscesses to malnutrition...from feeding tubes to skin ulceration. We have seen a strong and smart woman grow delirious and unintelligible. Each time we see Dona Olga, attempting to understand her evolving health adds another piece to our medical repertoire

And each time we grow to understand a bit more about the toll that hospitalizations and chronically deteriorating health can have on a patient and her family and further appreciate the incredible strength and reserve demonstrated by this patient each day.

(Ultimately, after this story was written, an occult diverticular abscess manifested as an entero-vaginal fistula and Doña Olga eventually recovered after a diverting colostomy. 6 years later, she still asks about Jenny)



Doña Olga

For me, the story of Doña Olga celebrates the power of continuity of care and continual learning. Our longitudinal relationship with her has created links between disparate hospitalizations and tests and appointments, ascribing a continuity of care rarely allowed for in our modern, fragmented healthcare system. And likewise, through this unique relationship, we continue to learn about myriad aspects of medicine, and about the ways in which illness is placed in a complex and full life.

The Harvard Medical School- Cambridge Integrated Clerkship Students

CIC 1

Nicole Baumer
Carolyn Casey
Joanna Epstein
Dante Foster
Nate Himes
Jenny Radesky
Jenny Siegel
Joe Wright

CIC 2

Rachel Bortnick
Moses Graubard
Andrew Herring
Annalise Keen
Libby Schaefer
Andrew Singer
Michael Tang
Siobhan Wescott

CIC 3

Karen Bos
Cathryn Christensen
Gloria Hou
John Allen Houston
Rachel Lapidus
Peter Liang
Ashley Morris
Joshua Ng
Roberto Novoa
Lisa Podgurski
William Soares
Dellie Sorel

CIC 4

Sara Alcorn
Kara Bischoff
Amber Frank
Erica Kaye
Kamden Kopani
Selena Liao
Clea Lopez
Sonia Miller
Sara Mixter
Michael Morse
Benjamin Smith

CIC 5

Krista Brucker
Jessica Greenberg
Michelle Hauser
Chris Lee
Scott Lee
Ashley Lewis
Hasan Merali
Steven Porter
Jason Rafferty
Renee Witlen
Sara Zaman

CIC 6

Imani Anwisye
Edith Gurrola
Ari Johnson
Julian Johnson
Sarah Kimball
Vanessa Redditt
Lindsay Ryan
Anjana Sharma
Gillian Sowden
Jonathan Takahashi
Leila Vaez-Azizi





Challenges for Discussion

- Teaching continuity relationship through longitudinal care
 - How much is enough?
 - How to measure?
- Teaching through continuity relationships with patients
 - Does it more effectively prepare students to take care of diverse populations?
- Teaching clinical reasoning through longitudinal care
 - Is it better?
 - How to demonstrate?
- Are we yearning for a past model of the devoted GP?
 - How does the Patient-Centered Medical Home/Team Care fit?
 - What competencies should we be teaching?