Episode 7 - What is a Primary Care Track

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Episode Summary:
In this episode of Everyday Medicine, Dr. Christopher Chiu discusses The Ohio State University's Internal Medicine Primary Care Track with Dr. Mark Troyer, Associate Program Director. They explore the unique aspects of the primary care track, its curriculum structure, training opportunities, and how it differs from the categorical residency program. Dr. Troyer shares insights about the program's emphasis on outpatient care, community building, and preparation for various career paths in medicine.

Key Takeaways:

1. Program Structure:
    - Alternating blocks between outpatient and inpatient experiences
    - Enhanced continuity clinic experience
    - Integration of subspecialty training in outpatient settings
    - Protected time for scholarship and professional development
2. Unique Features:
    - Strong community within larger academic setting
    - Longitudinal relationships with faculty and patients
    - Flexible curriculum adaptable to resident interests
    - Integration of social determinants of health
    - Emphasis on interprofessional teamwork
3. Training Opportunities:
    - Diverse clinical settings (urban, suburban, rural)
    - Specialty clinics (gender affirming care, women's health)
    - Research and scholarly activities
    - Medical education initiatives
    - Global health experiences

4. Educational Approach:
    - Evidence-based medicine
    - Shared decision-making
    - Cultural competency
    - Plain language communication
    - Interprofessional collaboration
5. Career Outcomes:
    - Various career paths available (not limited to primary care)
    - Success in subspecialties
    - Leadership in medical education
    - Innovation in healthcare delivery
    - Academic medicine opportunities
6. Program Benefits:
    - Protected time for scholarship
    - Mentorship opportunities
    - Professional development support
    - Work-life balance consideration
    - Individualized education plans
7. Resources:
    - Association for Academic Internal Medicine FAQ document
    - Integration with larger categorical program
    - Access to academic medical center resources
    - Strong faculty mentorship network

Transcript:
This transcript has been edited for clarity

[00:00:05] **Christopher:** Welcome to Everyday Medicine. I'm Christopher Chiu. This is a podcast from the Division of General Internal Medicine at The Ohio State University, where I'm the Director of Education for the Division. This podcast is focused on primary care and aims to provide current information to medical professionals from experts in Ohio. We're also graciously sponsored by collaboration with the Ohio Chapter of the American College of Physicians.

[00:00:29] They're finishing up residency interviews and actually doing the match very soon and had me thinking about our primary care track that we have here at OSU and I thought no better person to talk about this than Dr. Mark Troyer, who I have with me today. Hey, Mark.

[00:00:50] **Mark:** Hey there. Thanks for having me.

[00:00:52] **Christopher:** You've been the APD now for a while for our primary care track for a while. Yeah. And you've also been, even before that, you've been very closely working as a faculty with our with our residents on that track as well.

[00:01:03] **Mark:** Yeah.

[00:01:04] **Christopher:** So do you want to tell us a little bit about yourself and then we can dive into a little bit about our program.

[00:01:10] **Mark:** Sure. I am an academic physician here at Ohio State. My background is particularly in primary care and taking the best care of all patients. My interests in global health have really informed my practice.

[00:01:25] So now a lot of my academic work is done in taking care of refugees, immigrants, and limited English proficiency patients. I like to bring that passion with me when I am trying to train residents, trying to work with medical students.

[00:01:40] I like to bring that passion with me when I am working with residents training medical students, and particularly helping to identify curricula that are going to help make doctors who have that ability to Really meet patients where they're at. My background... I'm from Ohio, but I've been raised a lot of different places.

[00:02:00] When I was a kid, I lived in Haiti for three years while my parents worked in a hospital there. I've during medical school, during undergrad and during residency, I've done a number of clinical rotations in Appalachia, Ohio, working with Migrant and seasonal farm workers in Colorado as part of AmeriCorps and a number of global health rotations and the Navajo Nation, Tanzania, Mozambique, Honduras coming back here, it's been a really wonderful experience because I've been able to really marry that global health with the local care that we do here.

[00:02:34] We have a number of large refugee populations here in central Ohio and taking the best care of them that we know how is part of my passion.

[00:02:42] **Christopher:** And I've actually attended some of your resident lectures on refugee health. So maybe we'll have you back on to talk about that. Cause I think it's a very interesting population.

[00:02:49] **Mark:** I will talk your ear off about it.

[00:02:51] **Christopher:** All right. So let's get into about the primary care track and tell me. How is this different from the rest of our categorical residents here in internal medicine?

[00:02:59] **Mark:** Yeah, so about 10- 11 years ago a lot of programs were looking at their curricula residency programs.

[00:03:06] They were trying to figure out how to improve the continuity clinic experience, how to encourage primary care. And a number of changes came out of that. One of the things that they found was that. Rather than the traditional model where you're in the hospital, but then one day a week or something, you're going and working in the clinic and your continuity care clinic they moved to a block schedule that many of us know and recognize now.

[00:03:31] And so the block schedule was shown to have a much better. Continuity of care for the patients and for the resident providers themselves using that block model programs like ours, Ohio State and a number of other programs nationally develop primary care tracks. These are specialized programs within the categorical training system.

[00:03:56] So usually they're contained in that three year training that we expect for internal medicine training. But they really emphasize outpatient care. They emphasize longitudinal relationships with patients, and they really try to enhance that ambulatory experience while not really pulling punches from the inpatient experience at all.

[00:04:17] To get to the nuts and bolts of what you asked um, our categorical program residents are on a four week block schedule. So they will have two blocks of inpatient, eight weeks total, followed by one block of outpatient, four weeks total. And that's their continuity care experience, as well as an outpatient elective subspecialty experience.

[00:04:39] By comparison, our primary care track has every other block outpatient experiences, alternating with every other block inpatient care experiences, and you're, doing the math right now and trying to figure out how can you have both at the same time? What we find is that a lot of that comes from the consult experience.

[00:05:01] So rather than our residents having their specialty experience based on inpatient cardiology consults or inpatient pulmonology consults, we're actually putting them in the subspecialty clinics for those specialty experiences. So, in an outpatient experience, about half of their week, they're going to be seeing their own patients in their continuity clinic experience.

[00:05:23] But the other half days that they're working in the outpatient, they're going to be working in those elective clinics, working along with specialists in cardiology, pulmonology, nephrology, etc. And I'm not really sorry about that. If you look at this, the internal medicine specialties, everybody but a hospitalist basically spends most of their time working in clinic.

[00:05:43] You talk to cardiologists, even interventional cardiologists, you talk to pulmonologists, and yeah, you see them. Many of our residents see them on the wards or in the ICU, but they don't realize that this attending has a whole other life. And so we are better approximating what the full specialty experience is in the outpatient setting, I think while our residents still do have to do the same number of ICU months, the same number of night months, the same number of call months those general medicine floor services doesn't make it harder, doesn't make it easier.

[00:06:17] It just makes it different but I think it really, it helps to prepare people for the breadth of any specialty they want to go into. And you and I both being primary care doctors, I think that it prepares them for the breadth that's expected of any primary care doctor to be able to at least be able to speak the language of all of our specialists in the outpatient setting.

[00:06:38] **Christopher:** Yeah, I think some of the comments I've had talking to our own residents in our primary care track they've said that it's sort of cool with the breath because when you're on inpatient, if you're in one specialty, whether it's like renal or cardiology, you're just going to see that acute issue that's showing up and they're seeing a lot of those, which is not a bad thing.

[00:06:55] **Mark:** You're going to do AKI 10 times a day.

[00:06:57] **Christopher:** But when they're in clinic, they get to see a bunch of people who are stable or people who are getting stable and a lot other types of diseases that don't necessarily need hospitalization. So I think that's pretty cool. So tell me a little more about the training and the types of experiences that they can get.

[00:07:11] You've already mentioned a little bit about some of the areas they can go. Can you go into a little more detail on what's available, especially here at OSU?

[00:07:19] **Mark:** Yeah. So I think Primary Care Tracks are really well suited for to be integrated into perhaps larger academic programs. I say that because large academic programs do have the benefit of

having these super subspecialist rotations, these super high resourced settings ,a lot of research opportunities, a lot of mentorship opportunities.

[00:07:46] But as somebody who went through that in, in my training, you can sometimes get lost in that. You really do have to have a skill set of navigating. You have to have your mentorship network. And one of the things that I think suits primary care tracks to being integrated into these larger academic medical center.

[00:08:07] Categorical programs is that we provide that community. For instance, I was talking about longitudinal care drilling down on that a little bit more from the experience of a resident in our primary care track here, you, we are all Dr. Chiu, you and I are sitting right now at the East Clinic.

[00:08:25] This is the clinic that. Dr. Chiu, you and I are sitting right now at the East Clinic. This is the clinic that houses half of our categorical residents and all of our primary care track residents. And we have a core group of about five faculty who we see our own patients in this clinic as well.

[00:08:46] We are well aware of the resources. We are well integrated into the clinic staffing. And so we can really help to create that smaller, close knit community, that kind of core group of primary care interested faculty and residents so that if somebody joins my primary care track program and they're with me on Thursday afternoon, then they're with me on Thursday afternoon from the first day of their program till the end of their program. They're going to be working with other preceptors on other half days, but those relationships between them and their patients are not only the ones are not the only ones that are longitudinal. Their relationships with their staff members, their relationships with their preceptors and their relationships with their colleagues.

[00:09:32] Help them to have this longitudinal community so that they can really get to know their own version of medicine. They can get to know what they want to do rather than trying to spend too much time guessing what their attending wants them to do or other things like that. Within that tight knit community than faculty like you and I are able to really connect them to that deep network, that deep bench of the larger academic medical center.

[00:10:01] So I've got plenty of people that I mentor. both in the categorical program and the primary care track. So that helps me to be able to connect them with all the way from the primary care doctor who's really focused on women's health to connecting them with the doctor, who's really focused on obesity medicine to even that sub specialist in cardiac oncology.

[00:10:24] So I think that's one of the things that really sets the primary care track apart as far as being able to create that personalized tight knit community within the large resourced academic center. Did I get to the question? Maybe I went on a tangent.

[00:10:42] **Christopher:** So my next question does relate to this is now that you're able to connect people to all these different interests, especially some niches that we have, especially for some of our faculty, does this open up lots of other like scholarly work, other types of academic study, like what types of things are available for these residents?

[00:10:59] **Mark:** That's really a unique aspect of... compared to other primary care tracks of our program here. We are able to use the scholarship and discovery time that is integrated into each outpatient clinic week. We are able to use some other flexible longitudinal scheduling techniques to give people the ability to do their scholarship and discovery with this network of mentors over all three years, rather than not only as discreet blocks of, okay you have to do all of your research in one month and that's it.

[00:11:38] So we have some scheduling techniques that we use in the outpatient setting so that. One half day per week is your scholarship and discovery time. One half day per week is professional wellbeing time. It's truly protected time for you to take care of the things that you need to take care of as well as those that rich continuity clinic experience time, that rich elective experience time and the didactic or the interactive learning Tuesday afternoon is true for all of our categoricals and primary care track folks alike. So I think giving that longitudinal experience and then connecting people with that mentorship starts early. We actually, in our first two months make an effort to meet with all of our interns, categorical and primary care track, make sure that they're doing well, make sure the white knuckles are easing a little bit, but also starting that career development, starting that initiation of a mentorship network that will then allow them to do meaningful scholarship in whatever area they want to.

[00:12:42] You understand I'm saying scholarship because I'm not talking about bench research. A lot of primary care scholarship is going to be in medical education, in health outcomes, in community outreach. Those are the areas that I think we really flex well.

[00:12:54] **Christopher:** Now you had mentioned a little bit about electives and things like that. What other opportunities are there for our primary care track residents to do, things like, gender affirming care or maybe like women's health and things like that? Are those things available for residents here?

[00:13:10] **Mark:** Absolutely here. And I think this is an emphasis of the common rotations and experiences we see nationally. I think nationally you do get a lot of primary care tracks that are able to provide beefed up experiences with addiction medicine, with dermatology, women's health, with digital health and with additional things related to kind of outpatient procedures, I think where we really find our niche is in the areas that our own primary care residents have identified.

[00:13:44] One of the aspects that I think really makes our program unique is that yes, we do emphasize many of those same things that are emphasized nationally But above and beyond that we have things that have grown out of our own residents initiatives. So Dr. Andrew Keaster in particular I think is a good example of somebody who was actually trained in our internal medicine primary care track here.

[00:14:12] During that training, he identified this must've been five or seven years ago, even that there was a need for gender affirming care not only nationally, but also here locally. And so he and a colleague in the family medicine department here. Started the gender affirming care clinic. And he has been leading that along with the other folks in family medicine for our residents for their residents and for patients across central Ohio.

[00:14:40] That has become a resource where we identified a problem. Built a solution around it and then have actually taken that to become national thought leaders and academic leaders in one particular area. I think we also show those strengths in women's health in sports medicine with our collaboration with the sports medicine folks, getting a lot of joint injections um, and other procedural aspects there in dermatology and then our rural health rotation.

[00:15:09] And so we don't always think of rural health as a specialty, but I think that it's a good time to talk about how care across different settings is actually a type of specialization or focus area. A lot of our programs out West are going to have emphasis on rural health or limited resource care. A lot of our programs on the Eastern seaboard are going to have a lot of strength in urban care.

[00:15:35] I think Ohio state is really uniquely situated because everything both urban, suburban and rural are within arm's reach. So we are situated In a historically disadvantaged neighborhood here in the near east side of downtown Columbus .This area is particularly diverse not only culturally, but socioeconomically related to my interests.

[00:15:59] This is also an area that has a very high percentage of foreign born individuals. For somebody who wants to emphasize culturally and linguistically accessible care, it's a place where I can work closely with those patients that really bring meaning to my work. But there's also many rotations that we have here in suburban settings.

[00:16:23] Our residents are able to rotate across OSU clinics through urban and suburban settings easily. But our primary care track folks get that added advantage of a relationship that we have with a clinic about an hour and a half to two hours south of here in rural Appalachia, Ohio. It does have many of the same aspects that I experienced in my own rotations and rural and resource limited settings.

[00:16:52] I'm not saying it's like Mozambique, but it still has those aspects of people making different types of decisions just Depending on the different type of resource setting, the different type of appropriate options available. And so I think really expanding your perspective makes you a better doctor for more patients.

[00:17:13] **Christopher:** Now with such a, wide curriculum and opportunities for the graduates from this track. You mentioned how we have, we've had previous alumni go on to develop, this gender affirming care clinic. What are some other, can you give some other examples of what our previous graduates have gone on to do with, they can do more than just primary care.

[00:17:36] They can serve even niche among in primary care or use primary care to to add to the things that they're going to do.

[00:17:42] **Mark:** I think that primary care lends itself very well to making excellent medical educators. And to medical education innovations. So one thing that grew out of the primary care track was an emphasis on that being that best doctor for all patients.

[00:18:03] One of our residents said, we should be putting more material, more curriculum behind this theme because there's a lot of things that we were doing informally here, and I'll talk about that in a moment, but we should be really formalizing this into an education program, and that's what she Mary McAllister and Lisa Kearns and myself worked together to do, we created a series of interactive workshops, but also created an evaluation tool around that to measure, were we really making the difference in resident attitudes, behaviors, outcomes that we thought we were.

[00:18:42] And I'm proud to say that Mary's hard work developing that curriculum and us evaluating that curriculum. Resulted in nationally generalizable and publishable results, but also more just as importantly proved a test ground for us to develop a meaningful curriculum that then we've been able to expand to the categorical program here at OSU.

[00:19:05] And so that really doubles down on that emphasis that we have in addressing social determinants of health for our patients, meeting them where they're at and giving our residents, the kind of the pedagogical background to understand what's going on in the exam room from a macroscopic standpoint.

[00:19:28] That's what I really love about our program. Step two is wrong. There's not one right answer for each question. There's not one right drug for this person's hypertension. There's oftentimes three right answers. So your evidence based answers need to be multiple. And then you need to take that skillset that we teach here in our clinic, both in on by lecture and by example of addressing barriers to care and working in those interprofessional teams, the interprofessional teams that you and I both know. So instead of saying, Oh, I think you just should consult social work. We say, let's walk down the hall and go say hi to Nesa. Let's explain the problem and have her come in the exam room so that we can address this

transportation barrier or we can address this financial barrier to care. I'm really proud of those types of interprofessional teams that we have here because it helps us to emphasize how we work together.

[00:20:24] together rather than carrying all that on our back in true medicine, in true primary care. And we do that in a way that I think builds a sense of self efficacy for the residents and for the patients alike, rather than a sense of getting beaten down by primary care. So we emphasize all these things on the social determinant side.

[00:20:48] We utilize plain language communication. I make my residents utilize medical interpreters. We then, use that shared decision making model. So we take those three Right answers from evidence based medicine and have a frank discussion with our patients saying this one has these side effects.

[00:21:05] This one has this cost. This one's covered by your insurance in this way and build our own patients ability to make the decision that's best for them. That's how I think that we really Lead the way and making these doctors that can fit the mold for many different patients by working together in teams by building the capacity of their own patients meeting them where they're at and really being able to fill in the blanks rather than saying well, I prescribed that medicine and they're non- compliant. It's more of the kind of holistic view of the patient.

[00:21:39] **Christopher:** This curriculum and these opportunities even seem like the best of every world. What, why can't this just be the regular categorical curriculum? I mean, it seems, like this is well made for even people who want to go into specialties as you already said before that, whether you go into cardiology or pulmonology, they spend a lot of their time in the outpatient setting.

[00:21:56] I think we've even sent our our graduates to very primary care esque specialties like geriatrics and even HIV care. I don't know if I have much, do you have anything to add to that?

[00:22:06] **Mark:** Yeah. I think some people worry about with a primary care track, am I going to have to take some sort of blood oath that I'm going into primary care? Or is there some sort of commitment that I need to make? And the answer is no. Our curriculum is targeted toward people who are looking for a rich outpatient experience. It is well aligned with people who want to go into primary care or academic primary care. We do have a lot of strong alignment with many different more outpatient heavy specialties.

[00:22:36] I think endocrinology and rheumatology are some natural choices, but yes, we do match people to many different specialties. Even hematology. We have graduated people in hospitalist medicine who had an emphasis in health outcomes and medical informatics.

[00:22:53] I think one of the things with our individualized education that really helps is combining different things that may not seem to initially combine. And so we've got people who go into medical education plus allergy, people who go into geriatrics plus palliative. Those are the types of things that I think our primary care track really excels at.

[00:23:13] And this is not throwing shade at the categorical program. Many of the things that we're talking about emphasizing here in the primary care track are accessible to our categorical residents as well. We don't hide this all away or seclude ourselves. We integrate ourselves with the categorical program, we just try to lead the way in these areas where we think we really have strength.

[00:23:34] **Christopher:** Mark, thank you so much for talking to me today. Maybe if some of our perspective medical students are looking at our program here, they will listen to this and it'll answer some of the questions or some are faculty member who don't know as much about this track, come to know our

residents and find out what's going on with this. So I appreciate you spending the time with me today to talk about it. Do you have any other last remaining thoughts to leave with our audience?

[00:23:57] **Mark:** I'm super proud of the work that we do here at The Ohio State internal medicine primary care track, but I think that many people who are interested in seeing the breadth of what primary care tracks have to offer do themselves the service to really look around at many of the other programs nationally. I will provide a little bit of information that you can add to the link here from many of the colleagues. We work together in the Association for Academic Internal Medicine. For many of the different colleagues who work together in primary care tracks and in general internal medicine, they've put together a frequently asked questions document that I think really helps a lot of people who are trying to learn more about academic primary care programs nationally.

[00:24:44] **Christopher:** Excellent. Yeah, we'll put these in the show notes. So if anyone wants to go to those it'll be there. Thank you so much, Mark. I'll let you go. I know I've taken a lot of your time this afternoon, but I really appreciate it. Thanks a lot, man.

[00:24:53] **Mark:** No problem. Back to the rank list.

[00:24:55] **Christopher:** Bye.

[00:24:56] And for the rest of your listeners, Thank you again for listening to another episode of Everyday Medicine, OSU's Division of General Internal Medicine. Please consider subscribing to our feed on your favorite podcasting platform so you don't miss out.

[00:25:10] You can also get our show notes and transcripts soon from our division web page at https://medicine.osu.edu/GIM. Have a good day. Bye.