

The LIC medical community disconnected in time, space and infrastructure

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Continuity is King



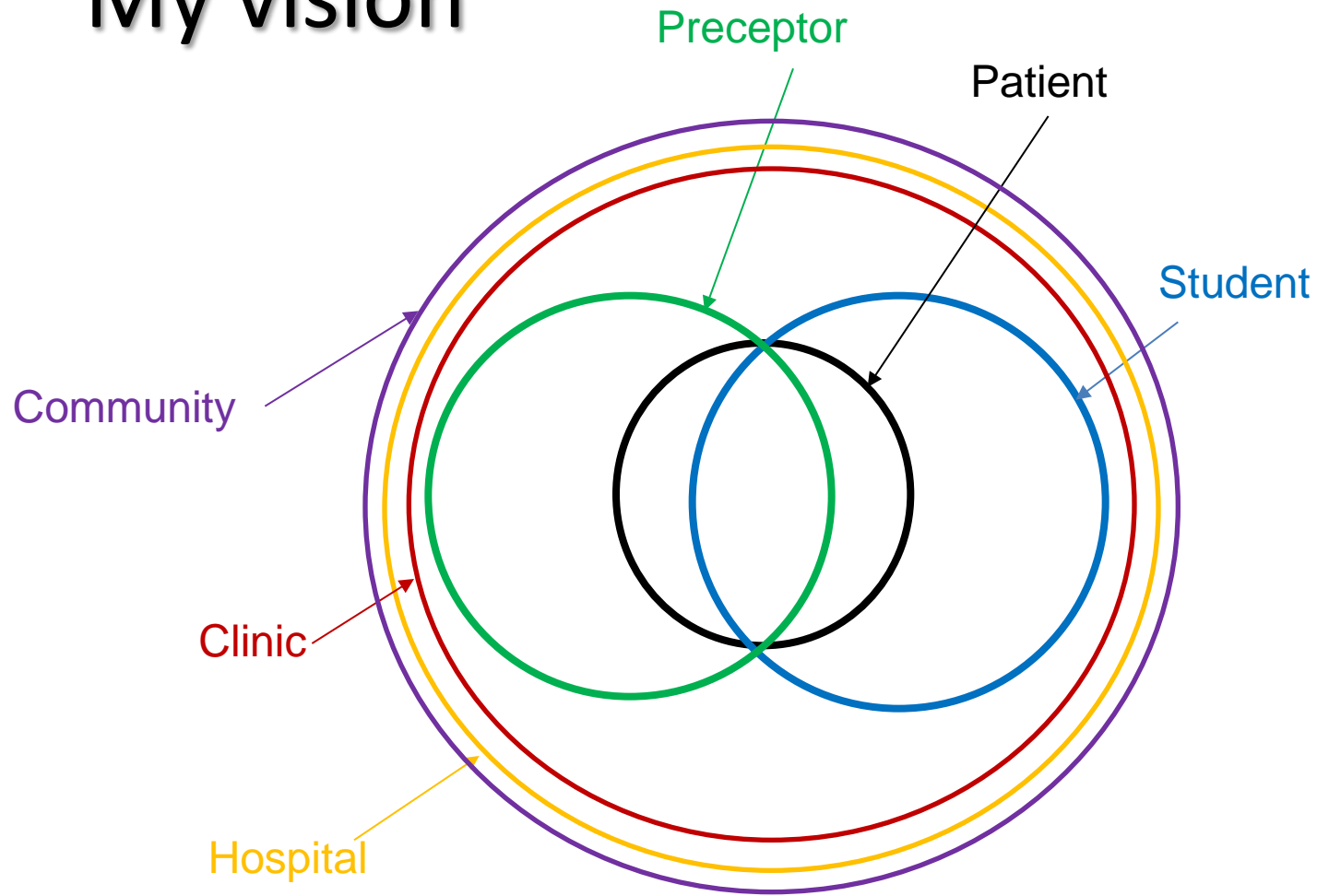
"Sire, the men think your battle cry of 'Continuity!' is terrific, but they'd love a chance to come up with something of their own."



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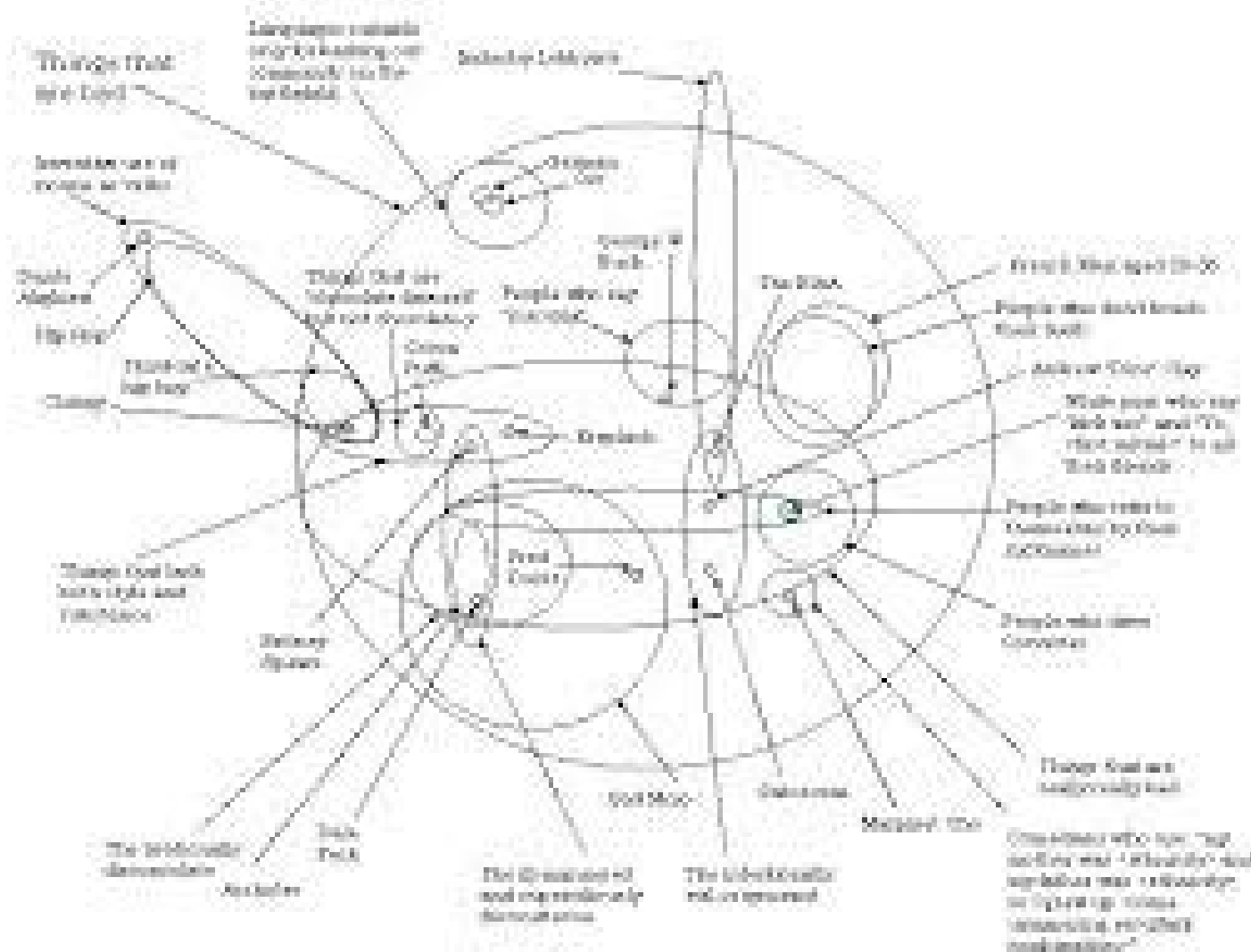
My vision



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My Reality



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Bloomington Indiana

A case study in medical discontinuity

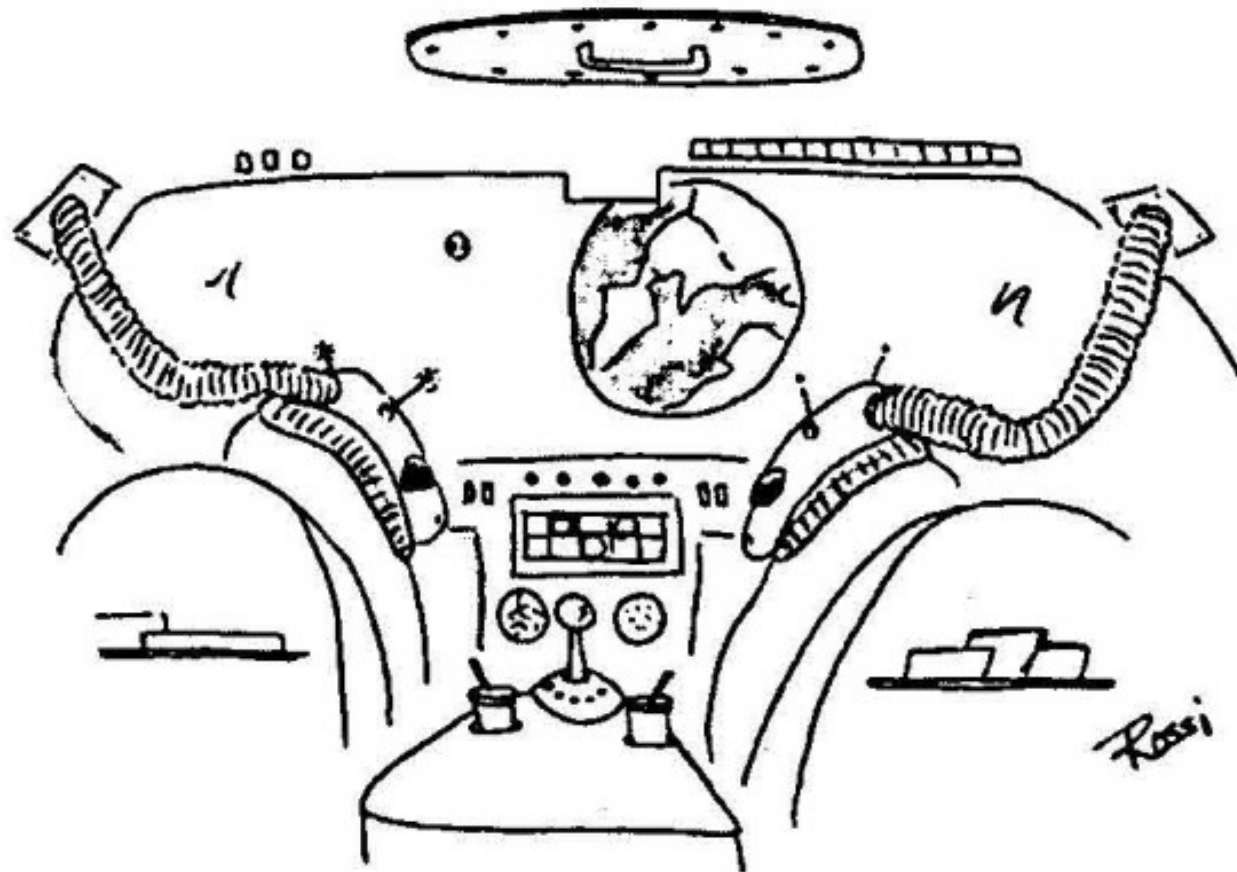
- Second year for LIC program
- Six to eight 3rd year students
- Population 80,000 with 350 practicing physicians
- 2 hospitals (320 total beds)
- Multiple practice structures – hospital conglomerates, multispecialty groups, single specialty groups, solo practitioners



Discontinuity, continued....

- Traditional “cradle to the grave” practices are now in the grave
- Relatively weak primary care presence
- Strong subspecialist presence
- Hospitalist service for inpatient adult medicine
 - Minimal continuity between inpatient and outpatient providers
 - Minimal continuity between inpatient shifts





**“Maybe there will be some primary care doctors
available on *this* planet!”**



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Discontinuity, continued....

- No integrated community wide electronic record or scheduling
- Many call groups and shared patient practices
- Mostly single specialty practices
- Practices located all over town





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Educational Objectives/Obstacles

- Student continuity with patient
 - Lack of central scheduling across specialties
 - Lack of integration between practices, specialties and hospitals.
- Student continuity with preceptor
 - Planning calls
 - Planning inpatient experiences
- Student continuity within practice sites
 - Multiple EMR's and office workflows, driving time



Making LIC viable in the average US community ?

- Despite all these obstacles, it still works!
 - Students like it
 - Preceptors like it
 - Patients like it
- Besides a “do-over” for the healthcare delivery system - how to make the best of what you’ve got?



Discussion?



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