

Conference abstract

Improving Continuity of Care in an Internal Medicine Resident Continuity Clinic

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INTRODUCTION

Continuity of care is a foundational principle of primary care and internal medicine, associated with improved patient satisfaction, better chronic disease management, reduced hospitalizations, and enhanced preventive care delivery. In resident continuity clinics, maintaining continuity is particularly challenging due to rotating resident schedules, limited clinic availability, and variability in scheduling workflows. These challenges can result in fragmented care, reduced resident ownership of patient panels, and diminished educational and patient-centered outcomes.

At the Sinai-Grace Hospital DMC Internal Medicine resident continuity clinic, informal observations suggested that a significant proportion of follow-up visits were being scheduled with providers other than the patient's assigned resident physician. Contributing factors included inconsistent documentation of the assigned primary care resident, limited awareness among scheduling staff, and lack of standardized processes to prioritize continuity during appointment booking. Given the central role of continuity in both patient care quality and resident education, this issue was identified as a feasible and high-yield target for a short-term quality improvement initiative.

The primary objective of this quality improvement project was to increase the percentage of follow-up visits completed with the patient's assigned resident physician over a three-week period in the resident continuity clinic. A secondary objective was to improve awareness among residents and clinic staff regarding the importance of continuity of care and the residents' role as the patient's primary care provider. The project aimed to evaluate whether a simple, low-resource intervention focused on resident documentation and scheduler awareness could meaningfully improve continuity of care without requiring system-level electronic medical record changes.

Improving continuity was expected to enhance patient-provider relationships, promote more consistent longitudinal care, and reinforce resident accountability for their clinic panels, while remaining feasible and sustainable within the constraints of a resident-run clinic.

METHODS

This project was conducted as a quality improvement initiative using a single-cycle Plan-Do-Study-Act framework in the Internal Medicine resident continuity clinic at Sinai-Grace Hospital DMC. The project was completed over a three-week period.

Baseline data were collected by retrospectively reviewing 15 recent follow-up clinic visits prior to intervention implementation. For each visit, data collected included the patient's assigned resident physician (primary care resident), the resident physician who conducted the visit, and whether continuity of care was achieved. Continuity of care was operationally defined as a follow-up visit completed with the patient's assigned resident physician.

A brief root cause analysis was performed to identify barriers to continuity of care. Key contributing factors included inconsistent documentation of the assigned resident physician, limited awareness among front desk scheduling staff regarding patient-resident assignments, and the absence of standardized scheduling processes prioritizing continuity.

Based on these findings, a single, low-resource intervention was implemented. Resident physicians were instructed to clearly document their role as PCP Resident in clinic notes and to verbally remind patients at the conclusion of each visit to request follow-up appointments with them at checkout. In addition, front desk scheduling staff were verbally educated to prioritize scheduling follow-up appointments with the patients assigned resident physician whenever feasible.

Following implementation, post-intervention data were collected by reviewing 10-15 follow-up visits using the same data elements and definitions as baseline. The primary outcome measure was the percentage of follow-up visits completed with the assigned resident physician. A secondary process measure included documentation of the assigned resident in clinic notes. A balancing measure assessed the ability to schedule follow-up appointments within an appropriate time frame.

Pre- and post-intervention continuity rates were calculated and compared to assess the impact of the intervention. The PDSA cycle concluded with evaluation of fea-

sibility, effectiveness, and potential sustainability of the intervention.

RESULTS

Baseline data were collected by reviewing 15 recent follow-up visits in the Internal Medicine resident continuity clinic prior to implementation of the quality improvement intervention. Of these visits, 7 were completed with the patient's assigned resident physician, resulting in a baseline continuity of care rate of 47%.

Following implementation of the intervention, post-intervention data were collected by reviewing 15 subsequent follow-up visits using the same operational definitions and data collection methods. Of these visits, 11 were completed with the patient's assigned resident physician, corresponding to a post-intervention continuity of care rate of 73%.

This represented an absolute increase of 26 percentage points in follow-up visit continuity over the three-week project period. Improvement was observed without delays in appointment scheduling or reported difficulty in booking follow-up visits within an appropriate time frame, suggesting that the intervention did not adversely impact clinic access.

Additionally, post-intervention chart review demonstrated more consistent documentation of the assigned resident physician as PCP Resident in clinic notes compared to baseline, indicating improved adherence to the process measure. Informal feedback from clinic staff suggested increased awareness of resident patient assignments during scheduling.

Overall, implementation of a simple, low-resource intervention focused on resident documentation and scheduler awareness was associated with a meaningful improvement in continuity of care within a short timeframe in the resident continuity clinic.

CONCLUSIONS

This quality improvement project demonstrated that a simple, low-resource intervention was associated with a mean-

ingful improvement in continuity of care within an Internal Medicine resident continuity clinic. Following implementation of resident documentation of primary care provider status and increased scheduler awareness, the percentage of follow-up visits completed with the patients assigned resident physician increased substantially over a three-week period. These findings suggest that small workflow and communication-focused changes can positively influence scheduling practices and continuity in resident-run clinics.

Several external factors may have influenced the observed outcomes. Resident clinic availability, rotation schedules, vacations, and patient preferences may have limited the ability to schedule follow-up visits with the assigned resident physician in some cases. Additionally, the short duration of the project and small sample size may have amplified the apparent effect size. Despite these limitations, the intervention achieved its predefined aim without negatively impacting appointment availability or clinic operations.

Based on the current results, future quality improvement cycles should focus on sustaining and expanding these gains. Potential next steps include incorporating continuity-focused education into resident and scheduler orientation, standardizing clinic note templates to clearly identify the assigned resident physician, and exploring electronic medical record enhancements to highlight resident patient assignments during scheduling. Longer-term data collection and repeated PDSA cycles would allow for assessment of durability and generalizability across clinic sites.

Overall, this project supports the feasibility and effectiveness of resident-led quality improvement initiatives aimed at strengthening continuity of care and enhancing both patient and educational outcomes in academic outpatient clinics.

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