

PCAA Practice Innovations Section

I. Introduction

Primary Care must be the foundation on which US healthcare is based. The two major areas of focus for healthcare reform, providing universal access to healthcare coverage, and containing healthcare costs, both depend on a strong, vibrant primary care infrastructure. Primary care is care that is longitudinal, accessible, and a point of first contact for most healthcare needs. Evidence is strong that good primary care reduces costs and improves outcomes. (starfield). States with better access to and higher utilization of primary care have lower healthcare costs and superior health outcomes, while states with more utilization of specialists and non primary care have higher costs and in many cases worse outcomes (Dartmouth)

Evidence is growing, however, that primary care is in crisis. Fewer than 4% of graduating medical students list primary care as their desired specialty (JAMA). Massachusetts, the first state in the US to provide universal access to healthcare coverage for its residents, is struggling to find access to primary care for the newly insured (ref). Primary care providers express low job satisfaction as compared to their peers in other specialties. Low salary compensation rates in comparison to other medical fields may contribute to this dissatisfaction, but evidence suggests that there are deep structural explanations as well. The burdens on primary care providers have been well documented, and include increasing paperwork, limited technological infrastructure, and increasing demands for uncompensated work activities such as care coordination. The largely fee-for-service reimbursement structure has led to the over-valuing of the face to face encounter. This has limited the adoption of potentially more efficient and effective tools such as the internet, email, and telephone consultation as well as well as the use of support staff such as nurses for assistance with routine care needs such as chronic disease management and urgent care. Primary care has been slow to adopt new technology such as the electronic health record. Many innovations in practice design that have been shown to improve primary care have been slow to be adopted. Advanced Access (Murray) can improve patient's access to care. The Chronic Care Model lays out a conceptual framework for improving chronic illness care. The Patient-Centered Medical Home lays out essential elements for practices to have in order to provide high quality primary care in the 21st century. Primary care must innovate and adopt some of these models in order to remain viable.

II. Access

Limited access to care is among the most frustrating and common complaints about the healthcare system. Long waits for routine care are common in primary care and many specialties as well. Most practices manage access by triaging urgent versus non urgent care needs, with the non urgent (routine physicals or follow ups) booked far out in the future, and the urgent booked into selected slots held in reserve, or over booked into already-full schedules. The result of this distinction between urgent and non urgent is the deferment of routine care, missed opportunities to provide care, higher "no-show" rates,

and overburdened schedules with physicians running late. One side effect of this limited access has been the profusion of urgent care centers, “minute clinics” and ambulatory urgent care sections of emergency rooms. Such facilities may fill a need in the marketplace, but they result in increased fragmentation of care and in many cases over use of resources. For acute or chronic care, a provider who knows a patient is the best person to see them and likely the most efficient sources of care.

Primary care practices need to meet the needs of a changing healthcare environment and provide expanded access for patients. Many patients have difficulty conforming to standard business hours for obtaining healthcare, and illness simply doesn’t always occur between eight am and five pm. Practices can accommodate patients and provide better care by expanding their hours of operation to include evenings and weekends.

Advanced Access Scheduling is a highly effective model that eliminates the distinction between urgent and routine care, emphasizing consumer choice and the provision of “just in time” delivery of healthcare. Predicated on achieving balance between supply of visit slots and demand for appointments, advanced access has been shown to ensure same day access for patients for all care needs, whether urgent or not. The advanced access model has been shown to improve patient and staff satisfaction and to result in more efficient practice management (murray) Incentives should be provided for practices willing to implement this highly effective model.....

School-based health centers offer an effective method of providing care to school aged children during the school day that helps limit missed school and provides highly effective care to this select and often time vulnerable population. Many school districts in Connecticut have embraced the school based model and offer full service primary care to children during the school day. More from SBHC team:

III. Care Coordination

In an increasingly fragmented healthcare system, the need for a provider to coordinate and manage the care of an individual patient is paramount. Studies have shown that primary care providers spend approximately 20% of their time engaged in non face to face activities aimed at coordinating care with the myriad sources of care that patients receive. One detailed examination of care coordination estimated that a primary care physician will have on average 229 other care providers with whom they must interact in order to coordinate and manage care for a typical panel of primary care patients (Pham). Thirty-three percent of Medicare patients have six or more physicians (Medicare payment advisory report), and many of them do not have a primary provider to help coordinate their care. Care coordination activities are broad and include such activities as discussing patients with specialists, conversing with families over the phone, reviewing care with home care providers, and obtaining details from recent hospitalizations, to name only a few. While such activities are vital to ensuring patient safety and quality, they represent non-reimbursed activities in a standard fee-for-service model.

Suggestions for how to address this issue: funding source for non face to face care management tasks.....

- IV. Communication ? Todd Staub
 - a. Need for non-face to face communication modalities for patients
 - i. Telephone care
 - ii. Telehealth support
 - iii. Internment/email/text consultation
 - iv. Reimbursement issues

- V. Team-based care Anderson
 - a. Complexities of care require a team-based approach to meet the growing needs of an elderly, chronically ill population
 - b. Chronic Care Model
 - c. Planned Care
 - i. Nursing
 - ii. Pt education
 - iii. pharmD
 - iv. integrated MH
 - v. disease management
 - vi. home care

- VI. Patient Centered Medical Home

- VII. Performance measurements: ? Rob McLean
 - a. Need for monitoring performance
 - i. Preventive services
 - ii. Chronic disease processes
 - iii. Chronic disease outcomes

Recommendations to State from PCAA....group

Bibliography

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Farber Ann Int Med 2007

Murray JAMA 2003

Medicare Payment Advisory report (Bodenheimer ref)

Starfield NEJM

Elliot Fisher Dartmouth atlas

Pham Annals 2008