

Specialty care within the medical home:

Use of circuit riders to expand access

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Goals of presentation

- **Background**
- **New model** – specialty care in the patient-centered medical home
- **Circuit-riders** – expanding access and quality at the same time

NOAH: "I never should have let the moth try steering"



CartoonStock.com

"I should never have let the moth try steering."

Current model of specialty care



Cost of a headache (estimated)

- \$ 300
- \$ 350
- \$ 1,000
- \$ 350
- \$ 5,000
- \$17,500
- \$96,000
- **\$120,500**



Cost of a headache (estimated)

- \$200
- \$300
- \$ 44
- **\$544**



“We did everything we could”



“We did everything we could.”

What happens when you add one doctor per 10,000 in the population?

- **Adding 1 specialist**
 - Worsens quality measures
 - Increases costs \$526/beneficiary
 - **Increases** mortality by 70 per 100,000 (9% more deaths).
- **Adding 1 primary care provider**
 - Improves quality measures
 - Decreases costs \$684/beneficiary
 - **Decreases** mortality by 16 per 100,000 (2% fewer deaths).

Baicker et al. Health Affairs 2004;W4:184-197

Shi. J Am Board Fam Pract 2003;16:412-22

Public health systems are no different....

- **In England, each additional primary care physician per 1000 (about a 20% increase) is associated with a decrease in mortality of about 5%.**

(adjusting for limiting long-term illness and for various demographic and socioeconomic characteristics).

To change costs, we need to change incentives



- Drivers for private practice specialists:
 - Economic
 - Medico-legal
 - “Tyranny of the standard of care”
- Drivers for academic specialists:
 - Pride in finding zebras
 - Research interests
 - Tertiary care bias
 - Plus all of the above

Unless you
change
incentives,
the problem
persists



“Can’t we just dye the smoke
green?”

“Every system is set up to produce the results it produces”

- How do we rank?
 - 1st of 223 countries -- size of economy
- Percent of GNP on Health Care
 - 16.5% US
 - 6% Great Britain
 - 8% Canada

How are we doing?



- **43rd for infant mortality**
 - Behind Slovenia and South Korea
- **45th life expectancy**
 - Behind Jordan, Puerto Rico and Bosnia
- **118th absolute death rate**
 - Behind Libya, Nicaragua, Mexico, Israel, Mongolia, Cambodia

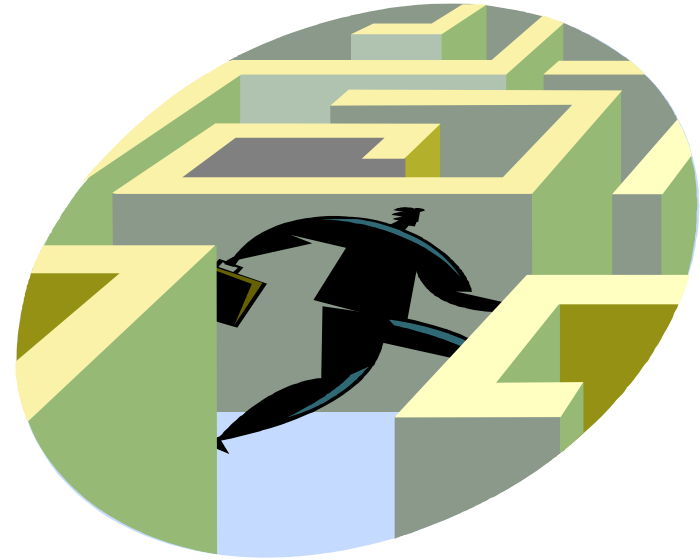
Why are community clinic patients referred to specialists?



- Nerves
- Gerbils
- Lawyers
- Equipment
- Actually physically need to see a specialist



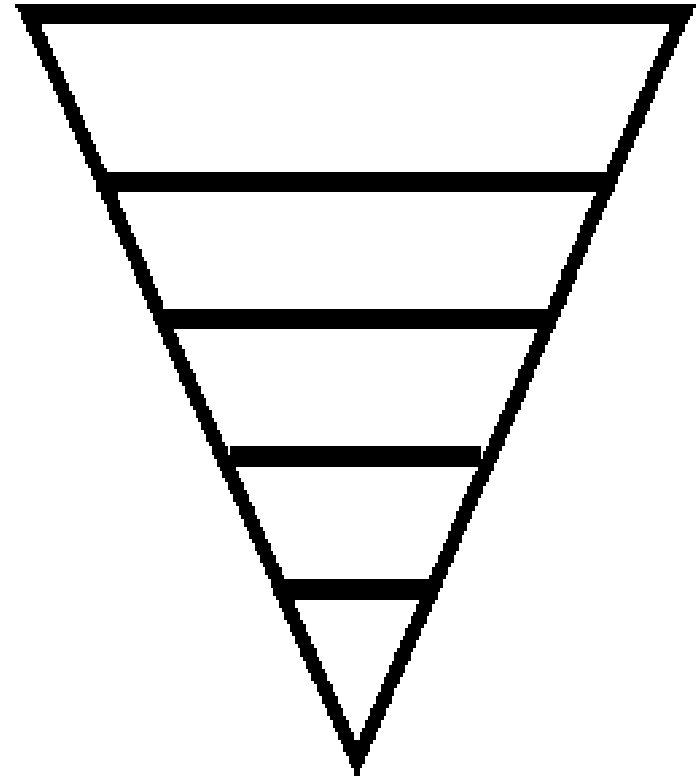
What can happen



- **Patient:**
 - I couldn't find it
 - I couldn't understand it
 - I couldn't afford it
- **PCP:**
 - What was "it"?
(Never got the consult note)

Vision: Patient-Centered Specialty Access, within the medical home

- PCP with accessible resources
- PCP with access to advice
- PCP-specialist co-management
- Specialty access on-site
- Off-site visits



New model of Patient-Centered Medical Home:

Expand principles to specialty care


- **Seven strategies to expand access:**
 - Decrease inappropriate referrals
 - Increase supply
 - Improve quality of care
 - Improve coordination of care
 - Allow shared regional resources

First strategy

“THREE CLICKS YOU’RE OUT”

- Evidence-based, practical specialty resources at point of care
 - Decision support linked to EMR
 - SERMO
 - Linked guidelines and protocols

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Limit on Number of Intrarticular Corticosteroid Injections?

My Rating: Average Rating:  (7 ratings) [?](#)

 The results are in.
32 have answered. Agree? Disagree? Let us know.

Limit on Number of Intrarticular Corticosteroid Injections?

This posting closed on December 15, 2007.
You can still submit responses.

This is a question I've always wondered about, and a how to best administer a cortisone injection got me w

I personally have had two intrarticular injections of co of my wrists (one time in each one) and one in my rig tunnel problems. I also have a very dear friend who r corticosteroid injections in her left knee prior to havin surgery, as well as two or three prior injections in her understand it, there is a "life-time limit" as to how mar one can have. I am just wondering if this is indeed tru considered the "life-time limit", or if there are other cc not get anymore I guess -- but I haven't had any real about 5 years ago, and I believe my friend has reach

Inquiring minds want to know -- this is not my special ask...

Tags

[cortisone](#), [injection](#), [injections](#), [pain](#), [problems](#)

Category: [General Interest](#)

 Posted on December 01, 2007 by [jprevdoc](#)

Comments (11)

[Wonposet](#) Pediatrics Po


There is a good review of the rational use of steroid injections in the Bulletin on the Rheumatic Diseases of the Arthritis Foundation.

[ww2.arthritis.org](#)

Iatrogenic infection is the most serious but least common complication. Its incidence may be as low as 0.005% and is more common in patients with rheumatoid arthritis, especially those who are immunosuppressed or debilitated. Obviously repeated intraarticular injections raise the risk of infection.

According to Christopher Wise, M. D. in the bulletin cited above, the insertion of a needle into a joint usually carries a small fragment of skin and at least 1/3 of the time has evidence of bacteria in it by identification of bacterial nucleic acid by pcr. Since infections rarely occur after arthrocentesis, it is likely that these bacteria are



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MeSH data created, maintained and provided by the U.S. National Library of Medicine. MeSH version "2006 MeSH".

Second strategy: Teach everyone to fish

- Measure referral patterns
- Develop curriculum based on high volume referrals
- Arrange local and regional trainings



Teach a few people to fish?

- Regional training
- Locate specialist champions
- Fund representatives to go to trainings
 - National Procedural Institute
 - American Academy of Family Practice

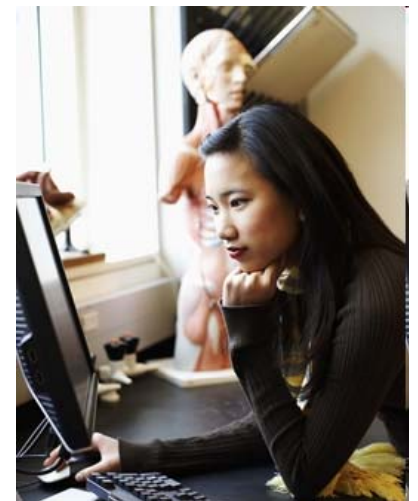


How many procedures can clinics keep in-house?

- **Gyn procedures:**
 - Colposcopy, EMB, D & C, IUI, IUC, Implants, Word catheter, breast cyst aspirations
- **Dermatology procedures:**
 - Multi-layer closures, flaps, facial biopsies, large excisions, cryotherapy, electrodesiccation and curettage
- **Orthopedic procedures**
 - Splinting, casting, joint injections
- **Podiatry**
 - Nail/callous removal
 - Diabetic foot care
 - Neuroma injections
 - Splinting
- **Rheumatology**
 - Joint injections
- **Office Ultrasound**

Third strategy: Facilitate easy PCP-specialist communication

- **GOAL:**
 - Don't refer patients who don't need to be seen in person
- **Formal options:**
 - Kaiser, SFGH, Santa Clara Valley Express
- **Informal options:**
 - Local relationships, secure email, SERMO



Fourth strategy:

Embed guidelines and protocols within electronic referral system

- Expands scope of practice
- “Packages” referrals to decrease waste, and therefore expand capacity
- Examples:
 - Kaiser (centrally developed template, regionally adapted)
 - Santa Clara (purchased from vendor)
 - Shasta (home-grown)

Fifth strategy: Specialty clinics on-site

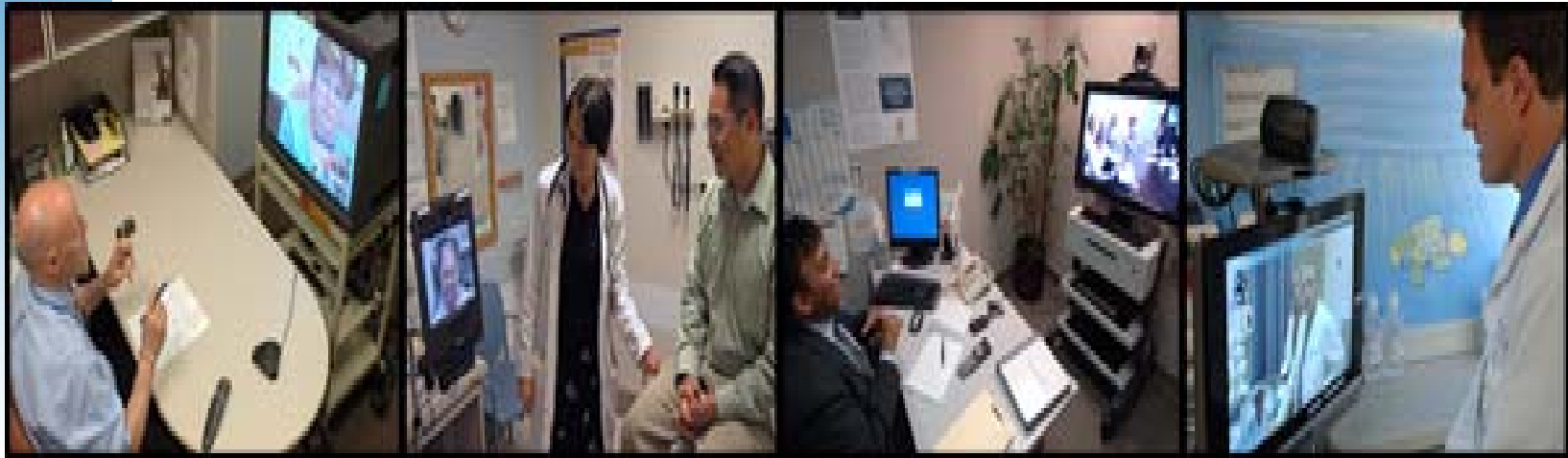
- On-site specialty clinics:
 - Specialists rotate in – volunteer or paid
 - Clinic network hires circuit-rider
 - Local “mini-expert” with relationship with outside specialists



Key elements of successful site clinic

- Simplified referral process
- Site coordinator
- Well-organized schedule and supplies
- Physician champion
- On-site PA or FNP
- Surgical referral agreements
- Simplified referral process

Sixth Strategy: telemedicine



Seventh strategy: network expansion and referral coordination

- **Examples**
 - Kaiser
 - KidsNet
 - Marin (centralized referral coordinator)

Circuit-riders – creative solution for high cost, low supply specialties

- **Sonoma/Marin County successes:**
 - Psychiatrist
 - OBGYN
 - Pain Management anesthesiologist
 - Neurologist
 - Retinal camera
- **Proposed:**
 - Orthopedic PA

Operational issues with circuit-riders

- Contracts
- Call (one hospital only)
- Scheduling:
 - “No confirmation, no appointment”
 - Productivity vs retention
- Everything in one room
- MA coordinator (go-to person)

Circuit-rider operational issues

- Massaging and chocolate
- Multi-site conference calls
- Standardized forms
 - Intake
 - Progress note
 - Billing
- Change of scope barriers

Retinal camera successes

- Model of Mexico
- One camera, four clinics
- Capture all diabetics in a three month window, once a year
- Shared grant, shared costs

Orthopedic PA proposal

- Same principles as site clinic
- Negotiations with local orthopedists
 - 2 surgical referrals per month
 - Fair distribution
 - Point-person for calls and emails re co-management

Protocols for referral coordinators

- **For all referrals:**
- The following must be in place (if not, send back to PCP)
 - Updated med list, problem list, demographics
 - Legible description of patient problem and question (NOT “evaluate and treat”)
- See disease-specific protocols
- Any referral that does not meet criteria, give to medical director to review with PCP.

Example of referral protocol for neurology

- **Referrals require:** Documentation of patient history and physical exam
- **Seizures:** consult only if seizures continue despite treatment (obtain sleep-deprived EEG if possible prior to referral) or if patient wants to stop anti-seizure meds
- **Do not refer:** pain management, radiculopathy due to cervical or lumbar DDD, intention tremor
- **Does patient need to be seen to answer clinical question? (if not, consider email consultation)**

Circuit-rider benefits

- Increase local supply
- Community-clinic focus
- Care within medical home
- Cross-pollination
- Affordable
- Buy-in for email consults



Circuit-rider challenges

- Contracting
- Benefits/vacations
- One person – multiple systems
- Recruitment strategies
- Call
- Scope issues

The Patient-Centered Medical Home

- If all these pieces are in place....
 - “Just in time” resources
 - Excellent PCP-specialist communication
 - Adequate decision support and protocols
 - Expanded scope of practice
 - Site clinics
 - Care management coordinators



The majority of care can happen within the medical home:



- Higher quality
- Lower cost
- The patient at the center

Thank you.

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