

The referral coordinator is tearing her hair out again....

Expanding scope of practice within the four walls.

Kelly Prisher, MD
Medical Director for Access
Redwood Community Health Coalition
Medical Director, Petaluma Health Center



For most community clinics, the current system of specialty care for the underserved is filled with miscommunication, fragmentation, and poor outcomes



A familiar tale....

- Primary care provider racing through four patients per hour
- Fearful about limits of knowledge?
 - Filling out a referral form is often faster than researching the answer



Where can the patient go?

- Typically, patients face a referral maze.
 - Referral coordinators scrambling for options
 - PCPs not realizing the patient ended up in another county
 - Long waitlists; delayed care
 - Patients get lost, don't have a translator
 - PCPs often don't get the report.



Who has had this conversation?

- "So how did it go? What did the specialist say you have?"
- "I don't know... something about my nerves."
- "What did she give you?"
- "Some little white pill... you know, the round one..."



We finally get our patient to the specialist... was it worth it?

- Off-site specialty visits are high risk for:
 - Poorly coordinated care
 - No case management:
 - prescriptions written that can't be filled
 - studies ordered that can't be done
 - One condition may be treated at the expense of another



And that is in the best of circumstances....

- Most of our patients never get referred . there is no one to take them.
- Not enough specialists in many rural areas, even for insured patients; improved reimbursement won't resolve access issues.
- PCPs give up and quit:
 - "I can't risk my license practicing without any specialty backup"
 - "I need more support in my first job out of residency"



What can we do?




"Put a bunch of medical directors in a room for a few days and slide pizza under the door...."



We can't do things the way we used to

- Expanding access to a bad system means bad care:
 - Increased morbidity
 - Increased mortality
 - Increased cost




Increasing physicians
1 per 10,000 population

- Adding 1 specialist
 - > Worsened quality measures
 - > Increase costs \$526/beneficiary
- Adding 1 primary care provider
 - > Improved quality measures
 - > Decrease costs \$684/beneficiary

<http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.97/DC1>

- > Baicker et al. *Health Affairs* 2004;W4:184-197
- > Richard G Roberts, MD, JD, FAAP. FCLM 10 January 2008




Expanding primary care capacity
saves lives

Family Physicians:
Adding 1 more family doctor per 10,000 in population **decreases** mortality by 70 per 100,000
9% fewer deaths

Specialists:
Adding 1 more specialist per 10,000 in population **increases** mortality by 16 per 100,000
2% more deaths

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



Why do people do worse with more specialist care?

- Outside area of expertise:
CAP, AMI, CHF, UGI bleed¹
- Late stage diagnosis of breast²
or colorectal³ cancer
- Excessive utilization⁴
- Handoff or communication errors⁵

- Weingarten et al. Arch Int Med 2002;162:527-532.
- Ferrante et al. J Am Board Fam Pract 2000;13:408-414.
- Rotezheim et al. J Fam Pract 1999;48:850-858.
- Greenfield et al. JAMA 1992;367:1024-1030.
- Skinner et al Health Affairs 2006;25:w34-w37



We need a new model of care

- Old model:
 - Uncoordinated, discontinuous care; PCP as "gatekeeper"
- New model:
 - Comprehensive medical home:
 - Majority of specialty needs addressed on-site:
 - By PCP or in coordination with PCP
 - Goal:
 - Services come to patient
 - Patient not lost in maze of services



Goal: Primary care = Multi-Specialty Generalist

- Able to manage the majority of patient needs in a coordinated way
 - Able to see how a disease in one system affects another
- Can quickly access current, evidence-based medical information
- Able to access help and advice when needed
- Maintains relationship of trust and support
 - Patients more willing to follow recommendations



Expanding PCP "comfort zone" is a key retention strategy

- Competence leads to confidence and decreased stress levels
- Prevent stagnation through environment of learning and growth
- Proactively address burn-out "hot zones"
Example: Pain Management 101



How do we get there?

- First strategy:
Expand access to "fingertip" knowledge
 - Web-based resources, in one to two clicks:
 - Up To Date
 - Links to national guidelines and protocols
 - Links to patient education information sites
 - Links to community resources:
 - \$4 drug program list
 - Alcohol/drug resources
 - Example: Petaluma intranet

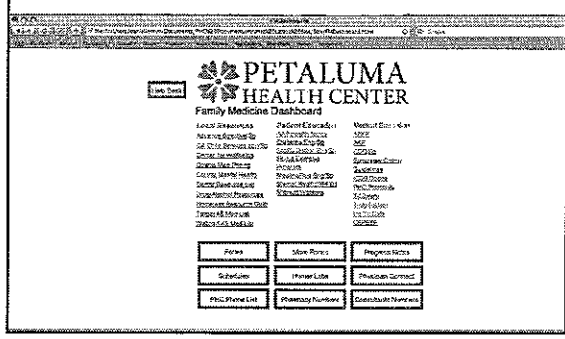


PHC intranet: links at a glance

- <http://web.mac.com/jendanielle/Site/Links.html>



PHC intranet: links at a glance



Efficient access to knowledge = decreases referrals

- Inadequate resources?
 - PCPs quickly refer out of anxiety.
- Adequate resources – at the fingertip?
 - PCP will handle initial work-up and treatment




Second strategy: facilitate easy PCP-specialist communication

- We need access to specialist advice when the answer can't be researched:
 - By e-consult
 - In person with on-site specialist
 - Through telemedicine
- Results:
 - Decreased referrals
 - Referred patients less likely to need specialist follow-up visits
 - Leads to increased specialty capacity




E-consults

- Not every question needs a formal consult
- Informal:
 - Importance of relationships
 - Local specialists often prefer questions to Medical referrals
 - "Curbside" consultations of all types are discouraged by risk managers
- Formal E-consults
 - Examples: Kaiser; SFGH
 - Specialists can field question pre-referral
 - Decrease demand; expand PCP comfort zone




Third strategy: EHR with protocol-driven electronic referrals

- Expand scope of practice of PCP
 - Prompts for initial workup and treatment
- Increase specialty capacity by decreasing referral volume.
- Maintain good specialist relationships
 - Less frustration from poor quality referrals
 - Improved retention of specialists in network



Fourth strategy: Increase local expertise

- Educate everyone:
 - A rising tide lifts all boats
- OR
- Cultivate mini-specialties among PCPs



Cognitive specialties are well-suited for expanded scope

- Examples: Rheumatogy, neurology, cardiology, endocrinology
- Consider yearly curriculum: focus on high volume referrals from knowledge gaps
 - Endocrine: hyperthyroidism; workup of nodule
 - Neurology: seizure disorder management 101; migraines
 - Cardiology: indications for stress testing; angina management



CME Resources

- Invite local specialists, tailor talk to high volume referral areas
 - Avoid industry-sponsored "one drug lectures"
- Tap into university or Kaiser grand rounds, or CME on line
- Use internal resources:
 - Each provider takes turns researching and presenting



Behavioral and mental health

Goal: decrease psychiatry referrals

- Year-long multi-county training program (Napa)
- Monthly chart review/mentorship (SW)



Comprehensive pain management

- Volume of patients >>> pain management specialty capacity
- Small investment in "Pain Management 101" and standardized protocols have huge pay-offs
 - Improved provider and staff retention
 - Decreased staff and provider anxiety about diversion
- All PCPs need to share the load
 - Don't depend on one provider; what if that person leaves?
 - Examples: www.communityclinicoice.org



Expand access through "local clinic expert"

- Provide family doc/FNP/PA with additional training
- Mold 'em while they're young
 - Encourage third year residents to choose procedural electives prior to finishing training
 - Arrange mini-apprenticeships early in career




Expand capacity for procedural skills

- 1-2 providers per site with expanded skill set
 - Flexible sigmoidoscopy
 - Gyn procedures:
 - Colposcopy, EMB, D & C, Word catheter, breast cyst aspirations, etc
 - Dermatology procedures:
 - Multi-layer closures, flaps, facial lesions
 - Cryotherapy, electrodesiccation and curettage
 - Orthopedic procedures
 - Splinting, casting, joint injections




- Podiatry
 - Nail/callous removal
 - Diabetic foot care
 - Neuroma injections
 - Splinting
- Cardiology
 - Stress testing
- Rheumatology
 - Joint injections
- Office Ultrasound




Where to learn?

- National Procedure Institute
- AAFP conferences (procedural breakouts)
- Mini-apprenticeships with local specialists
- Mini-apprenticeships with other community clinic sites



Fifth strategy: Co-manage, don't refer out

- Site clinics
 - Local specialists
 - Circuit riders
- Hub clinics



A specialist visit on-site is qualitatively different than an outside referral

- Private offices do not have the resources to manage needs of high-risk population
- When a specialty need is managed internally:
 - Access to entire chart
 - Fewer errors due to uncoordinated care and miscommunication
 - Care in their own language, in a setting they trust
 - PCPs stay involved, manage intersection between different diseases



How to bring specialists into the Four Walls

- Utilize resources of specialists who may have capacity (retired, new in town)
- Ask specialty group for each to commit to few hours per month.
 - Pay off for them – less office havoc from MediCal patients
- Appeal to hospitals for grants and logistical support
- Develop hub sites, share resources between clinics
- Hire circuit riders to share between clinics
 - Pain management, psychiatry, OBGYN



Inevitable gaps

- Expensive elective procedures
 - Colonoscopy
 - Surgeries:
 - Orthopedic
 - Gynecologic
 - Urologic
 - Etc.

Thank you, Operation Access!



Sixth strategy: Telemedicine

- We can't solve the access problem unless we eliminate the transportation barrier.
- Co-management through telemedicine is the most efficient way to learn:
 - "Give me a lecture, I remember for a day
 - Help me manage my patient, I remember for a lifetime."



Telemedicine is exploding statewide

- State-wide network of hub and spoke sites currently in development
- Funding and technical support opportunities in abundance
- Requires initial capital investment, physician champions, and detailed coordination



Ideal "starter specialties": Dermatology and ophthalmology

- What's in it for specialists:
 - Can bill MediCal without face to face visit
 - Can bill PPS rate for e-consults and retinoscope images if read on-site
- What's in it for PCPs:
 - Easy access to quick consultation
 - Fewer wasted visits ("not sure what it is -- here's some fungal and cortisone cream")
 - Over time, increased confidence with simpler cases



Conclusions

- We need to re-think our specialty access problem
 - not "where can our patients go"
 - to "why should our patients go?"

With good systems, resources, and access to help: PCPs can meet the majority of their patients' specialty needs.



Specialty care delivered by the primary care provider:

- improves quality
- decreases medical error
- improves coordination of care
- decreases barriers of transportation, language, cost, culture
- improves patients' trust in the plan

And more importantly, saves lives.



Opportunity for clinics: Invest in systems to support PCPs, during patient visits

- "One-click access" for "just in time" knowledge
 - Improves productivity, quality and PCP job satisfaction
- Set up secure email communication with specialists
- User-friendly decision support embedded in electronic record
- CME funding and support for off-site learning
- Set up site and hub clinics



**We must find regional solutions:
Each clinic can't re-invent the wheel**

- Opportunities for regional networks:
 - Technical support for IT solutions:
 - Shared EHRs with built-in decision support
 - Secure email for PCP-specialist communication
 - Telemedicine: store and forward, live video
 - Develop access to high demand specialties
 - Help set up site clinics and hub clinics
 - Advertise for circuit-riders
 - Provide CME and training opportunities



Opportunities at state level

- Funding and technical support for regional solutions
- Telemedicine is wave of the future
 - No other solution can adequately match supply and demand
 - Statewide networks can decrease disparities:
 - One county's feast is another's famine
 - Clinics will need a tremendous amount of technical and financial support to take this next step



To make this all work...

- We need enough primary care providers.
- Last year, half the number of medical school graduates chose FP residencies compared to seven years ago.
- Bringing students into a well-organized clinic, where PCPs have easy access to resources, support and advice, is one of the best recruitment and retention tools we have.
 - Example: PRIME program UC Davis



Kelly Pfeifer, MD

Medical Director for Access
Redwood Community Health Coalition
Medical Director, Petaluma Health Center
kellyp@phealthcenter.org
(707) 559 7581

- Resources:
- www.communityclinicvoice.com
- Example of "one-click" access
<http://web.mac.com/jendanielle/Site/Links.html>