



Specialty Care Access Initiative Roundtable #3: Scope of Practice

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San Francisco, CA

Small Group Discussions

Question #1: Given the difficulty recruiting and retaining primary care providers. Is expanded scope of practice an effective strategy in the safety net?

This question is too narrow

Address at least three separate issues:

- *Recruitment* - into PCP difficult given financial, workload, prestige disincentives
- *Retention* - different issue and more challenging for clinics – expanded scope if not framed right can be disincentive
- *Expanded scope* – need to balance workload. Need to take something away – to add new expanded scope of work. To do this right, adding additional scope of practice should not add to current workload – is not attractive to docs.
- Framing the question is important

Family medicine residency program seems more difficult

- Complex patient treatment approaches
 - Time pressure
 - Workload – follow up
- PCP less pay and more work.

Specialty Care vs. Family Medicine

- More interns interested in SC.
- How do we balance PCP crisis (demand for more docs) vs. / specialty care crisis?
- PCP training in SC?
 - PCP capacity
- New physicians going into specialties
 - Financial incentives, environmental incentives
 - Workload of PCP vs. specialists
 - Specialty physicians driven by lifestyle incentives

Strategies to Recruit Retain Family Medicine docs

- In some areas of the state, for example along the coast, it is easier to retain residents in Family practice. Lifestyle in these communities is an incentive
- Satisfaction drives people – incentive of filling the gap of SC services
- Focus on SC services most difficult to access
- Satisfactory job redesign

Expanded Scope of work

- Full scope – failed model; using didactic approach is a better approach:
 - No expectation that PCP does it all- takes
 - Increase scope of work for PCP – Key is to get broad group of docs w/training on different specialties to get full spectrum of services
- Incentives to expand scope
 - Depends on the system
 - Access to primary care
 - Coordination of resources, relationships
- FMP that received training left (Kaiser Perm).
- If framed correctly expansion of scope can be an effective strategy to recruit more Family Medicine docs
 - Skill dev/training incentive
 - Start expanded scope of work training during residence
 - Can be incentive for potential PCP that want to do more than family General medicine
 - Need to provide right environment – resources and support in clinic setting
- Need to provide right balance of workload – shouldn't expect PCP to do it all
 - Clinics should prioritize spec care need and focus on 1 – 3 areas
- Incentives depend on the systems
- Effective training – early focus on full scope
 - Focus on more common problematic diagnosis
 - Possible incentive
 - Higher confidence level
- Creative innovations in training may lead to fulfilled systems need vs. clinicians needs
 - Dev. Of niche

Question #2: If we adopt expanded scope of practice as a means of improving access to specialty care for our patients, how will we address issues related to provider productivity, scheduling and reimbursement?

Productivity:

- Reimbursement good w/in managed care
- Upfront training/relations
- More time/pt would be needed for SC work
- Lower # provider panel
- Depends on SC Intervention solution – some SC intervention less time intensive – e.g. dermatology
- Takes burden off other providers – who can then “pick up the slack” of the provider giving SC services

Reimbursement:

- SC services outside clinics – challenge
- Apply for higher SOP(Scope of Practice)...lead to higher reimbursement for all patients
 - Indirect
- Go to payor – reimburse for higher scope

Scheduling:

- Same time scheduling (e.g. all patients to see cardiologist scheduled at 9 AM and cardiologist sees patients in the order of patients getting into the clinic) – bad idea!
- Do not register at same time
- Call = 48 hours before the appointment
 - Build in some free time to give flexibility in order to accommodate walk-ins/urgent appointments
 - Active confirmation – patient calls clinic and says he/she will keep appointment, if no confirmation w/in 48 hours, appointment deleted
 - Time intense
- Passive confirmation – same as active, only clinic calls patient
 - DX – mobile radiology
 - ?path
- Integrate scheduling and referrals

Solutions:

- Other providers “pick up slack”
- Schedule simpler pts in 2nd half of the day
- Nonproviders doing non-provider activities (e.g., retinopathy screening)
- Policy changes – developing standards of care (the Associations)
- Research standards of care – time/pt(the Associations)
- Research and outcome(the Associations)
- Talk to providers re: interest and need
- Group visits
 - Migraine
 - Chronic pain
 - FM
- Money effective
 - E.g. PA doing colonoscopy
- Make systems more efficient
- Bundles for procedures
- Store and forward information (Richard.gooch@wellpoint.com)

Other Issues (opportunities):

- Access – providers’ schedules already overloaded
- Space – even if enough providers, not enough physical space to have equipment (e.g. retinal camera/colonoscope)
- Change in Scope of Practice – Bureau does not approve, clinic not covered for SC service under FTCA; therefore, clinic would need to address gap in liability insurance
- Training
- QA/eval
- Equipment
- Provider interest - could be a positive
- Community standards

Question #3: What local opportunities and challenges exist in given communities? Are practice boundaries important to the specialists in the community? How can they be addressed?

Opportunities:

- Referral process w/referral coord.
 - One hospital was able to lower external referral rates by 25%
- Sharing of referral guidelines via web-based
- Standardized training for referral clerks to ensure appropriate referrals
- Identify local specialists and maximize their services
 - Conduct local resource assessment
 - Database of available specialists through an allocation management software
- Include local specialists in creating ambulatory care referral guidelines to create buy-in and higher appropriate referrals.
- Sending PCPs for training
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Challenges:

- Anxiety of providers
- Access to primary care follow-up after specialist visits
- Inefficiencies in clinics
- Uninsured referrals from other clinics
- Unclear referral guidelines
- Need for e-referral
- Hard to get specialists to stay/come because of the private sector
- Specialists not excited at being a part of the solution
- How do you get the patients into the system when the payor is the problem?
- Issues with admitting patients
- Opportunity to explore collaboration between counties
- Excess specialists in some areas while limited in others
- Looking at regional approaches
- Follow the flow of the patients while looking at regional approaches
- Takes people that understand the mission
- Show the quality of care you are providing

Practice Boundaries:

- Yes there are practice boundaries as it relates to – reimbursement and scope
- Relationships and data
 - Academia – including training in residency
- What you want to do in their realm determines their support

Large Group Discussion

- Legitimize outcomes/scientific studies with all of the method we could do
- Website to access materials while doing work
- Group visits for cognitive specialty care
- Researching standards of care to provide guidance
- Collaboration between entities
- Law – specialists reimbursed for traveling costs.
- Offshoring telemed consults