Improving Access to Primary and Specialty Outpatient Care for Medi-Cal

Following are some of the strategies used by counties across the United States to improve access to primary and specialty care:

1. Improving Clinic Operation

The Primary Care Development Corporation of New York (PCDC) guided teams of health center staff to plan, implement, and evaluate changes to improve clinic operation. Their accomplishments include:

- Enabling health centers to collect more payments and improve cash flow by teaching organizations how to integrate all facets of their business — financial, clinical, and operational.
- Reducing patient wait times by streamlining work processes, e.g., eliminating bottlenecks in patient flow.
- Accelerating appointment availability by offering patients same-day appointments.
- Helping providers select, prepare for, implement, and use Electronic Health Records.

http://www.pcdcny.org/programs/overview.html

2. Holding Orientation Clinic for New Patients

Chinatown Public Health Center (CPHC) in San Francisco standardized how they introduced their clinic services to new patient and enhanced the efficiency of new patients' initial PCP visit by holding new patient orientation clinic (OC). The 12 new members in the OC were given a group orientation to the clinic, a review of medical insurance coverage, and a focused education on reading pill bottles and refilling medications. A Registered Nurse performed tasks such as measurement of the vital signs and completion of recommended diagnostic, clinical preventive services, and referrals in accordance to OC Standing Order Protocol. At the conclusion of the OC, each client's chart was forwarded to the Medical Director for review and co-signature. The OC max-packs several services into one visit and reduces the need for follow-up visits. When follow-up appointments are needed they are shorter visits because of all of the work done in the OC.

P:\Disease Management\CPHC Orientation Clinic Summary 090508.pdf

3. Using Open Access

Kaiser Permanente in Roseville, HealthPartners Medical Group and Clinics in Minnesota, Mayo Clinic's Primary Care Pediatric/ Adolescent Medicine team, and Alaska Native Medical Center reported improvement in reducing wait time for routine appointment, increasing patient satisfaction, increasing the percentage of patients who matched with their own physician, and decreasing the number of visits per patient by adopting open access. They gained capacity by doing the following:

- Offering every patient an appointment on the day they called the office.
- Questioning the frequency with which physicians brought patients back to the office for follow-up.

- Reducing future demand by maximizing today's visit.
- Using fewer appointment types to reduce the complexity of the scheduling system.
- Conducting group visits.
- Using improved care models to care for patients with chronic illnesses.
- Creating an effective telephone advice system that is seen as a service, not a barrier.

http://www.aafp.org/fpm/20000900/45same.html

4. Using Group Visits

In 2003, the Clinton Avenue Family Practice Center in Rochester redesigned medical practice to increase the efficiency and efficacy of care. They scheduled 90-minute group visits for eight to 10 diabetic patients at once. Two weeks beforehand, group members came in for lab work so their results were available during the visit. Some time of the group visit was taken up by administration — refilling prescriptions, taking vitals, noting address or insurance changes — but most of the time was devoted to answering patients' questions and discussing their illness. The group members' health status tracked from two years before group visits to one year after showed A1C, LDL and blood pressure had all improved significantly.

http://www.ihi.org/IHI/Topics/OfficePractices/Access/ImprovementStories/

http://www.ihi.org/IHI/Topics/OfficePractices/Access/ImprovementStories/NettingBetterResults.htm

5. Using Group Visits, Home Study Program, and Telephonic Information Sessions

Hill Physicians Medical Group in California used group visits, home study program, and telephone information sessions to improve access. The following are their accomplishments:

- Increasing compliance with clinical guidelines and improving quality scores by having group office visits for diabetes.
- Decreasing outpatient utilization in the year following a six-week home study program that included a weekly one hour video of a "Coping with Chronic Conditions" class/ support group and printed materials. The patients were given the opportunity, after watching the video, to call in for a telephone class/support group led by the psychotherapist in the video.
- Reducing demand for in-office visits to gastroenterologist by having telephonic information sessions, led by a gastroenterologist, on highly prevalent conditions (IBS, GERD and Hep C).

http://www.ihi.org/IHI/Topics/OfficePractices/Access/ImprovementStories/LowerTechCareDeliveryInnovationsthatWork.htm

6. Using Visual Aid Handout

CareSouth in South Carolina used visual aid handouts to enhance patient-physician communication and facilitate a working partnership between the providers and patients in the treatment of hypertension or other chronic conditions. The blood pressure visual aid handout consisted of a color thermometer and recognizable faces from smiling to frowning to indicate the patient's current blood pressure. There was also a very brief description of the importance of not only blood pressure goals, but also why it was important for patients to treat their blood pressure and how patients could help in their own care. As the patients became familiar with the handouts and the goals, recommended changes in medications became faster (less time needed to address the reason for the change) and more efficient.

http://www.ihi.org/IHI/Topics/OfficePractices/Access/ImprovementStories/UsingHealthLiteracyPrinciplestoImproveHypertension.htm

7. Using Phone-Based Triage, Treatment, and Patient Education

The Mayo Clinic in Minnesota introduced phone-based triage, treatment and/or patient education of adult viral URI/acute sinusitis and pediatric conjunctivitis across primary care sites. The clinic was able to decrease office visits for adult patients with URI/acute sinusitis and pediatric patients with conjunctivitis by 80 percent within an 18-month time frame.

http://www.ihi.org/IHI/Topics/OfficePractices/Access/ImprovementStories/MemberReportStandardizePhoneBasedTriageTreatmentandPtEducation.htm

8. Encouraging Physician Volunteerism

The Buncombe County improved access by using physician volunteers to provide free physician services. Lead physicians were identified to actively recruit physicians to participate in the program. Since the inception of the program in 1996, the participation among physicians has increased from 25% (the percentage who volunteered at the free Doctors' Clinic) to 90%.

http://www.physiciansinnovation.org/files/downloads/projectaccess_ncmj_winter_02.pdf

9. Offering Physician Loan Repayment

New Hampshire aims to recruit at least 50 new PCPs to practice in New Hampshire with an emphasis on medically-underserved regions of the state by offering physicians loan repayment of $40,000 over 2 years.

http://www.explorehealthcareers.org/en/Funding.45.aspx

http://www.unh.edu/chi/media/documents/NHCHIWorkforceReport.pdf

10. Improving Provider Recruitment and Retention

CareOregon increased its ability to serve Medicaid patients in Oregon by implementing the following:

- Encouraging specialists to use physician extender-- Physician's Assistant triaged surgical cases and provided some non-surgical treatment.
- Simplifying referral and authorization process -- stopped requiring referrals for many specialty categories, e.g., cardiology, oncology, pulmonology, GI, neurology and nephrology.
- Increasing the number of patients a provider could serve per day by paying providers for telephone consultations.
- Providing a grant for PCPs with >300 members to initiate programs like complex care management, reducing health disparities, and improving access to care and office efficiencies.

http://www.cmwf.org/usr_doc/852_Brodsky_best_practices_specialty_provider_recr.pdf

11. Improving Provider Satisfaction

The Community Health Plan of Washington improved efficiency and reduced administrative burden on physicians by implementing the following strategies:

- Simplifying claims submission, referrals, and credentialing.
- Providing an on-site administrative coach to bolster medical practice efficiencies, e.g., a coding coach to train clinic staff on coding and documentation.

http://www.cmwf.org/usr_doc/852_Brodsky_best_practices_specialty_provider_recr.pdf

12. Using PCPs and Clinicians Differently

Kern Medical Center Health Plan in Kern County used PCPs as champions to provide limited specialty care according to guidelines instead of referring patients to specialists, with specialists agreed to be reimbursed in return for being on call to respond to questions by PCP champions.

Marin Community Clinic arranged a six-month mini-residency in a dermatologist's office to train PCPs to handle less complex dermatology issues. Marin Community Clinic paid PCPs for their time spent in training. PCPs now staff on-site dermatology clinic and treat all in-house dermatology referrals (skin cancer screening, psoriasis, acne, inflammatory skin conditions) except complex cases, which are referred out.

Petaluma Health Center implemented the following strategies to improve efficiency and access:

- Hired "circuit rider" anesthesiologist to provide support, training and consultation for pain management primary care practice at three local clinics; developed comprehensive pain management program that standardized the management of

high-risk pain patients in which all family physicians were taught how to run structured pain management group visits. Decreased provider turnover was the most important result, since this challenging population was spread equally among all providers, in an organized, coordinated fashion.
- Physicians organized early morning weekly training/educational sessions for midlevel providers to increase their skills with skin biopsies and suturing; headache management; endometrial biopsies and IUD insertions; and orthopedic procedures such as splinting, casting and joint injections; initial orthopedics advanced training was obtained through NPI by two primary care providers.
- FNPs encouraged to assume specialty focus in addition to their primary care panel (hepatitis B and C management; diabetes; Coumadin clinic; pap/colpo management; OB ultrasound; asthma; wound care).
- Organized training/mentorship arrangement with local (broadly trained) private practice family physicians so three physicians could learn vasectomies.
- Spread medical director duties among physicians as an administrative "specialty" interest, creating four associate medical directors, each with a specific focus: technology, quality, hospitalist program, and operations. This increased physician investment in the clinic, improved leadership skills, and allowed faster pace of quality improvement and program expansion.

http://www.pachealth.org/docs/DiscPaperExpandedScope.pdf

13. Recruiting Frequently Used Non-contracted Providers

Hudson Health Plan in New York used the following strategies to increase access:
- Identifying non-participating specialists who submitted claims with frequency to potentially recruit them for the provider network.
- Providing quarterly site visits to PCPs and high volume specialists to troubleshoot provider complaints, introduce new administrative practices, and review QI initiatives.
- Awarding gifts based on performance, e.g., a Palm Pilot to providers who exceeded the state's QI score.

http://www.cmwf.org/usr_doc/852_Brodsky_best_practices_specialty_provider_recr.pdf

14. Reducing Demand for Ophthalmology

The Atlanta VA Eye Clinic was able to reduce demand for ophthalmology visits by adopting the following:

- Discontinuing routine yearly follow-up appointments for patients with normal eye exams.

- Instituting a Diabetic Screening Clinic for patients with diabetes. The clinic followed a strict protocol in which patients completed a questionnaire, were screened, and then had their retinas imaged with a digital camera (done by a Certified Ophthalmic

Photographer). Then the retina specialist reviewed the screening exam, read the images, and determined the appropriate follow-up. Because this work was done after hours or between clinic visits, the demand on regular clinic hours was reduced.

http://www.ihi.org/IHI/Topics/OfficePractices/Access/ImprovementStories/AdvancedClinicAccessTheCaseofAtlantaEyeCare.htm

15. Improving Utilization Management, Claims Process and Provider Relations

The Neighborhood Health Plan of Rhode Island improved access for their Medicaid members by offering the following:

- Incentive payments to providers determined according to performance in quality improvement, patient access, patient satisfaction, disease management, capital improvements, and administrative process.
- Eight new case management programs added to their UM program.
- Discontinuation of referrals for most specialty services, with the exception of audiology, obstetrics, physical therapy, plastic surgery, and podiatry.
- Enabling services provided to improve members' access to care (e.g., helping members arrange for transportation to and from their medical appointments). This reduced the number of missed appointments.
- Dedicated customer service telephone line installed for providers.

http://www.cmwf.org/usr_doc/852_Brodsky_best_practices_specialty_provider_recr.pdf

16. Streamlining the Consult Process

The Cardiology Clinic at the Cincinnati VA streamlined the consult process by triaging referrals and discharging patients to their PCP. The clinic performed "consult triage," directing patients into specific clinics as indicated. Consult triage allowed 15 to 20 percent of problems to be answered without the patient having to be seen in the cardiology clinic. The clinic discharged patients who were stable, with no hospital admissions or medication changes to their PCP.

http://www.ihi.org/IHI/Topics/OfficePractices/Access/ImprovementStories/CardiologyClinicatCincinatti.htm

17. Implementing a Disease Management Program

North Carolina began a pediatric asthma disease management program in 1998, which was found to lower hospital admissions by 34% and emergency room visits by 8%. Although medication costs rose (an expected result), the average episode cost for children was 24% less than for other children.

http://www.kff.org/medicaid/upload/Medicaid-Disease-Management-Issues-and-Promises-Issue-Paper.pdf

http://www.cga.ct.gov/2006/rpt/2006-R-0550.htm

Other Strategies to Consider:

- Subsidizing salaried positions at clinics or hospitals.
- Buying blocks of physician time to see members.
- Providing funding to recruit and support specialist positions at clinics.
- Bringing specialists to PCP setting if the service demand is large enough.
- Arranging for specialists to visit specific clinics on a regular basis to provide care in return for payment, with the HP taking care of all the administrative details.
- Paying Medicare-level rates to some types of physicians to ensure adequate access.
- Helping members connect with community resources.
- Facilitating access by noting on the Provider Directory the bus stops closest to each physician.
- Expediting patient access to specialty services via telemedicine consults.
- Contracting for certain special services – such as open-heart surgery – at the plan level to serve members of all the medical groups. Groups would not have to worry about recruiting particular specialists if they could access this plan-wide super panel.
- Aligning compensation with access goals.
- Increasing return visit intervals.

http://www.chcf.org/documents/insurance/AccessToSpecialtyCareForCalifUninsuredReport.pdf

http://www.chcf.org/documents/policy/AccessToPhysiciansInCAPublicProgramsIB.pdf

http://www.chcf.org/documents/policy/MediCalPhysicianNetworks.pdf