# PRIMARY CARE FIRST

CLICK HERE FOR LARGER MAP
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St. Lawrence River
Appalachian Mts.
Quebec
Van Buren
St. John River
Caribou
New Brunswick
Eagle Lake
Presque Isle
50 mi
50 km
Baxter State Park
Houlton
St. John River
CANADA
Longfellow Mts.
Mt. Katahdin
Fredericton
Millinocket
Quebec
Moosehead Lake
Maine
Lincoln
St. Croix
Penobscot River
Calais
Kennebec River
Old Town
Eastport
Bangor
Androscoggin River
Waterville
Ellsworth
Belfast
Bay of Fundy
Augusta
Acadia Nat. Park
Lewiston
NH
Brunswick
Rockland
Nova Scotia
Westbrook
Gulf of Maine
Portland
Biddeford
Atlantic Ocean
MAINE
LOW
HILLS
MTS
Kennebunkport
Concord

## THE JOB OF A PCP

DIAGNOSE , TREAT, AND PREVENT

## GOOD CARE MEANS

ACCESS
CONTINUITY
CARE COORDINATION
COMPREHENSIVE CARE

## AND SOME WOULD ADD:

CONTROL COSTS (REDUCE ER AND HOSPITAL ADMITS )

THAT PATIENTS CAN SAY THEY GET EXACTLY WHAT THEY WANT AND NEED WHEN THEY WANT AND NEED IT –AN AWKWARD PHRASE BUT USEFUL METRIC DREAMT UP BY DON BERWICK AND FRIENDS

# WHY THE CURRENT SYSTEM FAILS PART 1

-**Face to face visits** are the major way physicians get paid but are unnecessary (oximeters, nebulizers, bp cuffs ,email with smart phone photos all are available to consumers), are expensive, do not fit patients' needs, and are difficult for this population.

-**Coding and billing** is cumbersome , subject to penalties, and poorly matched to real scenarios.
Example: a Medicare wellness visit + an E and M code + a vaccine requires 4 cpt codes, 1 modifier, and a wellness dx + at least one dx code, + a dx code for the vaccine and for the vaccine administration code.

# WHY THE CURRENT SYSTEM FAILS PART 2

-**Non F to F code requirements are impractical**

-30 days of babysitting the code for Transitional Care Management

-Calendar month and two conditions for Chronic Care Management

-CCM can be denied and repayment demanded if the patient needs hospitalization in the same month

-PCPs are spending 30% of their time doing **unpaid administrative chores** – which often net payment to others, when they could be seeing patients .

Example Physical Therapy plans of care

# PART 3

PAYMENT IS JUST  FRANKLY INADEQUATE

COST TO TAKE CARE OF THE AVERAGE MEDICARE PATIENT AGE 72 WITH HIGH BP, DIABETES AND ARTHRITIS ?

ESTIMATE  PHYSICIAN'S  TIME $150/HR AND MA @ 15.00/HR

ASKING FOR THE MONEY IS 8%

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# PART 4

-**3** visits a year
-Review **2** sets of labs/year, record, communicate, tickler.
-Preventative care- explain ,order, record, tickler .
-Take **3-6** phone calls from them and family.
-Calls from pharmacy / med prior auths or re- do med as coverage changes/ send to patient assistance program / explain good rx/change pharmacies
-Record metrics
-Forms for driver's license, sleep apnea masks , form + note to DME for walker or glucometer but glucometer must be done on separate piece of paper than lancet or strips. And rite aid requires an entire form
-Sign off Physical Therapy Plan of care

-etc etc etc.

**Current payment**:

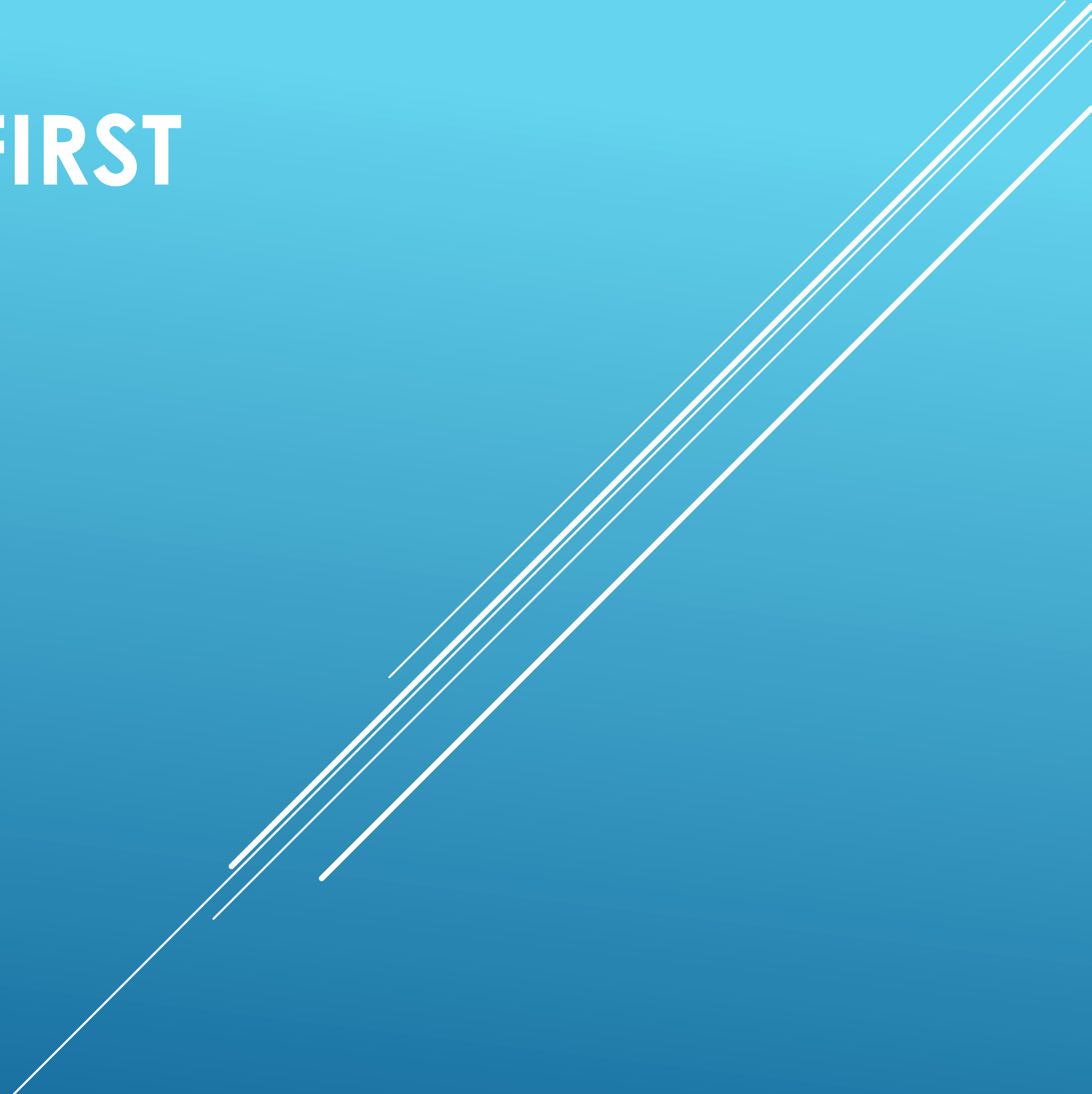
3 visits a yr is 139+ 200= 339+ 2x 99490=84-→ **$423.00**

**Current costs to practices**:

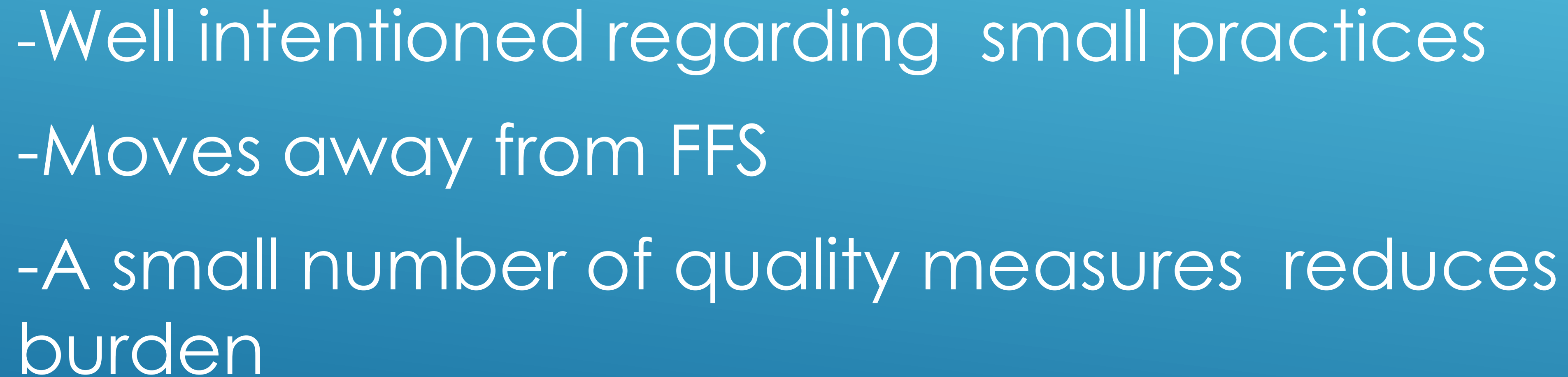
Time is approx. 4 hrs physician and 2 for MA→**$630.00**
630-423= $207 free work/patient/yr and x 100 patients= **$20,700** loss"free work/small practice/yr

# PRIMARY CARE FIRST

STRENGTHS
PROBLEMS
EXAMPLES
SOLUTIONS



# STRENGTHS



# PROBLEMS

--Small practices are excluded

-F to F  visits are encouraged

-Not transparent

-Demonstrates lack of knowledge of on the ground  mechanism of practice

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# EXAMPLES

-Colon cancer screening measure.

Will require financial loss and increased work for the 2/3 of patients who choose FOBT ( cost to buy vs reimbursement and work involved).

-Being paid for average groups of patients esp. in small practices

-Lack of payment transparency for a practice.

-Unrealistic bonuses ;27% of $24 is $6 and 13% of $24 is $9 so $24 →$33/ month.

-Cost of billing remains same though the bill for $50.00 generates a beneficiary balance equal to the cost of billing.

# SOLUTIONS PART 1

-Implement  the PTAC recommended proposals

-Open models to any and  all willing practice
-Include social determinants of health when estimating risk
-Risk  / patient
- Pilots
-Empower non  face to face

# An Innovative Model for Primary Care Office Payment

**https://aspe.hhs.gov/system/files/pdf/255906/ProposalAntonucci.pdf**

-Risk assessment(/patient), and quality outcomes both from a patient reported outcomes tool with social determinants of health and the 4 Starfield attributes included . Low burden. Free to small practices.

-Risk adjusted into low and medium risk, and high risk .

-Capitation monthly by patient

-Transparent payment

-Performance risk

- Drawn from boots on the ground innovative practices' work

"The Committee members believed that the key elements of the proposal were very innovative and had the potential to improve primary care quality and access, particularly in communities served by small and rural primary care practices."

# SOLUTIONS
# Part 2

# OTHER DANGERS

Whining

Language

Trust

AND FINALLY A
BRIEF STORY

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