Primary care provides first line access to healthcare, providing high quality care in an efficient manner, with an emphasis on patient experience. However, due to barriers surrounding access to primary care, many patients do not get the care that they need, allowing disease to worsen to the point that care is given in settings such as the emergency room or in the hospital.

At Coastal Family Medicine, our panel size is approximately 4,000 patients. 56% of our patients have primary Medicaid coverage with an additional 13% having secondary Medicaid coverage. Assessing our panel, we noted multiple social determinants of health that negatively impact our patient’s care. To begin addressing this, we created screening tools within our EHR to identify these factors. In the national literature, the most common barriers include distance to care, difficulty with multiple appointments, accessibility of appointments, and cost of care (Carrillo 2011). Another study showed that approximately 21% of the general population have nonfinancial barriers to care, however, 66.8% of the population with financial barriers also noted to have nonfinancial barriers (Kulgren 2007). This reflects the confounding effect that poverty has towards social determinants of health. A 2015 survey of 110 Coastal Family Medicine patients yielded similar results to the national studies with distance to the clinic (52 responses, 47%), clinic availability (40 responses, 38%), difficulty being able to make it to different clinic sites (25 responses, 23%), and hours of operation (33 responses, 30%) being the most common patient identified barriers to care for our population surveyed.

During a two-day Kaizen in effort to align with strategic priorities with New Hanover Regional Medical Center and improve clinic flow for our patients, the overall patient experience was assessed to see what aspects of the clinical experience could be improved. The first phase to improve care for our patients established a home visit program in 2015. This was designed to bring care to our sickest patients who had limited mobility and are home bound eliminating the barrier of distance to the clinic. These patients had the greatest Emergency Department (ED) visits and admissions. In phase two, which began in 2016, a walk-in clinic at Coastal Family Medicine was created to address our patients need for acute or same day care. In early 2018 Coastal Family Medicine began phase three by creating a no-show letter and call service which was directed at individualized patient barrier plans. The no-show and call service utilized our Community Care of the Lower Cape Fear (CCLCF) social worker who called those Medicaid patients after a no-show to Coastal Family Medicine clinic visits. With these calls the social worker would assess for patient barriers to care and assess what could be done to eliminate those barriers. No-show letters were also sent to patients and provided a direct line to call the clinic with instructions to call to discuss barriers to care. In April of 2018 Coastal Family Medicine clinic went into its fourth phase; which involved moving the lab testing from an affiliate office to inside the clinic. This directly combated the barriers patients had with having different clinic sites. The project has been a multi-year evolution and a systematic breakdown of barriers. With this, we have seen a decrease in admission rate, ED utilization, and lower cost than expected for our clinic’s Medicaid patients as well as other improvements in patient quality of care.

Introduction

Phase 1

- Phase 1 results through with home visit program resulted in an 85.2% decrease in emergency room use and 80.1% decrease in inpatient admissions for our highest risk patients (Figure 2-3).
- Phase 2 results through our walk-in clinic resulted in a 28.0% decrease in Medicaid admissions. The ratio of low acuity diagnoses seen in the hospital vs the clinic also shifted, with an increase in low acuity diagnoses seen in the clinic (Figure 4).
- Phase 3 results utilizing our CCLCF social worker and no-show follow ups have helped get more patients to the clinic, further improving our trends seen in Figure 7 for ED use and inpatient admissions.
- Phase 4 results with our in-house phlebotomist and Diabetic eye camera showed a large jump in lab order completion rate (Figure 6) as well as Diabetic eye screening rates (Figure 5). This improved the quality of care our patients were receiving by eliminating the barrier of multiple appointments/locations.
- Other Findings: As shown in Figure 7a, cost of care at our facility is approximately $40 per month per Medicaid patient less than expected.
- Our inpatient admissions for Medicaid patients are 38% below expected (Figure 7B, 7C), and our Medicaid Emergency room use is 13% less than expected with a continuing downtrend since starting our project.

Discussion

This project and process have been very exciting for Coastal Family Medicine and helps to explain the improved patient care that has been realized in patients identified barriers to care can have on medical care. It also has shown the improvement that can happen when taking the proper steps to eliminate these barriers. With the changes of managed Medicaid nearing and other discussions of value based care, these results are of importance to our medical system. Not only have these interventions showed a decrease in inpatient and emergency room use in Medicaid patients, our cost per patient per month remains $30-40 a month less than expected (Figure 7A). If you add this cost to the 2,296 patients on our panel primarily insured by Medicaid, this amounts to $68,000-91,000 a month at our facility costs less than expected to the Medicaid system. From their expected data we are 5.6 ED visits per month lower and 5.3 inpatient admissions per month lower than expected for Medicaid patients. The data shows clear decreases since the start of our project focusing on patient identified barriers to care.

Medicaid’s “Meaningful Measures” initiatives as well as Atrium’s Destination 2020 are a focus of this project through the following pillars: communication and coordination of care and decreasing admissions to the hospital, promoting effective prevention and treatment of chronic disease through improving our preventative care and management of chronic diseases, working with communities to promote healthy living by improving equity of care, improving affordability of care by improving appropriate use of healthcare settings and utilizing patient focused care, and strengthening patients to partner in their care by personalizing and aligning care to patient goals. Our project also meets Medicaid’s secondary goals to eliminate disparities, safeguard public health, achieve cost savings, improve access, and reduce burden to the system all through measurable outcomes and impact.

Every patient population has different sets of barriers to care. If a healthcare system wants to deliver the highest quality care possible these barriers need to be studied and steps taken to eliminate. The Medicaid population has been shown by multiple studies to be at higher risk of missing care opportunities and utilizing the emergency room for care. We have been taking the steps to bridge this gap between Medicaid patients and their care. With Managed Medicaid on the horizon we feel confident that our process will benefit both our patients and our healthcare system. We have been able to bring higher quality care to our patients while keeping inpatient admissions, Emergency room use and overall cost down. Much of this success is due to four phase improvement process focusing on patient identified barriers to care.

Resources


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