

Workgroup I: Primary Care (Ambulatory URI)

The first session of the Arkansas Healthcare Payment Improvement Initiative Primary Care Workgroup convened on November 3, 2011 to discuss opportunities to ensure the quality and efficiency of patient care in Arkansas. The workgroup meeting was the first in a series of discussions, which will inform the design and implementation of a new payment model.

Approximately 30 Arkansas healthcare professionals and patients were in attendance at the first workgroup, representing perspectives of patients, providers (internists, family medicine physicians, pediatricians, pharmacists, nurses), hospital leaders, advocacy groups, public health experts, nonprofit administrators, government officials, and others.

The first workgroup focused on ambulatory URIs. Key components of the discussion are summarized below.

KEY COMPONENTS OF WORKGROUP 1 DISCUSSION

- There was broad agreement around the importance of patient experience, evidence-based practice, and efficient delivery of care. In particular, workgroup participants highlighted the opportunities in Arkansas to:
 - *Invest in managing URIs remotely without the need for patients to visit a clinician:* The group discussed the potential to listen to symptoms, determine whether an office visit is warranted, and educate patients about the typical course of URIs by phone or email, but described resourcing challenges since remote consultations are not reimbursed. The group agreed that a new payment model should reward providers for investments in managing URIs outside of a clinical visit.
 - *Decrease visits for URIs to emergency departments and urgent care clinics:* Workgroup participants agreed that many URI patients visit emergency departments or urgent care clinics instead of primary care providers, incurring greater costs than they would in a lower setting of care. The group discussed that busier clinicians in these settings of care were more likely to order imaging, tests, and antibiotics and less likely to be able to spend time on patient education. The group noted, however, that emergency departments are attractive to patients due to lack of co-pays and ability to see clinicians outside of work hours.
 - *Promote more appropriate use of imaging and diagnostic testing:* Workgroup participants noted that clinicians often order imaging (e.g., chest or sinus x-rays) or laboratory testing (e.g., CBC, cultures) in cases where evidence-based clinical guidelines suggest these tools add little or no

diagnostic value on top of what is known from patient symptoms and a physical exam. Practice time pressures and additional revenue from imaging and tests were mentioned as some reasons for overuse of these tools.

- *Promote more appropriate prescriptions of antibiotics:* The group agreed that there was significant variation across providers in the rate of antibiotic prescription (e.g., proportion of ARKids children with URIs receiving antibiotic prescription by county varied from 11% to 66%). Participants noted that clinicians often prescribe antibiotics without indication due to patient demand or practice time pressures.
- Workgroup participants agreed that the current fee-for-service payment model fails to align incentives and does not reward providers who excel at patient education, efficient use of diagnostic tools, and appropriate use of antibiotics. The group viewed a new payment model as a promising mechanism to achieve many of the opportunities discussed to improve URI care.
- The workgroup discussed the need for payment design and implementation to take into account several important elements, including:
 - *Case load severity:* The proportion of office visits leading to diagnostic tests or antibiotics could increase if provider investment in patient education were to limit avoidable clinic visits. As a result, the appropriate rate of diagnostic test utilization and antibiotic prescription might vary based on practice structure.
 - *Non-medical reasons for patient visits:* Several non-medical factors outside of provider control may lead patients to visit clinicians for URIs (e.g., the need for a physician note as a school or work excuse; refusal of some day care clinics to re-admit children recovering from URIs without antibiotics; Medicaid’s coverage of OTC drug costs only after prescribed by clinician).
 - *Impact on provider structure:* Achieving opportunities to move URI care to more evidence-based practices may lead to significant changes in the structure of how primary care is provided.