Embedding a Specialist Within Primary Care to Improve Access for Low-Complexity Indications

Brynn Howard, M.H.A., Stephen Fischer, M.H.S.A., Julie Jensen, M.S. S., Ph.D., Jonathan Torres-Burton, M.A.
Mayo Clinic, Rochester, MN

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Background
Every year, 1.3 million people seek care at Mayo Clinic from highly specialized experts who treat rare and complex conditions. In addition to tertiary and quaternary care, primary care providers and generalists are providing care coordination for community, employee, and destination patients whose symptoms range from low complexity and acute to high complexity and acute.

Historically, there has been no operational process to differentiate symptom groups, resulting in high and low complexity patient populations competing for the same specialty access. This results in longer wait times and unnecessary utilization of subspecialist resources.

Methods
Implementation Methods: The Spine Center allocated 0.5 physician FTE to embed in primary care as “integrated community specialists” (ICS). ICS calendars were built with appointments and designated time for curbsides and electronic consults. The ICS providers developed criteria to triage incoming appointment requests to determine the type of consult the patient needed: ICS, Spine Specialty Clinic, electronic or curbside consultation (Figure 1).

Research Methods: Pre/post implementation data were collected from scheduling and finance databases to assess impact to patient volumes in ICS and Spine Specialty clinics.

Objectives
The goals of embedding a specialist in primary care:
1) Improve timeliness and access for community patients and employees by having low complexity and acute issues addressed within the primary care setting;
2) Facilitate “curbside” consultations, in which the primary provider and specialist are able to discuss patient issues and determine the best plan of care without patient requiring an appointment with a specialist;
3) Improve specialty clinic capacity for patients who require a higher level of care;
4) Reduce the specialist FTE required to appropriately address the needs of low complexity patients; and
5) Increase new referral capacity in the specialty surgical and procedural practices.

Results
• Integrated Community Specialists reduced primary care referrals to the Spine Specialty Clinic by 70% over one year (Figure 2).
• Spine Center specialty appointments for patients requiring a higher level of care increased from 588 in 2016 to 807 in 2017 due to open capacity from removing low complexity patients.
• The orthopedics and neurosurgical spine practices experienced a net increase of 208 surgical cases between Q4 2016 and Q4 2017.

Conclusions
Embedding a Spine specialist into primary care has provided 1) more rapid consultations in the primary care environment and 2) open capacity in this spine specialty practice for high complexity referrals. Curbside consultations with the embedded specialist resulted in educating primary care providers on the optimal spine care plans and patients not needing to see a specialist. By 2018, the embedded Spine specialist had become oversubscribed with appointment requests, requiring the FTE allocation to be revisited.

Lessons Learned
The successful implementation of an embedded Spine specialist within primary care has demonstrated an additional opportunity for an embedded Gastroenterology & Hepatology (GIH) specialist. This was successfully piloted for four weeks and will be fully implemented in January 2019.

Embedded GIH Pilot Results:
• 25% reduction in the number of referrals of low complexity patients to the GIH specialty practice.
• 100% of patients were seen 0-2 days after the primary care provider.
• Improved access to GIH specialist by reducing appointment times to 30 minutes for low complexity indications.

Thank you to our team of physicians and allied health staff. Contact Information:
howard.brynn@mayo.edu
torrensburton.jonathan@mayo.edu