(Archived) Domain 2 Project Discussion Subgroup

Participation of primary care and specialist doctors

1. Do you think it would be helpful, or harmful, to include PCPs in discussions about teamwork, integration of professionals and staff, handoff protocols, inclusion of EHRs, time studies and budget discipline in the earliest stages of the DSRIP process?
2. For disease management, prevention and other value-based services to support wellness, do you think experienced, and possibly retired or retiring, SPECIALISTS would consider taking positions as manager-PCPs in a transformed public health primary care delivery system?
3. At the January 13 NY Academy of Medice/PCDC meeting on Primary Care/DSRIP, a lone newly graduating doctor trained in primary care asked the panel, "what incentive is there for me to continue in the public health delivery system when I can hope to pay off all my loans in a reasonable period of time if I go elsewhere or become a specialist?" The answer from the speakers was that, "we will make the practice of medicine more fun, and maybe some of your loans will also be paid off for you." He did not seem to be impressed with this response. Is there a strategy for attracting the 'best and the brightest' to public health, especially for the limited five years of the DSRIP funding and incentives?

Question by Daniel Kalin 3

On march 05, 2015 at 16:32 - 83 views, 5 replies, 4 followers

Doctor Participation

Hi Daniel, and thank you for your questions.
I think that collaboration is clearly a key success factor within all aspects of DSRIP planning and implementation. Jason Helgerson himself appears to have the word etched in his skull! (check out his response to a similar question on regional collaborations during yesterday's live Q&A event: https://www.ny-mix.org/challenges/8-challenge-7-live-q-a-with-jason-helgerson...). In addition, our third challenge (integrating downstream providers) touched on some of these issues and holds some excellent discussion.
A couple of follow up questions for you (and others): given that collaboration is such an important aspect of the DSRIP process, are there specific examples that you have observed (or hope to observe) that you could share with the community here that could be "leading practices"? Additionally, what do you think would help to attract the "best and the brightest" to participate in the future public health delivery system?

By Darryl King, 11 months ago 0

Would suggest that the world of Disaster Response across multiple fed, state and local governments might present a useful planning approach. Because so many disparate agencies need to temporarily come together for specific disaster response, these agencies have learned to develop a COMMON OPERATING PICTURE detailing the shared objectives and goals. From there, each organization identifies its own role and responsibilities it has within that Common Operating Picture, along with key planning assumptions concerning its capacity to participate. From there, each organization outlines its own work flow, assigning specific roles to specific people who in turn create their JOB ACTION SHEET which details the specific tasks that need to be completed along with a timeline and how they will share SITUATIONAL AWARENESS for particular resident/patient/client events. I worked with Enterprise Community to adapt this approach for affordable housing organizations and many of these resources will come online on their website in June.
Breaks it down to enable everyone to contribute to COMMON goals without imposing process on them. Instead, each organization creates its own process which needs to circle back to align with the COMMON OPERATING PICTURE.
Am happy to share more insights about this with anyone, just send me an email.

By Peg Graham, 11 months ago 1

Upstream, downstream–the Hudson flows both ways down here in the Bronx, and so should the view of public health, collaboration, and the installed network of primary care providers who–hold your breath-provide the bulk of health services, and who are able to maintain low rates of admissions and readmissions for their patients, when permitted.
As an attending at both the Montefiore system and Columbia system, I can get scant information on my patients from either. Discharge information is sketchy at best. Fees by payers are less, and medicaid in NYS has decided to let my fees plummet by 42%. Yet no PPS has approached our NYS Academy of Family Physicians unless we pound on the door, and then we are told about how DSRIP will make practice fun and rewarding.
Can I see some contracts? Will we in primary care be on committees? Or is it time for independent practice to give up? Will the losses to the community health centers somehow be made up by the giant entities who are buying hospital systems with borrowed cash from venture capital, hoping to pay it back with cash flow from DSRIP?
The COMMON OPERATING PICTURE is not one of collaboration until the department of health, and perhaps the attorney general, looks into the monopoly control of funds to large entities, and the drying up of resources to independent practices and community health centers, not to mention other community service providers.
My independent family practice, and those of many of my statewide colleagues, have survived through meticulous frugality in management, and close attention to patient needs. Further cuts to our payments in the name of 'value' will undercut this fragile business model, and increase the use of EDs.
We are eager to unite with public health initiatives. I have no trouble recruiting my peers to public health projects that are funded. But all too often, the doors today are closed to our groups by large, competing entities. What is the plan to address the situation on the ground of exclusion of independent primary care from networks and information systems?

By Bob Morrow, 11 months ago 1

Darryl,
Thanks for responding and engaging.
1. Examples of integration:
How about looking at 'Chrystal Run's' experience, a multi specialty practice that claims to have reinvigorated, integrated, reorganized using teamwork & best practices, and from my napkin calculations, seems to have increased its patient panel size by a factor of 2 times, why keeping expenses almost constant?
Example #2 should come from physicians like Dr. Morrow here. The system needs to be responsive to his needs because primary care physicians are rare, and getting rarer, and the U.S. is already overbalanced with Specialists (ie 70%) versus primary care docs (ie 30%), when the need, especially to implement DSRIP objectives, is more like the reverse.
2. How to attract 'the best & the brightest'?
A) the 'best and brightest' need: better starting pay, better training, more power to make changes, and mentors they respect, can work in teams and can help negotiate with stalwarts of the current healthcare delivery system provide mentoring/ leadership training for 'the best and the brightest' new recruits.
B) the two best ways to find more primary care docs:
I. promote/retrain specialist docs (to manage/lead/develop disease-management protocols/best practices and prevention/wellness programs, and
II. Train/encourage new graduating doctors to commit and stay in primary care.
iii. Both require incentives: $400,000 salaries for the former and full payment of ALL student loans

By Daniel Kalin, 11 months ago 0

Darryl, continued
Student loan reimbursement amounts should carry a minimum value of $250,000 (remainder is bonus) and both incentive packages require 5 year guarantees, and various practice expectations (ie teamwork with ALL levels of staff/integration, etc).
Iii. To pay for the leadership packages, the model needs to become more integrated, wellness strategies need to work and less sickness will enable larger overall patient panels.

By Daniel Kalin, 11 months ago 0

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