Patient Access to Primary Care

Problem:

Throughout our region, patients seeking appointments with a primary care provider are experiencing longer wait times, sometimes nearly three months to obtain a physical exam, while new patients may have to wait as long as six months for an appointment for a physical. With these barriers, emergency department visits are on the rise, and complications related to chronic disease are becoming more prevalent; this ultimately increases the cost of health care, while creating more demand for services. Fostering greater levels of efficiency and employing a population health approach is needed to improve access and the quality of care we provide.

Goals:

1. Assure timely access to primary care appointments.
2. Build capacity to accept new patients and meet the needs of our community.
3. Ease the impact of chronic disease on our patients and on healthcare resources.
4. Reduce unnecessary emergency department visits.

Objectives:

1. Establish mechanisms to measure capacity and patient access.
2. Evaluate clinic work process to maximize efficiency.
3. Develop practices that capitalize on efficiency, allowing more readily available appointments and the ability to accept new patients.
4. Build care management and population health initiatives to improve access and the health of our community.
5. Achieve these objectives while reducing the administrative burden on our providers, in order to prevent exhaustion and burn-out.

Actions and Resources:

Grace Cottage Family Health has 11 primary care providers working tirelessly to serve the needs of our community. They care for patients of all ages with a wide range of health conditions. Together with a team of nurses, referral coordinators, and scheduling staff, they care for 7,600 patients.

1. Statistics will be generated monthly and compared to national benchmarks. These metrics will be used to gauge availability and capacity.
2. An assessment will be made of each area, with recommendations to assist in the best utilization of resources. Attention will be given to the quality of patient and provider experience.
3. Grace Cottage Family Health is committed to meeting the needs of our community. Once 90% of the capacity as defined in this initiative is met, primary care provider recruitment will begin, in order to meet the demand.
4. Medicare's Advanced Primary Care Management innovation program will be implemented to improve access and population health. Care management programs use care teams and care plans for a holistic and routine approach to caring for our most vulnerable patients. It has been demonstrated that they reduce the impact of chronic diseases, ultimately

reducing health care utilization, emergency department visits, and hospitalizations. Program enrollment will be measured, along with utilization of metrics among the participants.

5. Mobile Integrated Health will be explored collaboratively with neighboring facilities and our regional EMS service provider. This program capitalizes on the care management scheme discussed above, using the EMS service provider as a member of the care team. EMS care providers meet with patients in their home and routinely follow up with them to reinforce their plan of care. Programs such as these are known to reduce health care utilization and help to prevent acute exacerbation of chronic disease.

Cancer Screening and Prevention

Problem:

According to the Vermont Department of Health's 2025 Cancer Plan, cancer is the leading cause of death in the state, claiming more than 1,300 lives each year, with 3,800 newly diagnosed cases per year. According to the Vermont Department of Health's report, more than 36,000 Vermonters have had cancer at some point in their lives. The hardships on patients, families, and health care resources are immense, but can be greatly reduced with early detection; primary care is a crucial factor in prevention and/or early detection of cancer.

Goals:

1. Reduce the prevalence of cancer, through high-quality, accessible primary care and prevention.
2. The early diagnosis, intervention, and treatment of cancer, to prevent long-term complications and to improve quality of life.
3. Mitigate the wide-reaching impact caused by late-stage cancer diagnosis.

Objectives:

1. Foster primary prevention through community awareness, patient education, and screening for risk factors.
2. Track and monitor the use of clinically appropriate screening measures, including colorectal, breast, cervical, and lung cancers.
3. Track screening exam results to ensure timely follow up and referral to a specialist for all positive tests.

Actions and Resources:

1. Integrate the routine assessment of risk factors into the annual wellness and physical exam process. Use the information taken from these exams to consider educational and preventive approaches. Primary risk factors and preventive strategies to review include: routine annual physical exams; tobacco product use; obesity/body mass index; alcohol use; HPV vaccination; and food insecurity.
2. Build internal dashboards to track screening exam utilization. Align goals with the United States Preventative Task Force (USPSTF) and the Centers for Medicare & Medicaid's Quality

Measures for Colorectal Cancer (NQF 0034), Breast Cancer (NQF 0031), and Cervical Cancer (NQF 0032).
3. Define tools within the EMR and the care team to track screening exams and ensure a timely response for positive results. Develop metrics and monitoring of the referral loop—the process that starts with the initial order and tracks it through completion.

Vermont Department of Health's 2025 Cancer Plan

United States Preventive Task Force 2024-2025 Recommendations

Mental Health Treatment and Support

Problem:

Reported concerns about mental health have grown from 11% to 16% among Vermonters over 10 years of age, with 6% having considered suicide in 2021 (Vermont Department of Health, 2023). According to Kirkbride (2024) mental health is "inextricably linked to our life circumstances." His team places social conditions such as food security, housing, social support, safety, and access to affordable health care among the most important in "peoples' opportunities to realize safe, secure, prosperous, and healthy lives". Although these are some of the harder issues to face, awareness and helping when possible is essential in managing the health of our community.

Goals:

1. Improve our patients' quality of life.
2. Reduce the prevalence or reported severity of mental illness.

Objectives:

1. Understand the prevalence of social determinants of mental health within our patient population.
2. Outline connections between reported social determinants and pre-existing mental health conditions.
3. Explore opportunities and programs based on this understanding.
4. Select metrics to assist in monitoring the efficacy of proposed interventions.

Actions and Resources:

1. Incorporate social determinants assessment into the annual physical pre-visit planning or nurse-intake process.
2. Begin aggregating this data for evaluation and prevalence.
3. Assess patients with reported depression, anxiety, alcoholism, and substance use disorder, and the association of social causes.
4. Develop local and regional recommendations based on the first- phase discovery.

Vermont Department of Health (2024)

Kirkbride, J.B. et al. (2024). The social determinants of mental health and disorder: evidence, prevention and recommendations. World Psychiatry doi: 10.1002/wps.21160