



Monday Memo – February 16, 2015

Chairs' Corner: While our faculty are spread across Massachusetts and beyond, the core of our teaching programs are based within community health centers and at UMass Memorial hospitals in Worcester and Fitchburg. While CHCs are essential for the nation's safety net, what about clinics at teaching hospitals? The September, 2014 *Essential Stewardship Priorities for Academic Health Systems* from the Institute of Medicine points out that teaching hospitals provide crucial access to the safety net:

- Teaching hospitals represent 6% of hospitals but provide 40% of the nation's charity care, and
- 87% of teaching hospitals provide emergency psychiatric services, compared with 25% for non-teaching hospitals.

Like our CHC partners, our hospital clinics serve patients whose health is impacted by poverty, histories of trauma, language barriers, or lack of access to safe housing, education, jobs, transportation, etc. It can be challenging to care for patients whose circumstances cause them to forget doctor's appointments, who can't understand how to take their medications, or whose histories include deep secrets that shape their attitudes and behaviors.

Our hospital-based clinics serve another unique population, people with complex medical conditions, many of whom get specialty care in the same building. These are patients with traumatic brain injuries, developmental disabilities, or chronic neurologic problems; patients waiting for transplant surgery; patients with chronic mental illness and significant behavioral disorders; etc. Patients who came to see the specialist for a tertiary problem are referred to us because they have hypertension or diabetes or depression or insomnia, or they just need a PCP to talk to. If I watch the reception area, I'm astounded by the number of patients who arrive with a cane, a walker, a wheelchair, or a gurney. And the fact is that the hospital clinic is better equipped to welcome them – more wheelchair accessibility, more staff who understand their needs for durable medical equipment, etc.

This is who we are. I'm proud that we've recruited a faculty with a commitment to service, using a wholistic, biopsychosocial approach to care for patients who are chronically ill, who need special access, or who might behave just a little differently when they come in to register. We care for people who might arrive late or miss an appointment, have difficulty navigating our phone trees, or end up on a "hot spotter" list. Getting their glycohemoglobin checked twice each year may not be high on their priority list.

At teaching hospitals, there are even more patients who get their primary care in the specialty clinics, where it is fragmented, of low quality, and costly. New programs focusing on integrating Medicaid and Medicare services for dually eligible patients under 65 are starting to direct these patients to us, creating a new demand for primary care, as complex as it is.

These folks deserve high quality primary care, and our teaching practices have made the commitment to meet those needs. The data show that old fashioned primary care increases quality, reduces cost, and provides greater equity in health. Down the road, the new primary care systems we are slowly building within our teaching practices will further reduce fragmented, duplicated and unnecessary care, unnecessary emergency room visits or hospital admissions.

This is core to the mission of the academic health science center, where many of us trained. I've always believed that these settings are great for training family doctors. In addition to providing learners with a generalist approach to the full spectrum of family medicine, they provide them with experience in complex problem solving and expose them to systems of care that will serve them well, no matter where they go on to practice.

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