ACO Accelerated Development Learning Session

San Francisco, CA
September 15-16, 2011

Module 2A: Reshaping Care Delivery

September 15, 2011
3:30–5:30 pm

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Objectives for the Learning Module

- Why is primary care the essential foundation for any healthcare system?
- What are the problems with primary care in the United States?
- How should primary care be transformed as the ACO's foundation?
  - The primary care practice itself
  - The coordination of care between primary care, specialty care, in-patient care, and other services
- How can ACO leadership make this happen?

Each participant should write down two reasons why primary care must be the essential foundation for any healthcare system

Primary Care

- Persons who receive care in a primary care-oriented model are more likely to
  - Receive recommended preventive services
  - Adhere to treatment
  - Be satisfied with their care

  Bindman and Grumbach. J Gen Intern Med 1996;11:269
  Safran et al. J Fam Pract 1998;47:213
- Increased primary care to population ratios are associated with reduced hospitalization rates for ambulatory sensitive conditions

  Parchman and Culler. J Fam Pract 1994;39:123
- Healthcare costs are higher in regions with higher ratios of specialists to generalists

  Welch et al. NEJM 1993;328:621

Primary Care *continued*

- Dartmouth Atlas demonstrates that per capita Medicare expenditures in certain regions of the country are far higher than in other regions. In 2007:
  - Miami, Florida: $17,274
  - Portland, Oregon: $6,857
  - LA, NY, Miami, Chicago are high
  - Seattle, Minneapolis, Denver are low
- Per capita Medicare expenditures are almost three times higher in Miami than in Portland
- These differences are not explained by demographic, socioeconomic, or burden-of-illness factors
- Higher-cost areas tend to have a greater preponderance of specialists; lower-cost areas have more primary care
- Quality of care for certain measures is no better in the higher-cost areas

Fisher et al. Ann Intern Med 2003;138:273, 288
Fisher. NEJM 2003;349:1665

Primary Care *continued*

- 24 common quality indicators for Medicare patients: high quality significantly associated with lower per capita Medicare expenditures
- States with a greater ratio of generalist physicians to population had higher quality and lower costs
- States with a greater ratio of specialist physicians to population had lower quality and higher costs

Baicker and Chandra. Health Affairs Web Exclusive. April 7, 2004.

Primary Care *continued*

- Adults with a primary care physician rather than a specialist as their personal physician:
  - 33% lower annual adjusted cost of care
  - 19% lower adjusted mortality, controlling for age, gender, income, insurance, smoking, perceived health (SF-36) and 11 major health conditions

Franks and Fiscella. J Fam Pract 1998;47:103

Primary Care Works, but …

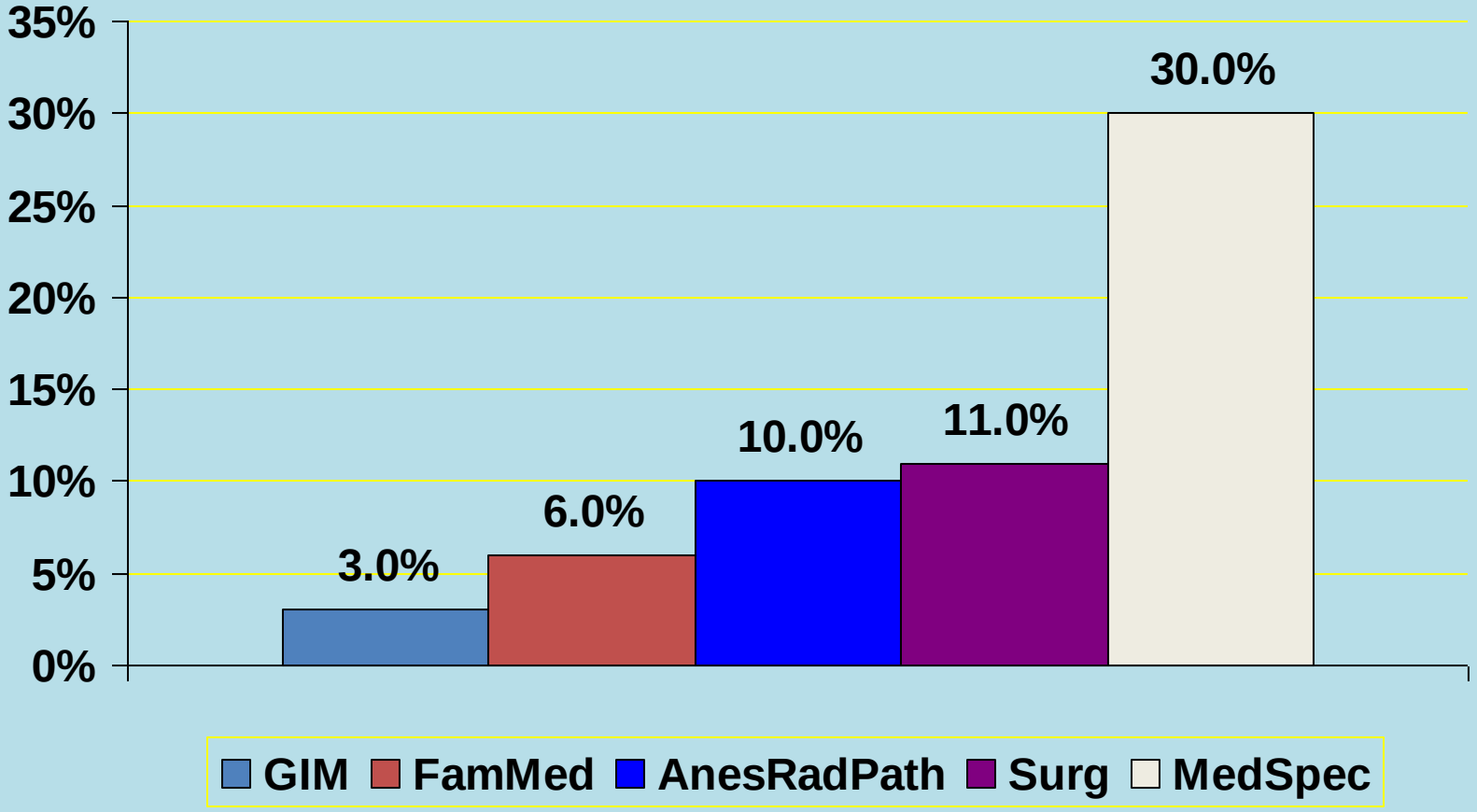
American College of Physicians (2006):

> *"primary care, the backbone of the nation's health care system, is at grave risk of collapse."*

The Crumbling Primary Care Home

- Plummeting numbers of new physicians entering primary care
- Primary care shortages throughout US
- Growing problems of access to primary care
- The primary care medical home is falling off the cliff

Residency Match, 2010
% of graduating US medical students choosing specialties

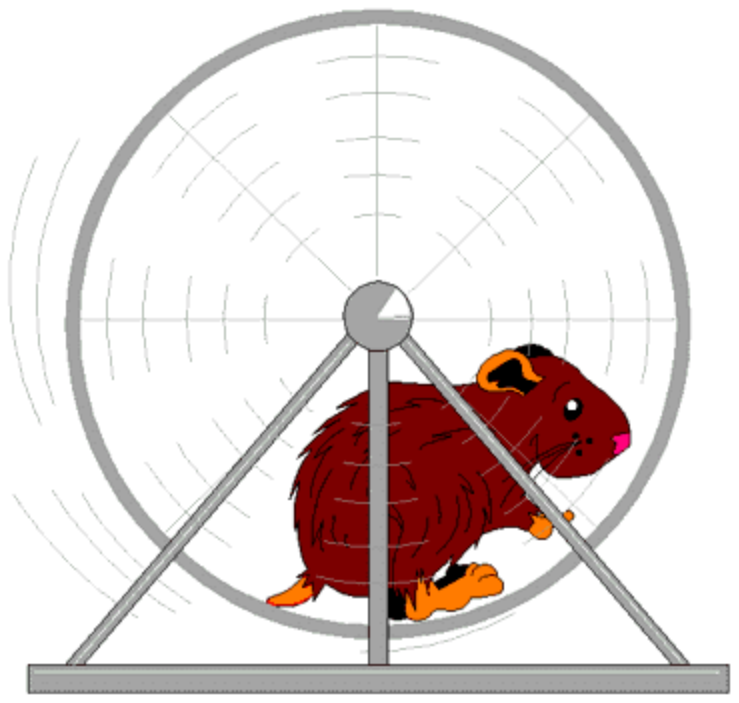


Write down three reasons why US medical students are not choosing adult primary care careers

Why?

- Reasons for lack of interest in primary care careers
  - Primary care providers (PCPs) earn on average 54% of what specialists earn, and most medical students graduate with >$120,000 in debt
  - Worklife of the PCP is stressful
  - Medical schools are often toxic to primary care
    "You are too smart for family medicine"

PCP Burn Out



"Across the globe doctors are miserable because they feel like hamsters on a treadmill. They must run faster just to stay still."

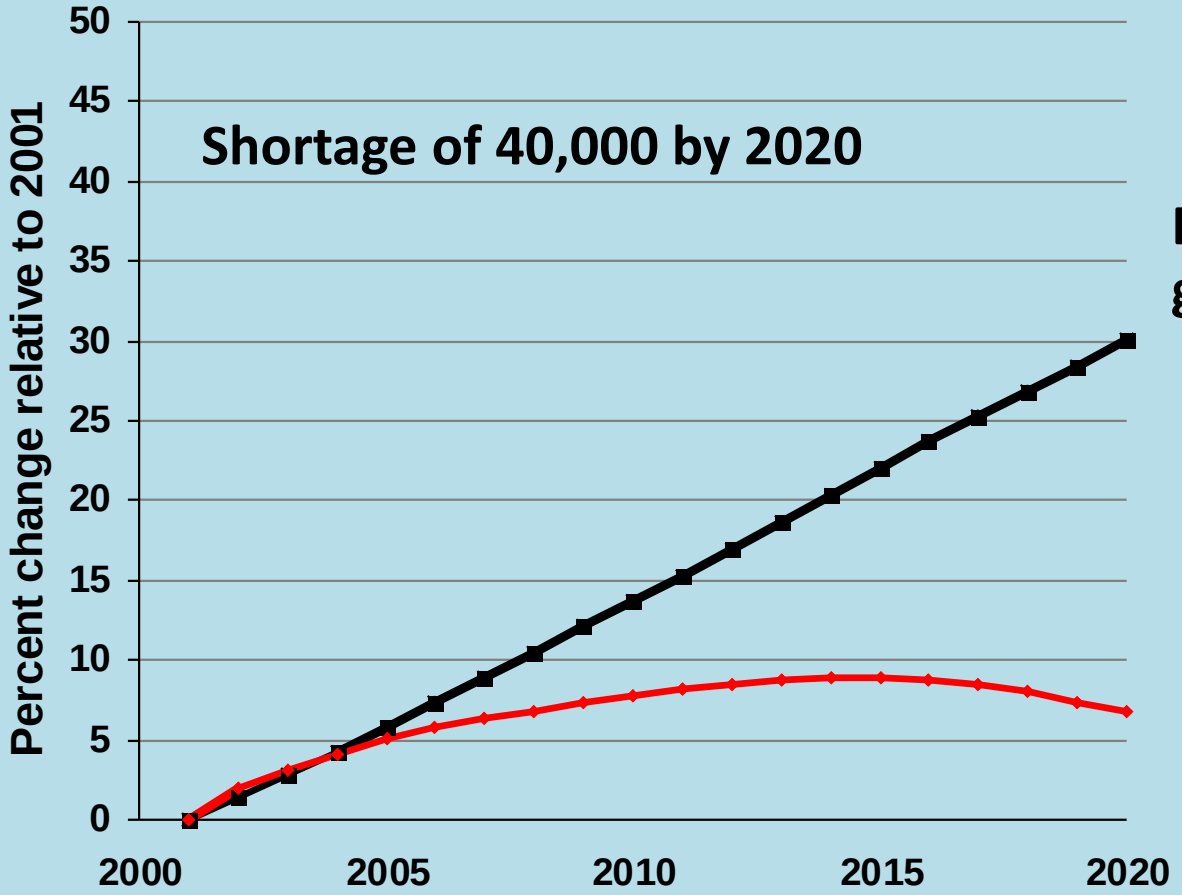
Morrison and Smith. BMJ, 2001

Stressful Worklife

- Survey of 422 general internists and family physicians 2001–2005
  - 48%: work pace is chaotic
  - 78%: little control over the work
  - 27%: definitely burning out
  - 30%: likely to leave the practice within 2 years

Linzer et al. Annals of Internal Medicine 2009;151:28-36

Adult Care: Projected Generalist Supply vs. Pop Growth+Aging



Demand: adult pop'n growth/aging

Supply: Family Med, General Internal Med

Colwill et al. Health Affairs, 2008:w232-241

NP/PAs to the Rescue?

- New graduates each year
  - Nurse practitioners: 8000
  - Physician assistants: 4500
- % going into primary care
  - NPs: 65%
  - PAs: 32%
- Adding new GIM, FamMed, NPs, and PAs entering primary care each year, the primary care practitioner to population ratio will fall by 9% from 2005 to 2020

Colwill et al. Health Affairs Web Exclusive, April 29, 2008;
Bodenheimer et al. Health Affairs 2009;28:64.

Effect on Patients: Access

- 22% of Medicare patients and 31% of patients with private insurance had unwanted delay obtaining appointment for routine care in 2008.

  MedPAC Report to Congress, March 2009

- 73% of adults with PCP had trouble contacting the physician by phone, obtaining care after hours, or experiencing timely office visits

  Closing the Divide. Commonwealth Fund, 2007

Effect on Patients: Quality

- In a national study of physician performance on 439 process indicators for 30 medical conditions plus preventive care, physicians provided only 55% of recommended care

  McGlynn et al. NEJM 2003; 348:2635

- Despite well-designed guidelines for hypertension, hyperlipemia, and diabetes …
  - 50% of people with high blood pressure are poorly controlled
  - 62% with elevated LDL have not reached lipid-lowering goals
  - 63% of people with diabetes have HbA1c >7

  Egan et al. JAMA 2010;303:2043;
  Afonso et al. Am J Manag Care 2006;12:589;
  Saydah et al. JAMA 2004;291:335

Problems of Primary Care

- A study of 264 visits to primary care physicians using audiotapes
- Patients making an initial statement of their problem were interrupted by the physician after an average of 23 seconds
- In 25% of visits, the physician never asked the patient for his/her concerns at all

Marvel et al. JAMA 1999;281:283

Problems of Primary Care: The 50% Rule

- Asking patients to repeat back what the physician told them, half get it wrong

  Schillinger et al. Arch Intern Med 2003;163:83

- Asking patients: "Describe how you take this medication"—50% don't understand and take it differently than prescribed

  Schillinger et al. Medication miscommunication, in Advances in Patient Safety (AHRQ, 2005)

- 50% of patients leave the physician office visit without understanding what the physician said

  Roter and Hall. Ann Rev Public Health 1989;10:163

- Discussion: Why??

Problems with Primary Care: Shared Decision Making

- Evidence on collaborative decision making is persuasive
  - Participatory relationship between physician and patient is associated with patient adoption of healthy behaviors

    O'Brien et al. Medical Care Review 1992;49:435
  - Study of 752 ethnically diverse patients, the combination of information giving and collaborative decision making is associated with healthier self-reported behaviors, medication use, dietary adherence, and exercise

    Piette JD et al. J Gen Intern Med 2003;18:624-633
- Patients with diabetes supported by their providers to have some control over healthcare decisions had lower HbA1c levels than those without such control

  Williams et al. Diabetes Care 1998;21:1644

Problems with Primary Care: Shared Decision Making *continued*

- Patients more actively involved in their care (medication use, glucose testing, diet, exercise and foot care) had better HbA1c levels than those less involved

  Heisler et al. Diabetes Care 2003;26:738

- The greater the amount of patient participation in the medical visit, the higher the level of medication adherence

  O'Brien et al. Medical Care Review 1992;49:435

- Study of 1,000 physician visits, the patient did not participate in decisions 91% of the time

  Braddock et al. JAMA 1999;282;2313

The Diagnosis

The fundamental pathology of primary care:

The 15-minute visit

In primary care, time flies by

Panel Size Too Large for Physician to Manage Alone

- Average primary care panel in US is 2,300
- A primary care physician with a panel of 2,500 average patients will spend 7.4 hours per day doing recommended preventive care

  Yarnall et al. Am J Public Health 2003;93:635
- A primary care physician with a panel of 2,500 average patients will spend 10.6 hours per day doing recommended chronic care

  Ostbye et al. Annals of Fam Med 2005;3:209

The Dilemma

- Panel size too large for average PCP to manage
- We can't reduce panel size due to worsening shortage of PCPs
- Shortage = larger panels, poorer access for patients, poorer quality, less five-step evidence-based medicine, more PCP burnout
- More PCP burnout means fewer medical students will be attracted to primary care
- Doomsayers: it could become a primary care death spiral

The Doomsayers Forgot One Thing

- Upsurge of energy within primary care practices and clinics all over the country
- Intelligence and dedication of many people working in primary care: nurses, clinicians, medical assistants, practice leaders

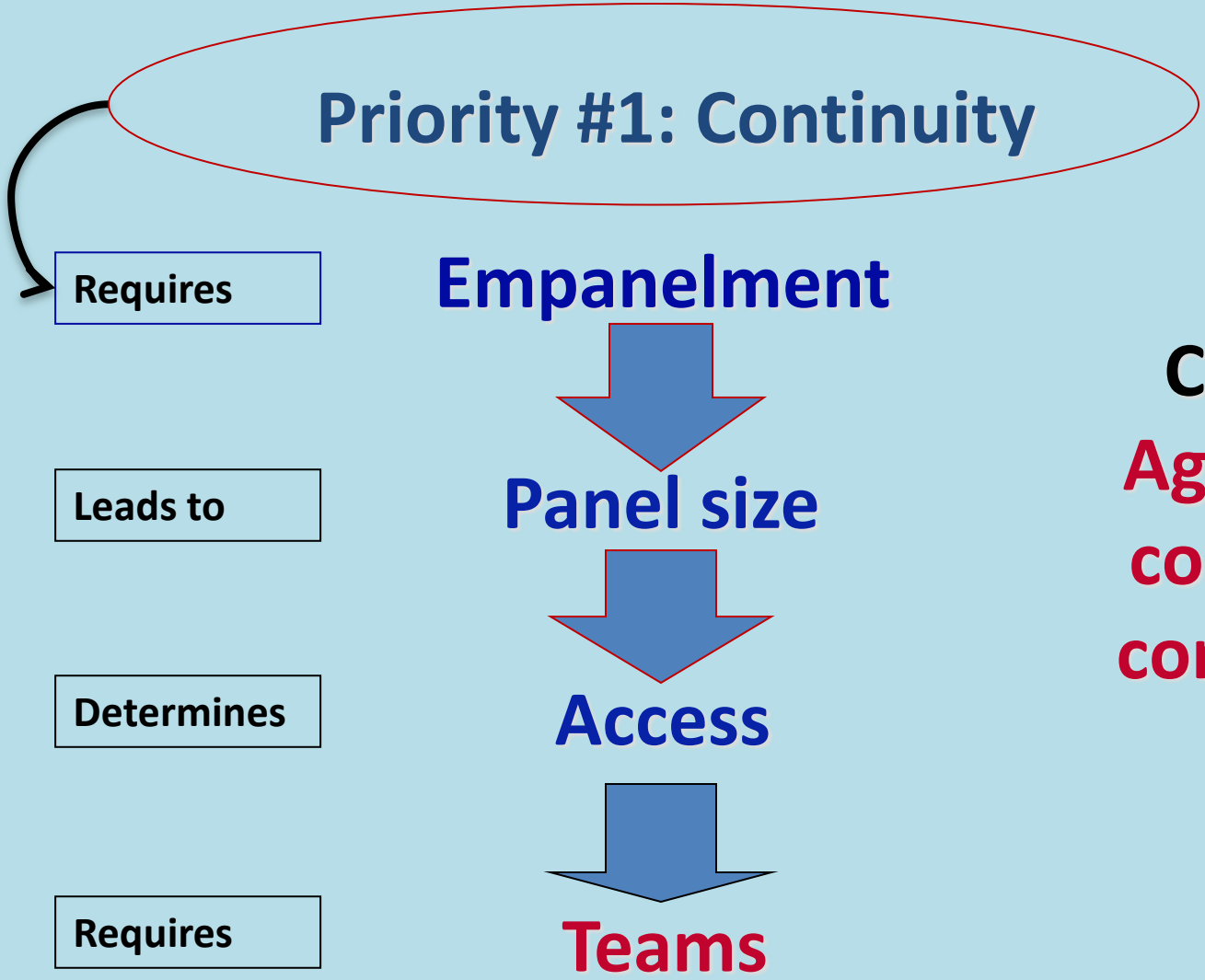
First Primary Care Revolution

- Providing improved diabetes, asthma, congestive heart failure, cholesterol, hypertension management
- Made possible by
  - Chronic care model
  - Health disparities collaboratives
  - New culture of measurement

Second Primary Care Revolution: Deep Transformation of Primary Care

- Building blocks of good primary care
  - Continuity of care
  - Empanelment
  - Proper panel size
  - Access
  - Teams
  - Healing populations in addition to individuals
  - Data-driven improvement

Second Primary Care Revolution



Culture:
Agree that continuity comes first

Start with Continuity of Care

- Continuity of care is associated with
  - Improved preventive care
  - Improved chronic care outcomes
  - Better physician-patient relationship
  - Reduced unnecessary hospitalizations
  - Reduced overall costs of care

    Saultz and Lochner, Ann Fam Med 2005;3:159
- Continuity is related to patient satisfaction

  Adler et al. Fam Pract 2010;27:171
- For older adults, continuity with a PCP is associated with reductions in mortality (adjusting for many other factors)

  Wolinsky, J. Gerontology 2010;65:421
- Primary care physicians want continuity of care

  Stokes. Ann Fam Med 2005;3:353

You Can't have Continuity without Empanelment

- Each participant should write down a definition of empanelment
- Discussion: what is empanelment?
- Each person should write down two reasons why empanelment is essential
- Discussion

Improving Continuity of Care

- Discuss with the person next to you
  - What is a good measure of continuity of care?
  - How would you improve continuity of care in a primary care practice?
- Discussion

Continuity of Care

- Measure and report monthly number of patient visits to their empaneled PCP divided by total number of visits to primary care (and to emergency department)

  Or

- % of visits to the patient's empaneled primary care team
- Measure by practice and by provider
- Regular team discussions of data: uncover causes of suboptimal continuity and make plan to fix it
- Clerks are key drivers of continuity
  - "Next available appt with any clinician is tomorrow" NO
  - "Next available appt with your clinician is next Monday" YES
  - If the patient rejects next Monday appt, try to get patient in to his/her clinician (not another clinician) sooner
  - If access is good (open slots, clinicians squeezing in their own patients), continuity improves
- If continuity is the #1 priority (which it should be), it needs to be a key leadership priority

Prompt Access to Care

- The two most important elements of patient-centeredness are continuity of care and access to care
  - Continuity: allows ongoing trusting relationship, and trust in the physician is a major determinant of disease outcomes

    Thom et al. Health Affairs 2004;23:124-132
  - Access: patients want or need care when they want or need it
- Prompt access to primary care in the United States is poor and getting worse due to primary care shortage
- Access to care includes
  - Access to a care provider during weekday hours
  - Access to a care provider during nights/weekends
  - Phone access

Prompt Access to Care *continued*

- Each participant should write down three changes that primary care could make to improve prompt access to care during weekdays. Assume that the patient:clinician ratio cannot change (i.e., panel size remains the same).
- Discussion of participants' ideas

Continuity and Access

- "See your own, don't make them wait"
  Mark Murray, founder of same-day access scheduling
- Requires leadership intervention and weekly monitoring to succeed
- Metrics
- Third next available appointment (TNAA)
- Ask patients if they feel they have access
- % unfilled appointment slots 1 week from today
- Good primary care practices
  - All clinicians have open slots each day (for access)
  - Are required to squeeze in their patients, but not patients of other physicians (for continuity)
  - Leaders visit practice to troubleshoot if TNAA > 5 days

Access Requires Multiple Transformations

- Reduce unnecessary demand
  - Continuity of care reduces demand
  - Longer visit intervals don't reduce quality

    Schectman et al. Am J Med 2005;118:393-9
  - Substitute telephone and e-mail (patient portal) encounters for face-to-face visits
  - Addressing high primary care users
    - Social visits: behaviorist
    - System barriers (refills)
    - Truly complex patients: plan for each patient

Access Requires Multiple Transformations *continued*

- Increase capacity
  - No-shows drop with prompt access

    Whittle et al. J Amb Care Manage 2008;31:290-302
  - Group visits increase capacity 30% (Clinica Family Health Services)
  - Panel management: MDs shouldn't be doing routine preventive and chronic care tasks
  - Diabetes, hypertension visits to RN or pharmacist, using standing orders
  - Back pain directly to physical therapy; PT sends red flags to MD
  - Behavioral health visits
  - To increase capacity you need a team

Access at Clinica Family Health Services

- Did not work down backlog
- As of July 1, 2001, schedule template open for 2 weeks
- No-show rate when schedule open for 2 weeks 8%.
  For 3 weeks, 30%.
- Intensive patient ed: expect same-day appointments
- Third next available appt max 2 weeks
- Fill slots 8 to 10 AM, try to keep rest of slots open
- 50% of slots fill before the same day
- Demand-reducing, capacity-increasing policies
- Keeping panel size reasonable
- Third next available appointment past 10 years never over 5 days, usually 1–2 days

Building Teams in Primary Care: Paradigm Shift: I to We

- From … How can the clinician (I) see today's scheduled patients and do the non-face-to-face-visit tasks?

Monday	Patients
8:00 AM	Sr. Rojas
8:15 AM	Ms. Johnson
8:30 AM	Mr. Anderson
8:45 AM	Sra. Garcia

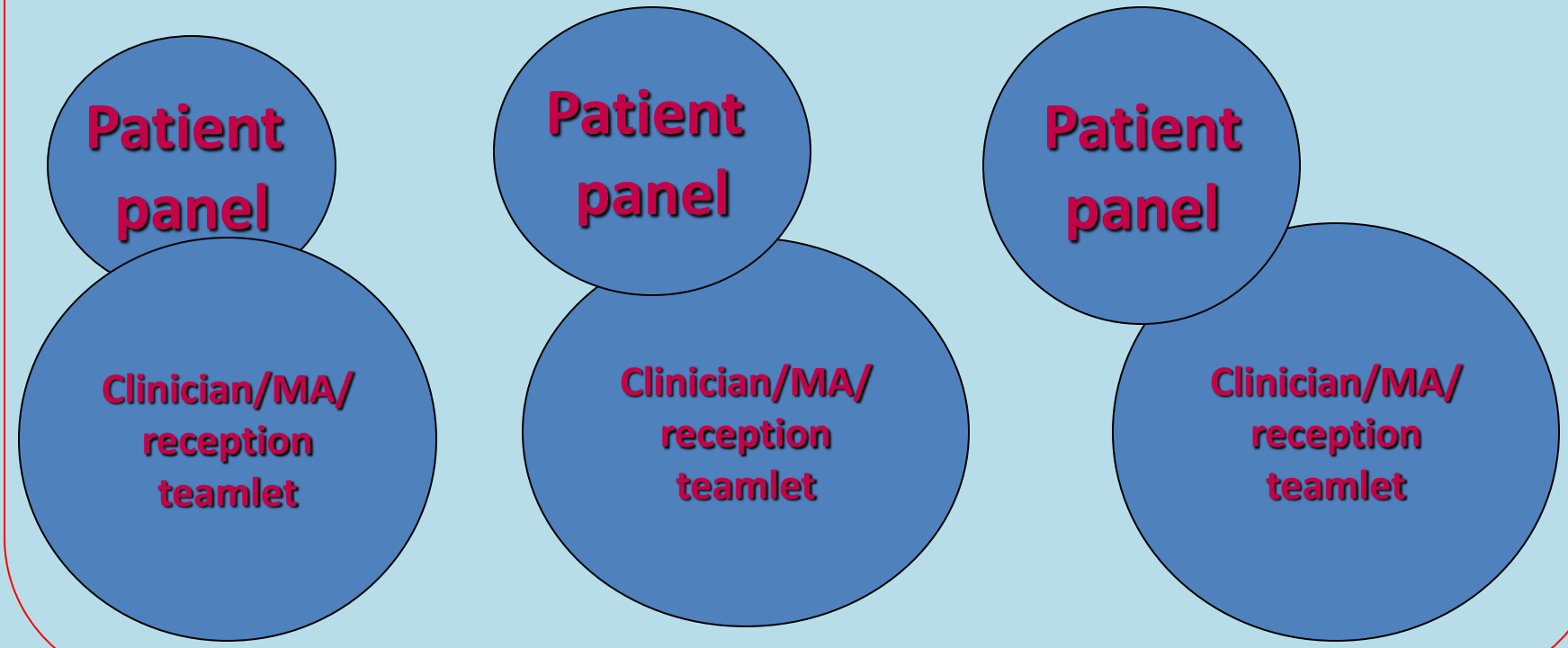
- To … What can the team (We) do today to make the panel of patients as healthy as possible?

The Transformation to Team Care

- 50% of what physicians do could be done by someone else on the team

  Yarnall et al. Am J Public Health 2003;93:635;
  Ostbye et al. Annals of Fam Med 2005;3:209

- "Offloading physician work to other team members" alienates non-physician team members
- Share the care
  - Tasks are redistributed among the team
  - Each team member feels proud to share responsibility for the team's patient panel
  - RNs, pharmacists, behaviorists could be the person primarily responsible for a sub-panel



RN, social worker, pharmacist, health educator, nutritionist, care manager, panel manager

1 team, 3 teamlets

Continuity and Teamlets

- Continuity is redefined as continuity with a teamlet rather than with a clinician
- The same people need to work together all the time; then patients know who is their team
- Teamlets are small, so that continuity is not continuity with 8 people, but with 2 or 3 people
- Trust in the clinician can be transferred to trust in the teamlet

Will Patients Accept Teams?

- Some evidence suggests that this can work for patients if:
  - The same people work together all the time so patients know who is their team
  - Teams are small (teamlets) so patients know and are comfortable with all team members
  - Teams are visible rather than invisible
  - Patients already have a relationship with the team's physician; ideally the physician introduces the team to the patient

Rodriguez et al. Medical Care 2007;45:19;
Rodriguez et al. JGIM 2007;22:787

Creating Team-Based Primary Care

- Discuss what ACO and primary care leaders should do to create high-performing teams in primary care

Stratifying the Patient Population

- Build different models for different strata of panels. All patients cannot be funneled into 15-minute visit
  - People who need same-day acute care (RN, NP, PA)
  - Healthy people who need preventive care (panel managers)
  - Women who need pregnancy and infant care (RN, NP, PA, MD)
  - People with a chronic condition (health coaches)
  - People with complex healthcare needs (MD, RN complex care manager)
  - People with mental health/substance use issues (MD, behavioral health provider)
  - People who need care at the end of life (MD, RN complex care manager)

Complex Care Management in Primary Care

- Care Management Plus
  - Extensive training of care manager RNs
  - Care managers work with primary care team
  - Clinic visits, home visits, phone calls
  - In the higher-risk subgroup, hospital admissions significantly lower in CMP group

Dorr et al. JAGS 2008;56:2195

Complex Care Management in Primary Care *continued*

- Guided Care, Johns Hopkins
  - Extensively trained RN care managers work with primary care team, caseloads about 50
  - Clinic visits, home visits, phone calls
  - RNs teach patients/families self-management skills including early identification of symptom worsening
  - Improved several quality measures
  - No reduction in ED visit or hospital days

Boult et al. Arch Intern Med 2011;171:460

Hospital-to-Home Studies

- Transitional Care Model
  - Advanced practice nurses care-managed patients during hospitalization and post-hospital at home with at least 8 home visits and phone contact
  - Extensive care manager training
  - Reduced hospital and ED utilization compared to controls, with 38% total cost reduction

  Naylor et al. JAGS 2004;52:675

Hospital-to-Home Studies *continued*

- Care Transitions Intervention
  - RNs trained as “transition coaches” to teach patients/families skills to care for themselves
  - 1 hospital visit, 1 home visit post-discharge, 3 post-discharge phone calls
  - Significantly lower readmission rates and lower hospital costs compared with controls
  - Less intensive intervention than Transitional Care model

Coleman et al. Arch Internal Med 2006;166:1822

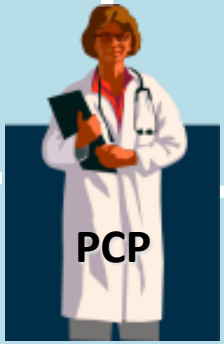
Panel Management, Coaching, Care Management

- Patients with routine preventive and chronic care needs—panel manager to make sure all recommended services done in a timely fashion
- Patients with one or two poorly controlled chronic conditions—health coach
- Patients with complex healthcare needs—RN care manager

Care Coordination within Primary Care Practice

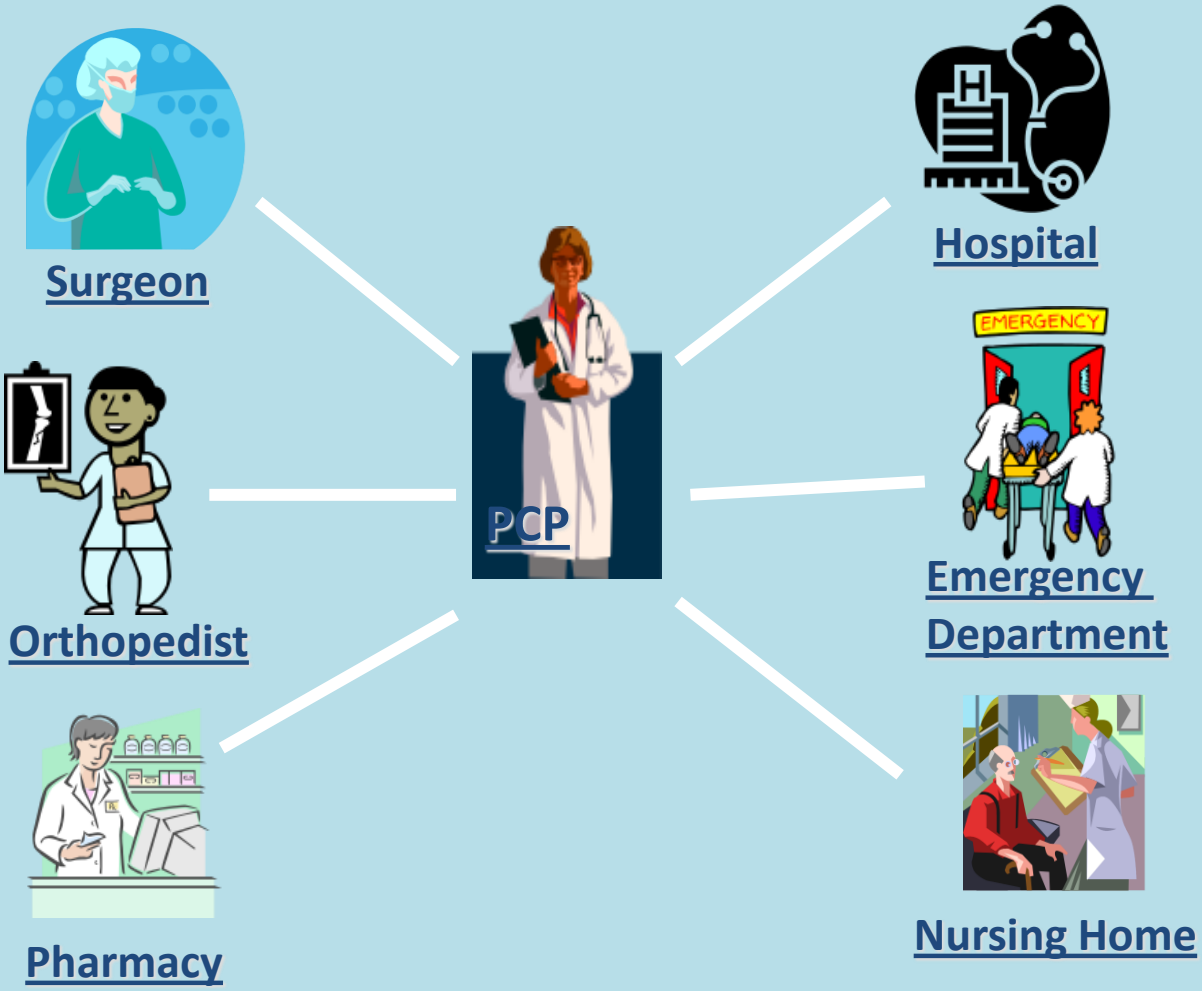
PCP—on call nights and weekends

Other PCPs in the practice

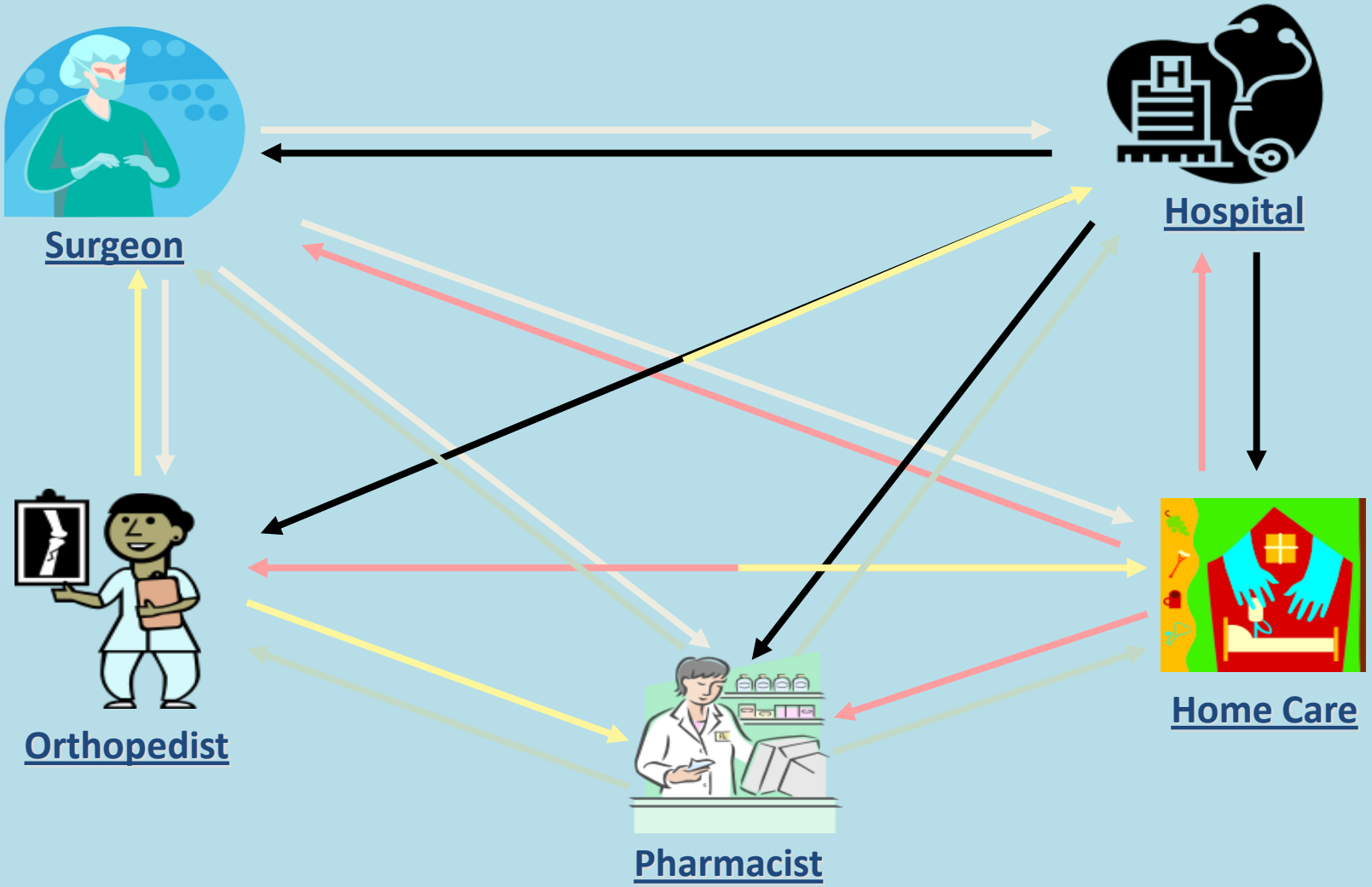


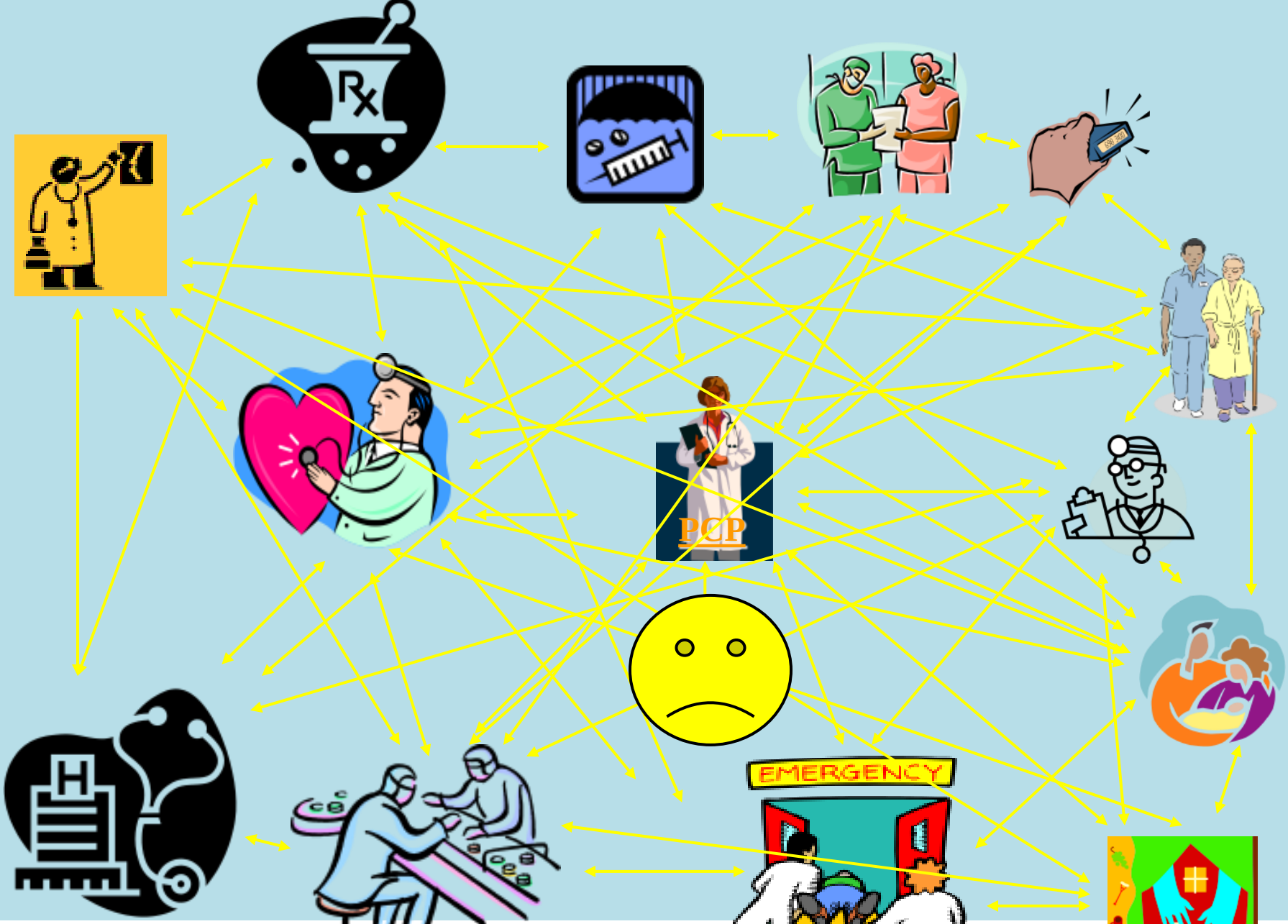
Non-clinician staff

Care Coordination between PCP and Other Caregivers



Care Coordination among Other Caregivers





Risk Factors for Needing Care Coordination

- A small number of healthy patients with a PCP always available
  - Enjoy continuity of care
  - Don't need care coordination
- Most of the 300 million people in the US need care coordination at some point in time
- 125 million people with chronic illness, disability, or functional limitation are at greatest risk for needing care coordination

Coordinating Care: How Are We Doing? Patient Voices

- "I've basically kind of fixed up most of it myself. I think what it comes down to is who's the coordinator? The coordinator seems to be me."
- "Don't leave it to them. Take your situation in your own hands. You have to take the situation into your own hands."

Harrison and Verhoef. Health Serv Res 2002;37:1031

Coordinating Care: How Are We Doing? Research Studies: Provider-Provider

- US academic medical center, adult referrals
  - 68% of referrals—specialists reported they had received no information from PCP
  - 25% of the time specialty consultation reports had not reached PCP 4 weeks after specialty visit
  - Lack of time important contributor to poor referral process

Gandhi et al. JGIM 2000;15:626

Coordinating Care: How Are We Doing? Research Studies: ED

- 33% of emergency department visits
  - Information about the patient (medical history and lab results) absent

Gandhi. Fumbled handoffs. Ann Intern Med 2005;142:352

Coordinating Care: How Are We Doing? Research Studies: Discharge

- Information transfer between hospital-based and primary care physician (lit review)
  - PCP involved in discharge plan: 3% of the time
  - PCP told that patient is discharged: 17%−20% of the time
  - PCP never got discharge summary: 25% of the time
  - Discharge summary: no lab reports: 38% of the time
  - Discharge summary: no med list: 21% of the time
  - PCP cared for post-hospital patient before receiving discharge summary: 66% of the time

Kripalani et al. JAMA 2007;297:831

Coordinating Care: How Are We Doing? Research Studies: Provider-Patient/Family

- 2004 survey of people who had seen a physician during the past 2 years
  - 18% received conflicting information from different doctors
  - 24% reported leaving a physician visit with important questions unanswered
  - 20% were not told the results of a diagnostic test, or the explanation was unclear

Schoen et al. Health Affairs, October 28, 2004

Barriers to Care Coordination

- The overstressed primary care home
- The uninformed, passive patient
- Lack of interoperable computerized records
- Dysfunctional financing
- Lack of integrated systems of care

The Uninformed Passive Patient

- 50% of patients leave the office visit not understanding what the doctor said

  Roter and Hall. Ann Rev Public Health 1989;10:163

- One study, half of patients want physicians to make final decisions; 96% want to be offered choices and be asked their opinion. Patients want to be involved in decisions.

  Levinson et al. JGIM 2005;20:531

- Study of 1000 physician visits, the patient did not participate in decisions 91% of the time

  Braddock et al. JAMA 1999;282;2313

The Uninformed Passive Patient *continued*

- Active participation in care is associated with
  - Healthier behaviors
  - Better chronic disease outcomes
  - Medication adherence
  - Improved care coordination

Heisler et al. JGIM 2002;17:243
Coleman et al. Arch Intern Med 2006;166:1822

Dysfunctional Financing

- Most healthcare dollars are paid based on quantity, not quality
- Procedures and imaging are paid at a higher rate per time spent than cognitive services
- Neither hospitals nor physician practices have a financial incentive to provide post-hospital care that is so often lacking
- Pay for performance (P4P) is based on specific measures that are less pertinent to the multiple-diagnosis patients at highest risk for needing care coordination

Dysfunctional Financing *continued*

- Providers are paid more for amputating a diabetic leg than for proper outpatient management to prevent amputations

Improving Care Coordination

- Addressing the overstressed primary care home
- Health coaching to transform uninformed, passive patients into informed, active participants in their care
- Interoperable computerized records
- New modes of financing
- Integrated systems of care

Primary Care Teams Are Needed To Improve Care Coordination

- Clinicians are needed for care coordination but cannot do it all themselves – much too busy
- Some aspects of care coordination can be done by health coaches or RNs (for complex patients)
- If teams share the care, clinicians will have more time for care coordination

ACOs can Address Dysfunctional Financing and Lack of Integrated Systems

- Hospitals must not make more money by admitting more patients
- Primary care must be rewarded for reducing inappropriate ED visits, specialty visits, and hospital admits
- Everyone in ACO on same electronic health record
- Implement Eric Coleman's Care Transitions Intervention
  - Transition coaches, for the crucial post-hospital transition (don't rely on hospitalists)
  - Main function of coach: train patients/families to be informed, activated participants in transitions process ("You have to take the situation into your own hands")

Payment Reform for Primary Care Transformation

- Primary care teams are necessary
  - For continuity and access
  - For chronic, preventive, and complex care
    - Panel managers and health coaches
    - RNs complex care managers
  - For physician worklife
  - To reduce inappropriate ED visits and hospital admissions
- If only MD/NP/PA is reimbursed, the team is an expense, not a revenue source
- Patient-Centered Medical Home concept (PCMH) helps: fee-for-service plus Per Member Per Month (PMPM) capitation plus P4P
- Allan Goroll's payment concept: risk-adjusted capitation plus P4P

JGIM 2007;22:410

Payment Reform for Primary Care Transformation *continued*

- Primary care does not cost much (average 6% of total system costs), but primary care is needed to achieve reductions in hospital days, specialty visits, ED visits
- To reduce total healthcare costs
  - Invest in primary care
  - Make primary care assume some risk

Investing in Primary Care

- RN complex care management – Can reduce healthcare costs

  Bodenheimer and Berry-Millett. 2009 www.rwjf.org/pr/synthesis

- Prompt access including nights and weekends. Primary care practices with >12 evening hrs/wk, compared with those lacking evening hrs, reduce Medicaid ED visits by 20%.

  Lowe et al. Med Care 2005;43:792

- Elevating continuity of care to the fundamental guiding principle of primary care. Continuity with a clinician is significantly associated with reduced ED visits in Medicaid populations.

  Gill et al, Arch Intern Med 2000;9:333

- Primary care cannot do these things without receiving a financial investment

Putting Primary Care at Risk

- If primary care practices do not assume any risk for their patients' total healthcare costs, they are unlikely to
  - Hire RN complex care managers
  - Expand evening/weekend hours
  - Create culture that puts continuity first
- Risk: capitation, shared savings, bonuses for reducing costs or penalties for failing to reduce costs
- First invest in primary care necessary to give practices funds and tools needed to succeed at cost reduction
- Then, have primary care assume some risk so that there is an incentive to reduce total healthcare costs

Tools and Resources

- Safety Net Medical Home Initiative implementation guides at www.qhmedicalhome.org/safety-net/publications.cfm
- Bodenheimer and Grumbach, Improving Primary Care: Strategies and Tools for a Better Practice (McGraw-Hill, 2007)
- Clinica Family Health Services (detailed description of a high-functioning primary care practice), at http://familymedicine.medschool.ucsf.edu/cepc

Module 2A: Reshaping Care Delivery

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