Transforming primary care

Progress notes from the frontlines of patient-centered care

By Jason Cunningham, DO and Mary Szecsey

LIKE IT OR not, for those of us in healthcare, we find ourselves now in "interesting times." Our health care system is inherently broken because it emphasizes procedures above prevention, reaction above relationships, and standards above self-management. Our country's healthcare system is among the best in the world at treating and reacting to emergencies and complications such as heart attacks, stroke, and kidney failure. There is no other system that boasts the advances in imaging technology or pharmaceutical innovations and we are second to none in research institutions and referral centers. Yet, despite the highest per capita spending on healthcare among developed nations, the United States is well behind other developed nations in infant mortality rates, rates of preventable death, life expectancy, and deaths due to medical errors.[1, 2]

One reason is that our fragmented system limits rapid flow of information between physicians and hospitals. Patients frequently have two or more treating physicians, often without shared knowledge of what medications were prescribed or which interventions were performed. Clinicians tend to be unaware of valuable health resources in the community and rarely assist patients in utilizing these or spend time helping them with lifestyle choices or health goals. The system's structure undermines long-term relationships between medical providers and patients by forcing patients to change providers whenever their insurance carrier changes or when health insurance is lost altogether. When patients do get office visits, providers spend on average 12-15 minutes with them. Patients usually initiated these visits because of an urgent need, and often wait days or weeks for an appointment. Physicians have little to no financial incentive to provide proactive or preventative services such as health education, disease case-management, or preventative care. Finally, the rising cost of providing health care this way affects every aspect of our society. The compounded losses of our system are profound, creating challenges for our society as we make increasingly difficult decisions in spending precious dollars on healthcare at the expense of other needed services and programs. In 1960, national health spending as a percentage of GDP was 5.2%; it is projected to be almost 19.6% by the year 2019.[3]

These "interesting times" have created fertile grounds for innovation and transformation. Our current primary care system—built around incentives geared to in-person, episodic, procedure-based care—is ill equipped to become the foundation of an advanced healthcare system. Yet we are now seeing a significant effort to redefine primary care that includes not only investing the necessary financial resources to pilot meaningful change but also fostering non-traditional collaboration across our health system to improve the spread of new ideas and lessons learned.

At West County Health Centers, we believe primary care will be asked to care increasingly for a distinct population of patients and will be held accountable for both clinical and financial outcomes. Accountable Care Organizations, block grant funding, demonstration projects, and pre-paid contracts

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will be more common, and other payment models that offer a comprehensive payment structure will become more prevalent from a variety of insurance products, employers, and payers. We expect primary care will begin to share both financial savings and financial risk for the care delivered across the health delivery system.

In anticipation of this transition, West County Health Centers strategically moved toward a care delivery model that focuses on relational, continuous, accessible, team-based care. The approach provides both diagnosis and treatment across the spectrum of disease acuity and additionally offers proactive preventative care, self-management support, care coordination, chronic disease case management and focused behavioral modification support for patients with complex health conditions. It is clear that different kinds of patients will require varying levels of investment as they move through successive life stages and health challenges. They will need to be empowered to engage more fully in their own health solutions. Additionally, patients who develop more complex health needs will require a more comprehensive, system-wide approach that maximizes traditional healthcare delivery and provides additional case management and care coordination. A smaller number of patients who tend to utilize a disproportionate amount of resources in the current healthcare delivery system will require new approaches to care delivery that focuses on behavioral interventions and helps them utilize health care services in a more appropriate and cost-effective way.

Photo courtesy of West County Health Centers

Sebastopol Community Health Center Care Team members May Wyman FNP, Crystal Lopez MA, and Jymmey Purtill, RN with patient (second from left).

In 2008, we began this systemic redesign of care delivery led by what was regarded at the time as a novel concept: the "Patient Centered Medical Home." We chose to adopt our electronic health record at the same time and recognized early on that it was both a potentially powerful tool for improved patient care and an opportunity to rethink all of our systems of care.

We were determined to make these changes within our current environment instead of waiting for external forces or changes in funding. What ensued has been a remarkable journey, full of creative solutions, new collaboration with traditional and non-traditional health partners, difficult times of change management, and supportive staff willing to partner in this change. The following is a brief overview of what we have tried to do and the principles that guided us.

Principle I: Relationship

"It is much more important to know what sort of patient has a disease than what sort of disease a patient has." –William Osler

In the outpatient, ambulatory setting, we know that patients are in complete control of their health outcomes. This is not just a goal – it is a reality. A patient's motivation, belief structure, and social infrastructure will determine whether they listen to the advice we give, choose to accept a certain treatment, pick up a medicine from the pharmacy, or make necessary dietary changes. Furthermore, for all of us, our behaviors as patients—what we eat, how active we are, who we associate with, what addictions we have—are more important in determining our overall health and life expectancy than access to healthcare or receiving appropriate medical treatment.[4] In the traditional health care

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Care Team members Kathleen Jenkins RN, Sheena Toledo CCMA, and Anabel Gonzalez listen as Dr. Jason Cunningham speaks with a Sebastopol Community Health Center patient.

model, we focus on being excellent diagnosticians and providing evidence-based clinical advice and treatment. Although these have obvious inherent worth, they have not led to health care providers developing therapeutic partnerships with our patients to see real health improvement. We need to fundamentally change our approach with our patients to emphasize teaching, coaching, motivating, and listening if we want to make a real impact on chronic illness, improve patient self-management, and reduce health costs.

Establishing a long-term, trusting, nonjudgmental, healing relationship is not merely important, we believe this is our *most* valuable product. This underlies every initiative, changing whom we hire, how we train, how we motivate, what we measure, and the culture we establish in our health centers.

Ensuring that each patient has a relationship with one clinician and a small group of support staff is at the core of our strategy. It is difficult to develop an intimate relationship with more than a few people. We have worked hard to make sure patients interact with the same team during every interaction – from the office visit to scheduling future appointments to coordinating their healthcare. Close examination of how many patients each primary care provider and Care Team are responsible for, how our supply and demand are managed, how we schedule our staff, and how available we are to our patients are critical components of success in this area and require continuous management.

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Further, our patients' experience with our system is an important component of building trust and confidence in that relationship. Support staff members play a vital role in enhancing that experience. We have chosen to look toward the hospitality industry rather than traditional healthcare consultants to gain insight into strategies to improve the patient experience. We have invested in customer service training and worked to create a culture that values the patient's perspective and experience as central within the healthcare team. We have reevaluated everything from our phone system to staff training, changing our measurement structure, and empowering our staff to listen and innovate to come up with creative strategies to improve the patient experience. Some of the ideas from our staff include implementing a pager system to allow waiting patients to take a walk when we are running behind and piloting a program to text patients with scheduled appointments ahead of time so they can adjust their arrival times to our schedule changes. We want to create an environment that values the impact of our system on our patient's daily lives. Many small acts create confidence and trust over time.

Principle II: Meaningful Access

All barriers to timely access to this relationship should be removed.

Meaningful access to primary care is critical in transforming our health system. If we build incredible systems that promote high-end relationships but patients don't have timely access, the real relationship patients have with our health system will continue to be primarily with the Emergency Room, if at all. Furthermore, the traditional model that requires the patient to disrupt their day by waiting for an office visit needs to be completely overhauled, giving way to a portfolio of options for patients to address their specific need at the right time. This is particularly difficult to change because of the way health care providers and facilities are reimbursed currently for very specific services but we are

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finding that with creativity, we can make significant headway.

We have implemented a web-based patient portal that gives patients online access to their team via secure e-mail, allows patients to view their lab results and history, and complete surveys or questionnaires that staff can review before or during the next visit. Our centers are open until 8 p.m. four days a week with additional office hours on Saturdays to accommodate patients unable to come during standard business hours or with urgent needs. We continue to see house-bound patients at home and we are piloting a secure video conferencing solution that will allow us to provide enhanced face-to-face consultation when appropriate. Our telemedicine and specialty services center allows for access to traditional specialty services for our patients on site and will offer enhanced access to specialty services at a variety of referral sites via sophisticated tele-health equipment. Traditional visits with a single primary care provider are now enhanced by group visits that allow patients to engage with each other around similar health goals or needs. We believe this creates an environment for innovation and advocacy as health care moves forward with payment reform.

Principle III: Team-Based Care

Excellent care can only be offered when integrated Care Teams with clearly defined roles work together to partner with patients in meeting their needs and reaching their health goals.

Traditional primary care is designed to address one specific need in a 15-minute office visit, provided by a single, well-trained provider. Moving to the primary care of the future—one that is able to manage patients with complex medical problems, coordinate multiple health providers, and proactively assist patients in managing preventative health—requires a sophisticated team of healthcare professionals who understand their roles and are equipped and empowered within the team. This has been the most challenging and fulfilling part of our care delivery transformation and will require ongoing management and innovation going forward.

Our core Care Team consisting of a clinician, medical assistant, front office representative, and RN care manager are relationally connected to distinct groups of patients. Each team is accountable for their clinical outcomes and empowered to creatively assist those patients in meeting their healthcare goals. An on-site mental health department, referral, and billing staff support the core team. We are piloting a Patient Navigator, a trained person who assists patients in realistic goal setting around patient identified self-management goals and with accessing needed health resources. We also are implementing a pharmacy specialist to assist our patients with their prior authorization and medication needs.

Our most important challenge as we move closer to an enhanced Care Team

Empire graduates Brydie Burke and Missy Daini with Dr. Dale Westrom

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Dr. Cunningham with Sebastopol Community Health Center patient.

model is creating systems that enhance communication across our team and with health partners outside our agency. We have looked to the business sector for ideas and are in the process of implementing tools such as instant messaging, text messaging, and video conferencing both within our system and externally to connect readily with specialists and community health partners.

Principle IV: *Comprehensive* Primary Care

Move beyond traditional services.

Traditional services that treat acute medical issues need to be enhanced with services that effectively manage chronic disease, assist patients with improving self-management, and move beyond disease-focused care to proactively engage with patients around health goals.

We are in the middle of this exciting part of our transformation. Support staff members spend dedicated time reviewing their patient panels proactively to assist patients in ordering labs or securing chronic care items outside of the office visit. They are also authorized to order tests based on clinical protocols. This has allowed us to focus both on the needs of individuals and groups patients. We have seen a measurable improvement in our clinical outcomes as a result of these team-based care measures.

At the core of redesigned primary care is a proactive approach to assisting patients, managing complex medical needs, coordinating care during transition from inpatient settings, and managing patients at the extremes of healthcare utilization and cost. Our RN staff has been invaluable in providing triage support and education, along with assisting our providers in completing needed patient documents and refilling medication in a timely manner. We have struggled to have the staffing capacity to realize this complex model of care but having now committed the necessary staffing and training resources, we are moving into this next level of care this year.

The newest addition to our agency, the Forestville Wellness Center, allows space and energy to provide health education and addiction services in addition to complementary services such as homeopathy, osteopathy, acupuncture, therapeutic massage, and herbal consults. We have seen incredible benefit from creative partnerships. The Northern California Center for Well-Being, Drug Abuse Alternative Center, and Ceres Project offer excellent services on site for our patients. We also continue to explore new partnerships. This creative endeavor has excited our staff and community more than many of our previous efforts. We are finally touching on a way to offer *health* care, not just "sick care."

Principle V: Know the data

The care we provide must be adaptable and measurable.

Early on we realized that data would be a transformational element in our redesign. We chose to challenge our assumptions and broaden the type of data we use to inform improvement efforts.

Gleaning actionable clinical data has been an inseparable part of our Care Team redevelopment. We have invested in staffing and tools to provide front-line staff with the information needed to make appropriate clinical decisions. In partnership with our regional network of community health centers, Redwood Community Health Coalition, we invested in an electronic health record system in 2008. In our vendor selection, we placed a premium on functionality that would equip us to analyze patient data. We regard the electronic health record as more than a way to document episodic interactions with individuals; it is an invaluable tool to allow us to see the bigger picture, identify trends, and proactively manage certain populations of patients.

One of our newest endeavors is exploring ways to incorporate non-traditional data into our redesign efforts. We are recruiting patients to sit on patient advisory panels and we are also setting up "listening posts" to gather suggestions and concerns from patients. We hope to create a program that will allow us to gather stories from patients and shadow them as they interact with our system. We can't assume we are providing patient-focused care successfully without inviting honest, meaningful feedback and involving patients in our redesign process.

Principle VI: Every person matters

The social and financial cost of care to our patients and society must be valued.

One thing West County Health Centers is most proud of is that we are transforming the care we provide for some of the most disenfranchised members of our society. We are able to look our patients in the eye and assure them that our relationship will be available regardless of their socioeconomic status or access to health insurance. We provide care because we have a passion for the individual and the value that they bring.

We recognize that primary care will play an increasingly important role in containing healthcare costs. We are proud of our history and innovation, and we will continue to creatively partner with our patients as we navigate a challenging and uncertain future within our national and state health care system.

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