

Strategies to Increase Primary Care Access, Use and Coordination

PATRICIA DONOVAN: This is Patricia Donovan for Healthcare Intelligence Network. Today I am speaking with Chris Wise, administrative director of the Medical Management Center at the University of Michigan Health System. Chris is presenting at HIN's audio conference on "Strategies to Increase Primary Care Access, Use and Coordination." Thanks for joining me today Chris.

CHRIS WISE, ADMINISTRATIVE DIRECTOR OF THE MEDICAL MANAGEMENT CENTER AT THE UNIVERSITY OF MICHIGAN HEALTH SYSTEM: My pleasure.

PATRICIA DONOVAN: First of all how does teaching the chronically ill to manage their own conditions increase access to primary care?

CHRIS WISE: There are several aspects to this. One being we have many who, with a chronic disease, may not be managing their care as effectively as they should. Especially initially in relation to the evidenced based clinical requirements. For example in diabetes the evidence is fairly clear that an annual or semi annual foot exam, eye exam, testing of their hemoglobin A1C values will benefit them in the long term. These patients will be much less likely to lose a limb, lose their eyesight etc. And yet our patients with diabetes may not understand those needs and may not engage the health system as often as they should. So in some instances we want to increase demand for these appropriate services.

However at the same time, if we can help the patient understand how best to manage their disease including exacerbations of their disease. An asthmatic understanding their peak flow meters and when to engage the provider side and when they might have alternatives for managing their disease can decrease the demand for need to access the primary care physicians. In addition, we

are working hard at the University of Michigan Health System and with several other physician groups through both the country and in the state of Michigan to try to improve our models of delivery of chronic care. Trying to assure that the evidenced-based requirements of care over time for these diseases is addressed fully and comprehensively. There was an article a couple of years ago that estimated that for a primary care office to do just the evidence-based HEDIS requirements for 5 chronic diseases would overwhelm their practice throughout the year.

In other words, there was not enough time for a physician in a year to just address the evidence-based requirements on a disease for their patient panel. So barring even any acute episodic care delivery for any patient, which is of course, unrealistic. So we need to improve the design of the clinic office in primary care improve efficiencies, address the issues of infrastructure that the physician needs to support chronic care management so that we can address these issues much more effectively and efficiently and improve access with the patients.

PATRICIA DONOVAN: Thank you Chris. How does the involvement of the physicians or the nurses change the dynamic of UM's disease management initiatives? I saw that they play a pretty important role. Are patients more responsive when they know a doctor is going to call them and see them versus a health coach on the phone?

CHRIS WISE: Yes. We certainly believe so. And as importantly the individuals within our system know how to manage our system and the patients through it. We started working on this 10 years ago with Ford Motor Co, who at that time cited that their employees number one complaint was feeling lost in a complicated healthcare system. The need for transitional care support is significant for these patients and especially in a system like ours where we have there major hospitals, and 10 ambulatory care clinics and the large campus and we're not as integrated as we would like to be.

And sometimes the patient struggles through that to have a clinician who both understands their clinical needs in association directly with their physician overseeing their care and who understands the system under which they need to access that care has proved to be extremely helpful.

In addition, as part of the Medicare demonstration program out of the University of Michigan Health System and faculty practice was selected as 1 of 10 physician groups in the country to participate in a Medicare demonstration program to improve the management of chronic care and population based care for Medicare patients. We've enhanced the role of our health navigator. These are social workers and nurses that help provide transitional care and follow up support for patients, the patients in our panels. And we're finding many who have been recently discharged who may have poly pharmacy issues are confused about their appointment have not engaged their primary care physician post discharge as follow up. Many unmet needs for this population and the health navigator and this transitional care support is really helping link the components of care to our large system.

PATRICIA DONOVAN: Thank you Chris. The term navigator that's important because we often read about the complaint that people have about being unable to navigate the healthcare system. So it's more than a coach. It's really holding their hand I guess and taking them through the system.

CHRIS WISE: I think you'll see a slide—I have a slide. Avedis Donabedian is commonly recognized as the founder of the definitions for quality in healthcare. He was a faculty member of the University of Michigan. And in his older years sought care at the University of Michigan, which resulted in a publication in health affairs where Avedis Donabedian the founder of quality says, "In many places in the University of Michigan Health System, the points of care are not connected. In patient doesn't connect with outpatient and in many cases the patient is left on

their own. The system is the problem. Tell the University of Michigan Donabedian said they have a problem." This was published in Health Affairs in 2001. And this was part of our orientation to try to address this, our points of service are excellent, but sometimes the patient gets lost in the gaps between those points of service and connecting those pieces is really a critical point. And in our initial work with Ford Motor Co.

Health Navigator was the term identified and you're right it's an important nomenclature in part because while we are doing case management, it's a newer version of case management, that instead of trying to authorize and deny visits we started turning that upside down to find what is needed and get the patient there. And that's proven to be very helpful.

PATRICIA DONOVAN: Thanks Chris. Getting back to the self-management portion of your effort, how long does it take to put a patient on the road to self-management and how long do the clinicians need to stay involved with the patient? Do you have a way of determining whether participants are staying on track?

CHRIS WISE: Right. It's a great set of questions and I think the ranges are highly variable. Certainly patient dependant. And we have I think it's dependant on the populations themselves the elderly, some of the underprivileged underserved don't necessarily have the resources, or engage in the resources of computer tools, web-based tools. A presentation I saw yesterday suggested that about 44% of patients would use the web, which is quite a few, but that means over 50% of people will not. So the mechanisms to engage the patient in self education are still under development, despite there being many good tools being developed especially through electronics or the IT system. And some will take to that immediately and want to address their own care, others may have other pressing issues in their life social

demographic issues or may just be slower to accept the responsibility for that management.

So I believe that the provider will play an important role throughout the disease aspects of their patient and their need to self manage. How we do that efficiently and effectively is something we're still learning about. So we have done several pilots including one simple one about some gaps in evidence-based care where we had one clinic try to call the patients to try to get them in to try to address those needs and mailed to another clinic. These were 800 patients total and we had slightly better response through mail, which showed us that it was much cheaper and much less requirement for the staff and the clinic.

So those are simple methods that we're still learning about which is better mail or call. And it turns out that mail is better. And I think we need to continue to link the patient self-management into a broader aspect of the physician's office and it's provision of a medical home and chronic care model.

PATRICIA DONOVAN: Thank you Chris. I know that a basic tenet of your program is lean thinking. How are you asking your patients in this self-management effort to be lean thinkers, or how is that important in this program?

CHRIS WISE: We're not really asking our patients to be lean thinkers I don't think, but University of Michigan participates with Blue Cross Blue Shield of Michigan, the largest payer in our state and many other now, physician groups in the state of Michigan. 14 was the last count by me, are trying to implement this chronic care model of care over time, and evidence-based focus and patient self-management. And throughout the course of this effort with the other physician groups and Blue Cross there was discussion over this last year about the difficulties we all felt we were having in trying to implement a chronic care model at Wagner's Chronic Care Model into a setting that was

traditionally built for acute episodic healthcare delivery. We tried to fit a square peg into a round hole almost. And most of our physician groups were trying to do these aspects, but we all felt as though we were doing it without a good discipline. We were not necessarily assured we were picking the right place to start, choosing the right priority on which to try to implement or even for those choices doing it as efficiently and effectively as possible. And at the same time our institution at the University of Michigan was beginning its path in trying to bring in the concept of lean thinking, the Toyota model to healthcare. And we have several champions in doing that including Dr. Jack Billy.

So as our discussions with the physician groups and Blue Cross began we linked that with our interests in lean. We have just identified 8 physician groups, including the University of Michigan, who will use a lean facilitator to have us each look at 2 clinics in our physician groups and ask ourselves what is the current state map value stream, what is the current value stream in our primary care clinics for an advanced medical home and the chronic care model. So what we're excited about is finally having some tools and processes the lean thinking initiatives to help us be more disciplined in how we approach advancement, innovation and change in the primary care setting. That way we can meet the patient needs and improve access and reduce the work load of the physicians.

PATRICIA DONOVAN: Well that sounds interesting, and perhaps I'll have an opportunity to follow up on that effort in the future.

CHRIS WISE: Does that make sense?

PATRICIA DONOVAN: Yes.

CHRIS WISE: The lean initiative is really sort of a method for which you can look at what you currently do and then a future

value stream of where you want to get to and where the barriers are to doing that. And I feel very excited because we're not just doing this as independent physician groups, we're doing it collaboratively with several different physician groups and we're doing it in accordance with the largest payer in our state who is very visionary and championing this effort. So we hope to all learn together and perhaps address barriers that we might not be able to address independently.

PATRICIA DONOVAN: That sounds great. It sounds like it would perhaps reduce some duplication of effort too.

CHRIS WISE: One of our medical directors of one of our physician organizations I was talking with last week about this. We're still newbies in this and we're wondering if lean is the right set of tools to use, and her response was, "Well it may not be perfect Chris but we have to do something. It's not acceptable the way we're doing things now." And I think it takes that kind of vision and leadership to say what are we going to do to tackle this issue? What we're hoping is that we can really improve the workflow within a clinic to perhaps free up opportunities to address clinical needs that everyone in those clinics wants to do.

PATRICIA DONOVAN: Thank you Chris. I just have one more question for you and that is when a patient is referred from the UM emergency department is participation in your program required? Actually a two part question. How do you train your ED staff to identify these high fliers who might be good candidates for the self-management program?

CHRIS WISE: To the first one, are they required, no. However, we've had—because of the success of our health navigators, our director of social work and our director of our visiting nurse program developed a program within the emergency department basically to support transitional care. And if you spend much

time with the ED clinicians identifying the frequent flyers is not hard. They know them off the tip of their tongue in most instances.

However, we have several other data tracking mechanisms, including our medical management center navigators are listed in our registration forms as a referring physician such that we get a notification by fax within 24 hours of any ED visits for the populations we're responsible. So we can have pretty close to immediate follow up with those individuals. And the emphasis will be to make sure they reconnect with the primary care physician, and to make sure they're following up on the needs to address the care for which they saw it in the ED. And yet with the advancement or development of this new program in the emergency department we have a very nice link in our clinicians in the medical management center to help navigators to know the group in the ED very well.

And so we have I think integrated that path. The patient is certainly not required to follow up but in most instances the patient loves these calls. They're often confused and possibly in part because the initial instructions for them are being delivered at a time when they're still perhaps suffering from the symptoms for which they sought treatment. It may not be the most teachable moment. This is true in many cases with discharge planning in a hospital where the programs could be done very well, but the patient isn't yet ready to learn that. So they get home and they start asking themselves, what did they say? What am I supposed to do? So these follow up connections in general are extremely well received and we've received many letters from patients thanking us for this type of service.

PATRICIA DONOVAN: And I'm sure you've cut down considerably on your perhaps unnecessary emergency room visits as a result.

CHRIS WISE: Last year in Disease Management Journal in February I published a comparison study of the populations we address at the medical management center versus a very similar population that we did not touch and showed a savings of \$63 per member per month. This was after adjustments for case mix and other things. In the Medicare demonstration project, we are evaluated by Medicare and its evaluation arm against our comparison group. There will be adjustments for severity and the cost of the treatments for our population on a whole are assessed against that comparison group. And there is a pay-for-performance model in that program, such that we can earn back any savings, some of the savings we achieved. I think the pay-for-performance models are just beginning to develop in this Medicare demonstration project is an exciting one but may not be where we ultimately end up and we're hoping all to learn from that very soon. So we're beginning to get promising data but we have a lot to learn.

PATRICIA DONOVAN: Well it sounds like you have some exciting beginnings on a lot of fronts here. So we wish you luck with that, and those are all the questions that I have today Chris. Thank you for being with us and we're looking forward to hearing more from you during the audio conference.

CHRIS WISE: You're welcome.