Connecting Primary Care & Community Health

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WHO World Health Report 2008 Reaffirms Primary Care 30 years after Alma Ata Declaration of Health for All.

Primary Care Matters!!!
Primary Care: Healing with our “Radical Human Presence”

- Listening
- Touching
- Affirming
- Comforting
- Diagnosing
- Treating
- Grieving
- Supporting
- Healing

Radical Human Presence is a phrase used in a presentation called “How the Heart Learns” by Landon Saunders; AAMFT, 2004 annual mtg.
Primary Care: The Ultimate Connection
Primary Care is a Team Sport
What’s the Purpose?

- **Monopoly**: The purpose of the game is to become the wealthiest player through buying, renting and selling of property.

- **Parcheesi**: The goal of the game is to move all of one's pawns "home" to the center space.
Is There any Purpose?
Or Just Frenetic Activity?

In *Angry Birds*, the player controls a flock of multi-colored birds that are attempting to retrieve their eggs, which have been stolen by a group of hungry green pigs. The objective of the game is to eliminate all the pigs on the level. Using a slingshot, players launch birds with the goal of either striking the enemy pigs directly or damaging their structures, causing the blocks to collapse and squash the pigs.
Primary Care
Under Pressure
Primary Care Must Do More!

- EHR Meaningful Use
- PCMH Certification
- ICD-10 Conversion
- Maintenance of Certification

- Behavioral Health Integration
- Panel-Based Management
- Outcomes Management
IN LATE JANUARY, the U.S. Department of Health and Human Services (HHS) announced that by the end of 2016 it aims to link 30% of Medicare reimbursements to the “quality or value” of providers’ services, and 50% by the end of 2018. The goal, according to HHS Secretary Sylvia Burwell, is “to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care.”

Outpatient value-oriented payments to primary care physicians

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>6%</td>
</tr>
<tr>
<td>2014</td>
<td>24%</td>
</tr>
</tbody>
</table>

Source: Catalyst for Payment Reform

Reimbursements through alternative, non-fee-for-service payment models

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>0%</td>
</tr>
<tr>
<td>2014</td>
<td>20%</td>
</tr>
</tbody>
</table>

Source: CMS

The form of money and personnel payers are making available to help practices improve their services, track their quality data, and improve their patients’ health.

QUALITY-ORIENTED REIMBURSEMENT GROWING

To get an idea of how pervasive the emphasis on quality and outcomes has become, consider the following statistics:
The ultimate goal of primary health care is better health for all.
Does Medical Care Really Matter?

“Medical Care only accounts for 10% of health status . . .”
Community Health Promotion

Graphic from Rhode Island College (www.ric.edu)
Triangulating on Success to Improve America’s Health

• Cardiovascular:
  – Heart Disease
  – Stroke

• Cancer:
  – Uterine/Cervical Cancer
  – Gastric (Stomach) Cancer

• Traumatic Injuries
  – Unintentional Injuries

• Infectious Disease:
  ▪ HIV-AIDS
  ▪ Tuberculosis
  ▪ Syphilis
  ▪ Influenza / Pneumonia

What accounted for the successful reduction in mortality (>50% in 50 years) for most of these conditions?
## TABLE 1—Adjusted Mortality Rates (per 100,000) for Selected Conditions: United States, 1950–2000

<table>
<thead>
<tr>
<th>Condition</th>
<th>Year 1950 Rate</th>
<th>Highest Rate (Peak Year)</th>
<th>Lowest Rate (Trough Year)</th>
<th>Year 2000 Rate</th>
<th>Decline From Peak Year, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>180.7</td>
<td>180.7 (1950)</td>
<td>60.9 (2000)</td>
<td>60.9</td>
<td>66.3</td>
</tr>
<tr>
<td>Heart disease</td>
<td>586.8</td>
<td>586.8 (1950)</td>
<td>257.6 (2000)</td>
<td>257.6</td>
<td>56.1</td>
</tr>
<tr>
<td>Gastric cancer</td>
<td>24.2</td>
<td>24.2 (1950)</td>
<td>4.6 (2000)</td>
<td>4.6</td>
<td>81.0</td>
</tr>
<tr>
<td>HIV</td>
<td>...</td>
<td>16.3 (1995)</td>
<td>5.2 (2000)</td>
<td>5.2</td>
<td>67.9</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>25.5</td>
<td>25.5 (1950)</td>
<td>0.2 (2000)</td>
<td>0.2</td>
<td>91.4</td>
</tr>
<tr>
<td>Syphilis</td>
<td>6.1</td>
<td>6.1 (1950)</td>
<td>0.0 (2000)</td>
<td>0.0</td>
<td>100</td>
</tr>
<tr>
<td>Influenza and pneumonia</td>
<td>48.1</td>
<td>48.1 (1950)</td>
<td>23.7 (2000)</td>
<td>23.7</td>
<td>50.7</td>
</tr>
<tr>
<td>Unintentional injuries</td>
<td>78.0</td>
<td>78.0 (1950)</td>
<td>34.9 (2000)</td>
<td>34.9</td>
<td>55.3</td>
</tr>
</tbody>
</table>
Shared Success Story – (in parallel, or in partnership)?

Hunink et al. were able to explain 92% of this decline in cardiovascular mortality from 1980 to 1990 in a multivariate model of secular trends during this period.

Across the pond, researchers were able to attribute two thirds of the reduction in CV mortality to declines in the prevalence of 3 risk factors: smoking, high blood pressure, and high serum cholesterol levels.


25% of the decline was explained by primary prevention,

29% was explained by secondary reduction in CAD risk factors and

43% by tertiary improvements in treatment in patients with coronary disease.

Team Sports

• Primary Care is a Team Sport!
• Community Health is a Team Sport!
• Connecting them both is the Ultimate Team Sport!!!
New Directions

• **BEYOND** One Patient at a Time in the Exam Room

• Diabetes Registry – one disease at a time
  
  *how are all my diabetic patients doing?*

• Patient-Centered Medical Home
  – Team-based Care
  – Panel-Based Care Management
  – Whole Person Outcomes (health status, ED visits, Hospital days, etc)

• Person-Centered Health Neighborhood
  – Healthy Behaviors at Home and Work
  – Chronic Disease Self-Management / Self-Efficacy
  – Mobilizing Family & Community Resources

• Community Health Promotion

• Population Health Outcomes
Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties

George Rust, MD, MPH, FAFP, FACP;1 Peter Baltrus, PhD;1 Jiali Ye, PhD;1 Elvan Daniels, MD;2 Alexander Quarshie, MD, MS;2 Paul Boumbellan, PhD;2 and Harry Strothers, MD, MMM3

Who Can Do This?

CHCs!!!
What’s the Right Team???
Quarterback-Driven Team?
M.D. Model

• Doctor’s *Orders*
• *My* Office . . . *My* practice
• *My* nurse . . . *My* receptionist

Me . . . Me . . . Me . . .
Why Build a Team?

Example: To prevent complications of obesity and diabetes, *all you have to do* is modify a person’s health beliefs and attitudes, daily habits, eating preferences, daily activities, exercise habits, grocery stores, neighborhood walk-ability, food advertising, self-care, employability, economic empowerment, access to medical care, clinical inertia, provider quality, and medication adherence, all in the context of his or her family and social relationships.
• Michael Jordan – where’s everyone else?
How’s that workin’ for ya???
We Need More Teamy-Teams!
Personalismo, Respeto, & Confianza

Trusted Relationships Trump Evidence-Based Arguments
Mental Health ↔ Physical Health

• “Baseball is 90% mental -- the other half is physical.”
  -- Yogi Berra

- Stress
- Depression
- Anxiety
- Substance Abuse
- Domestic Violence
- Schizophrenia
- Bipolar Illness

- Nervios
- Susto
- Mal de Pelea
- Social Isolation
- Migration Stress
- Acculturation Stress
Teamwork!

- Community Health Workers (*Promotoras*)
- Medical Assistants
- Nurses / Nurse Practitioners
- Pharmacists
- Social Workers
- Health Educators
- Respiratory Therapists
- Physical Therapists
- Primary Care Practitioners
- Psychologists
- Behaviorists
- Sub-Specialists
- Administrators
Staffing Models:
(8,000 patient panel)

- 5 MD’s
- 2 PA’s
- "support staff"

- 2 MD’s
- 3 PA’s
- 1 NP/Care Mgr
- 1 LCSW or Psychol/Behav
- 1 RPH/Pharm D (+ pharm tech)
- 3 Promotoras
Promotores / Promotoras & Community Health Workers

- Enhanced Access to & Use of Complex Health Systems (Navigators)
- Immunization Rates
- Breast & Cervical Cancer Screening
- Blood Pressure Control
- Control of Asthma Triggers in Households
- Healthy Eating & Exercise
- Safety Eyeware Use Among Farmworkers
- Compliance with Directly-Observed Treatment of Tuberculosis
The simple act of offering a sympathetic and understanding ear, and answering questions, many of which were unrelated to the medical problem at hand, had a salutary effect on overall patient and family satisfaction with both nursing and medical care.

Teamwork Includes Patients!

- Keep Patients on the Team!
- Patient Self-Management Education


- Hospitalizations RR = 0.64
- ED Visits RR = 0.82
- Days off work or school RR = 0.79
- Nocturnal Asthma RR = 0.67
- Caveat: Little change in measurable lung function
There was poetry as well, a luminous world always present beneath the surface, a world that people might offer up as a gift to me . . .

. . . If I only remembered to ask.
What’s the Role of Each Team Member?

• What’s the Highest / Best Role for Each Person on the Team???
  – What is he/she well-equipped to do?
  – What is he/she licensed to do?

• Who’s the best person on the team to perform each role?
  – Most suited to the task
  – Most cost-effective
  – Most fulfilled

• What’s the patient’s role on the team?
Teamwork: Everyone works up to the Level of their License

- Example: Empower More Clinical Staff to Initiate Preventive Services
  - Medical assistants and Licensed Practical Nurses offer mammography as a routine part of the clinic encounter

Teamwork: Enhanced Diabetes Education via Community Pharmacists

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients with HbA1c ≤7%</td>
<td>19%</td>
<td>50%</td>
</tr>
<tr>
<td>% of patients with LDL cholest ≤100</td>
<td>30%</td>
<td>56%</td>
</tr>
<tr>
<td>Patients taking Aspirin</td>
<td>42%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Diabetes Nurse Educators

• Impact of a diabetes disease management program in which certified diabetes nurse educators visited five participating primary care practices biweekly for 1 year providing education to physicians and office staff on standards for diabetes management and to patients regarding self-management.

• Bottom Line?
  – Average HbA1c Before = 9.0%
  – Average HbA1c After = 7.7%

Behavioral Health + Primary Care Continuum of Integration

Separate → Referral → Coordinated → Collaborative → Integrated

Separate → Co-located → Common
Cultural Relevance / Cultural Ownership

South Central Foundation – Anchorage, Alaska
How Well Do You Play Together?
Cherokee Health Systems “Integrated Care” Model:

- Biopsychosocial approach
- Addresses the whole person by integrating behavioral services into primary care.
- Combines the best traditions of primary care and mental health services in an integrated health care team to treat the whole person.
- Services include education, behavioral management, assessments, brief interventions, as well as treatment for mental health disorders.
Re-Define Workflow and Processes

• **Key Concept:**
  Re-set the default setting to do the right thing *automatically* unless the doctor says no!

**Examples:**
- Standing order flu shots
- *Point of Care* A1c or INR Testing (or patient home-testing)
- Checklists for patient to self-order mammography and other indicated preventive services
- 12-month Rx refills on contraception, blood pressure meds, etc.
## Systems Change: Re-Designing Processes of Care

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Diabetic gets finger-stick blood glucose; patient <em>may</em> have fasted</td>
</tr>
<tr>
<td>Step 2</td>
<td>Doctor sees patient, and <em>may</em> order Hemoglobin A1c test.</td>
</tr>
<tr>
<td>Step 3</td>
<td>Patient <em>may</em> go to the lab and <em>may</em> wait to get their HbA1c drawn.</td>
</tr>
<tr>
<td>Step 4</td>
<td>Doctor <em>may</em> notice that HbA1c is elevated</td>
</tr>
<tr>
<td>Step 5</td>
<td>Dr. <em>may</em> ask staff to call patient back for follow-up</td>
</tr>
<tr>
<td>Step 6</td>
<td>Doctor / nurse <em>may</em> be able to reach patient by phone.</td>
</tr>
<tr>
<td>Step 7</td>
<td>Patient <em>may</em> agree to come back, and <em>may</em> actually keep appt.</td>
</tr>
<tr>
<td>Step 8</td>
<td>If patient comes back, doctor <em>may</em> intensify regimen.</td>
</tr>
</tbody>
</table>
Systems Change: Re-Designing Processes of Care

Step 1
• Nurses follow standing order for fingerstick Hgb A1C on every diabetic

Step 2
• Results on chart when doctor sees patient;

Step 3
• Doctor may intensify regimen

• Avg A1c 8.55 before
• Avg A1c 7.84 after

• Re-set the default setting to do the right thing automatically unless the clinician says no!
Overcome Team Dysfunction

- Unrealistic Expectations
- Hidden Agendas
- Professional Guilds
- Turf-Protection
- Mutual Disrespect
- Medicolegal Fears
- Financial Disincentives
- Miscommunication Across Professional Cultures
  (nurse-doctor-administrator)
What Works? Create a Culture of Excellence

- Measure Excellence
- Paint a Picture of Excellence
- Embrace Constant Learning
- Embrace Continuous Change
- Empower Decentralized Re-Design
- Invest in Excellence
- Reward Excellence
Manage the In-Betweens!

Interfaces:
- Patient ↔ Practice
- Practice ↔ Health System
- Practice ↔ Community
- Practice ↔ Outcomes
- Community ↔ Outcomes
Diabetic Patients Ranked by A1c Levels

HTN Patients Ranked by Systolic BP

Patients to Call re: Medication Adherence

Mary Smith in Clinic today
- Systolic BP >200!
Follow-up Indicated!

Shift Seamlessly Between Individual Patient Care & Panel-Based Care
Group Visits and Panel-Based Care Mgt

- Who says group visits have to happen in the clinic?
Free-Range Humans
(when patients escape from the exam room!)
Example: Childhood Asthma

Scenario: Your local-area, chronic disease monitoring and rapid-cycle feedback surveillance system has detected tremendous local-area variation and racial-ethnic disparities in emergency room visits in the Atlanta metro area.

Objective: Establish a culturally-effective, community-respectful, strength-driven initiative for decreasing asthma burden of disease in specific segments of the community.

<table>
<thead>
<tr>
<th>Primary Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
</tr>
<tr>
<td>Obesity</td>
</tr>
<tr>
<td>Indoor Air Quality</td>
</tr>
<tr>
<td>Outdoor Air Quality</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAEPP Clinical Guidelines</td>
</tr>
<tr>
<td>Steroid Inhalers w/ spacers</td>
</tr>
<tr>
<td>Self-Management / CHW Peer Counselors</td>
</tr>
<tr>
<td>Primary Care / School Policies / Care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tertiary Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring &amp; Follow-up of Adverse Events (ED Visits &amp; Hospital Admits)</td>
</tr>
<tr>
<td>Care Management</td>
</tr>
</tbody>
</table>
Managing Clinical and Social Complexities for Whole Persons

**One Diabetic Patient:**
- Diabetes
- Arthritis
- COPD
- CHF
- Stroke
- Pneumonia
- Cancer
- Depression
- Alcohol / substance abuse

* 21 ER Visits    * 143 hospital bed-days

<table>
<thead>
<tr>
<th>Hosp cost</th>
<th>outpt</th>
<th>physician</th>
<th>other</th>
<th>meds</th>
<th>diagnost</th>
<th>Total $$$</th>
</tr>
</thead>
<tbody>
<tr>
<td>$217,657</td>
<td>$7,105</td>
<td>$29,756</td>
<td>$10,498</td>
<td>$3,155</td>
<td>$12,182</td>
<td>$280,353</td>
</tr>
</tbody>
</table>
Poor Outcomes are Rooted in Clinical & Social Complexities
Risk Stratification

On-Going Surveillance
(for windows of Vulnerability, or "Risk-Moments" for Adverse Events)

Outcomes Tracking
(real-time for patient care-management, plus aggregate for rapid-cycle program improvement)

The Right Care in the Right Setting at the Right Time

Risk Stratification

Super-High Risk

Mid to High Risk

Low Impact

Low-Risk

The Right Care in the Right Setting at the Right Time

Alcoholics Anonymous

CALL WITH ?'s

The Right Care in the Right Setting at the Right Time
Partnership with Community

Integration means working seamlessly together on a shared agenda!
Clinic (PCMH)

Home & Community

Population Health Outcomes
(Hospital Bed-Days, Disability, Death)
Moving Toward Optimal Health for All in the Agalto Valley, Honduras

In the 1980’s, Infant Mortality in the Olancho state of Central Honduras was over 70 per 1,000 (7%); Since 2006, there have been no infant deaths in the 27 villages covered by the comprehensive community development work of Honduras Outreach (Rancho Paraiso).

Infant mortality rate
Infant mortality rate is the number of infants dying before reaching one year of age.

Data source: World Bank, World Development Indicators - Last updated Apr 26, 2011
What Accounts for Success in the Agalto Valley, Honduras?

Public Health / Sanitation

Education / Nutrition

Prenatal Care / Primary Care

Economic & Community Development
Tying it All Together to Achieve Optimal, Equitable Health Outcomes
Disparities Success Stories!

Decline represents 29 infant deaths prevented (expected vs. actual)

29 babies saved!!!
Humility in Working Together

“We are all as angels, with only one wing;
We can only fly when we embrace each other.

-- Luciano de Crescenzo