



IMPROVING PRIMARY CARE, ONE PATIENT AT A TIME

BY ALISON SZOT**PHOTOGRAPHY BY MICHAEL RANDOLPH**

Patients with depression cost the health care system hundreds of millions each year—and their doctors are often unaware of their condition. In West Michigan, health care leaders hope care managers that help patients navigate a complex system hold the keys to filling in this critical gap.

The scene is almost like something out of a movie: a group of highly educated individuals from different disciplines and backgrounds plotting change in a basement in Grand Rapids, Mich. The basement houses offices for the Michigan Center for Clinical Systems Improvement (Mi-CCSI), a partner organization of the Alliance for Health, West Michigan's health planning agency and one of 16 grantees in the Robert Wood Johnson Foundation's *Aligning Forces for Quality* (AF4Q) program.

Together, the region's health care stakeholders passionately talk about both the need for transforming a health care system that is obsolete and doesn't serve the needs of individual people, while offering up real solutions to both improve quality and bring down costs—especially in the primary care setting.

"When the practice of primary care fails, it is mostly because it doesn't have the resources to succeed," says Paul

Woods, MD, a family physician and interim medical director at Mi-CCSI. "A primary care physician has to know a dizzying array of things, and today's fragmented health care practice environment has created a number of gaps that primary care physicians aren't equipped to fill."

In West Michigan and elsewhere, many health care leaders see care managers—charged with both assessing and "navigating" high risk patients throughout their journey to better health—as key to filling those gaps, particularly for patients who suffer from depression. While 75 percent of patients with depression see primary care physicians, those physicians don't detect depression in more than 50 percent of patients who have it. Depression is complicated to treat, too. Only between 20 and 40 percent of patients improve substantially within 12 months of being diagnosed.

Beyond depression, there are other social determinants of health that can hamper clinical interventions. For instance, rural patients without access to cars may miss follow-up appointments or have difficulty filling prescriptions, while homebound patients may experience social isolation. Care managers can often identify these issues and help patients and physicians alike identify solutions to overcome them.

“We believe that care management is proving to be a better way of delivering health care to a population of patients than usual care is today,” says Steve Williams, Mi-CCSI’s executive director. “It gets you off the treadmill, and provides impactful interventions to patients with more complex needs by unpacking some of the more opaque issues complicating treatment.”

Addressing these issues takes collective effort which West Michigan, home to several large integrated delivery systems designed to align the interests of physicians and hospitals to deliver efficient, effective, high-quality care, is particularly fertile ground for. These organizations include Spectrum Health, Mercy Health Physician Partners and Lakeshore Health Network Muskegon and Michigan Advantage Health/St. Mary’s Care Network.

“Medicine and doctors’ practices have always had a little different quality in Western Michigan,” Thomas Ruane, MD, medical director for Blue Cross Blue Shield of Michigan’s PPO and Care Management programs, and Mi-CCSI board treasurer says. “They’ve tended to be in fairly organized groups, and have been really amenable to trying new things.”

David Van Winkle, MD, a family physician in Muskegon, Mich. and medical director at Lakeshore Health Network and Mi-CCSI board chair, agrees.

“I set up my practice in Muskegon 23 years ago in part because I saw it was an area that had a lot of collaboration,” Van Winkle says. “As I took care of my patients, I increasingly understood that what I do is not in isolation and has to occur within a collaborative system of care. This is a team sport.”

PUTTING THE PATIENT BACK AT THE CENTER OF CARE

The care managers in West Michigan operate through two distinct programs—COMPASS (Care of Mental, Physical, and Substance Use Syndromes), a federally-funded collaborative care management model designed to improve the care of patients with depression and diabetes and/or cardiovascular disease, and the DIAMOND (Depression Improvement Across Minnesota Offering a New Direction) initiative, which focuses exclusively on identifying, diagnosing and treating depression.

Cindy Allen-Fedor, RN, director of care management at Spectrum Health Medical Group, oversees her organization’s participation in both projects, which she says are part of a larger movement to re-establish the patient at the center of the health care experience.

“Years ago, primary care practices always had a registered nurse in the office,” Allen-Fedor says. “But at some point RNs became too expensive, so they were replaced by medical assistants. MAs cost a lot less, but don’t have the same level of clinical training. As primary care has moved toward more volume production, we’ve really lost some of that quality stuff.

Patients are not getting educated, setting and working toward goals, and nobody is reaching out to patients who should be coming into the office.”

Susan Viviano, RN, director of medical management at Mercy Health Physician Partners in Grand Rapids, has worked as a care manager in an acute care setting and on staff at an HMO, both settings where care managers have traditionally operated. Viviano believes care managers are often underutilized in primary care settings, where they can coordinate care, helping patients navigate the system and connect them with community services and resources.

“I always came to the same conclusion,” Viviano says. “If you could do this in the primary care setting and you can follow a patient through the whole care continuum, you’d have more of an advantage to coordinate care, keep patients from falling through the cracks, educate them, and reduce duplication of care and overutilization.”

Richard Robinson, a 60-year-old patient from Kentwood, Mich., says the support he’s received from his care manager has been key in helping him manage his diabetes, noting both the educational and moral support he’s received throughout his care journey. In particular, Robinson’s hemoglobin A1c level—one of five key measures, known as the D5, that measure patient diabetes control—has improved significantly since he began working with a care manager. Robinson attributes his turnaround to increased confidence in managing his disease because of the education his care manager has provided, as well as the sense of accountability he feels, knowing that he has to report back to her on his progress and experiences.

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Steve Williams, Executive Director

**Michigan Center for Clinical
Systems Improvement**

“In the past, there have been times when I’ve really struggled,” Robinson, a truck driver, says. “The food on the road is too tempting, and too unhealthy. In the past, I would have a bad day, and overeat. Then I was like, ‘I screwed up; I might as well give up.’”

Greg Gadbois, MD, a family physician in Coopersville, Mich., who serves as a primary care consultant to seven Spectrum Health Medical Group practices in the COMPASS program, said that from the beginning, physicians have seen the benefit of having care managers who are responsible for keeping in touch with patients between office visits.

“Frequent touchpoints with patients instill a trust that we want to help, and gives us more of an opportunity to see

what else is going on in their lives that could be complicating treatment,” Gadbois says.

INTEGRATING BEHAVIORAL HEALTH INTO PRIMARY CARE

Primary care practices involved in both care management programs actively screen patients for depression using the PHQ-9 screening tool, which is derived from the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV). Eligible patients are referred into care management and given a comprehensive assessment, followed by a team discussion that includes a consulting primary care physician, the care manager, and a psychiatrist. From there, a plan of care is developed and the patient is followed downstream with the care manager staying highly involved and in close communication until the patient has been “treated to target.”

Robinson attributes both the screening efforts and the ongoing education from his care manager in dramatically improving his ability to manage his health. During his initial case review, a psychiatrist recommended a change in medication—since that time, Robinson’s score on the PHQ-9 has improved.

The information also helps primary care physicians integrate the findings from their patients’ depression screens—along with insights from their care managers—into their care plans. Van Winkle described a recent appointment in his Muskegon practice with a middle-aged patient who had recently lost his wife to cancer and was feeling depressed. Van Winkle diagnosed him with a deep-vein thrombosis (DVT), a life-threatening

emergency, and sent him to the emergency department (ED). After being treated in the ED with intravenous blood thinning medication, the man went home with a prescription for a blood thinning medication. But the medication required laboratory monitoring to ensure correct dosage, and Van Winkle’s care manager noticed the patient had not come into the lab as he had been told to.

“She got a visiting nurse out to the house that day who checked his PT (prothrombin time) and saw it was out of control,” Van Winkle recalls. “The dose he had been given completely overshot, and he had active bleeding.”

Van Winkle switched his medication to one that doesn’t require as frequent monitoring, while the care manager arranged for a hospice grief counselor to visit the patient at home.

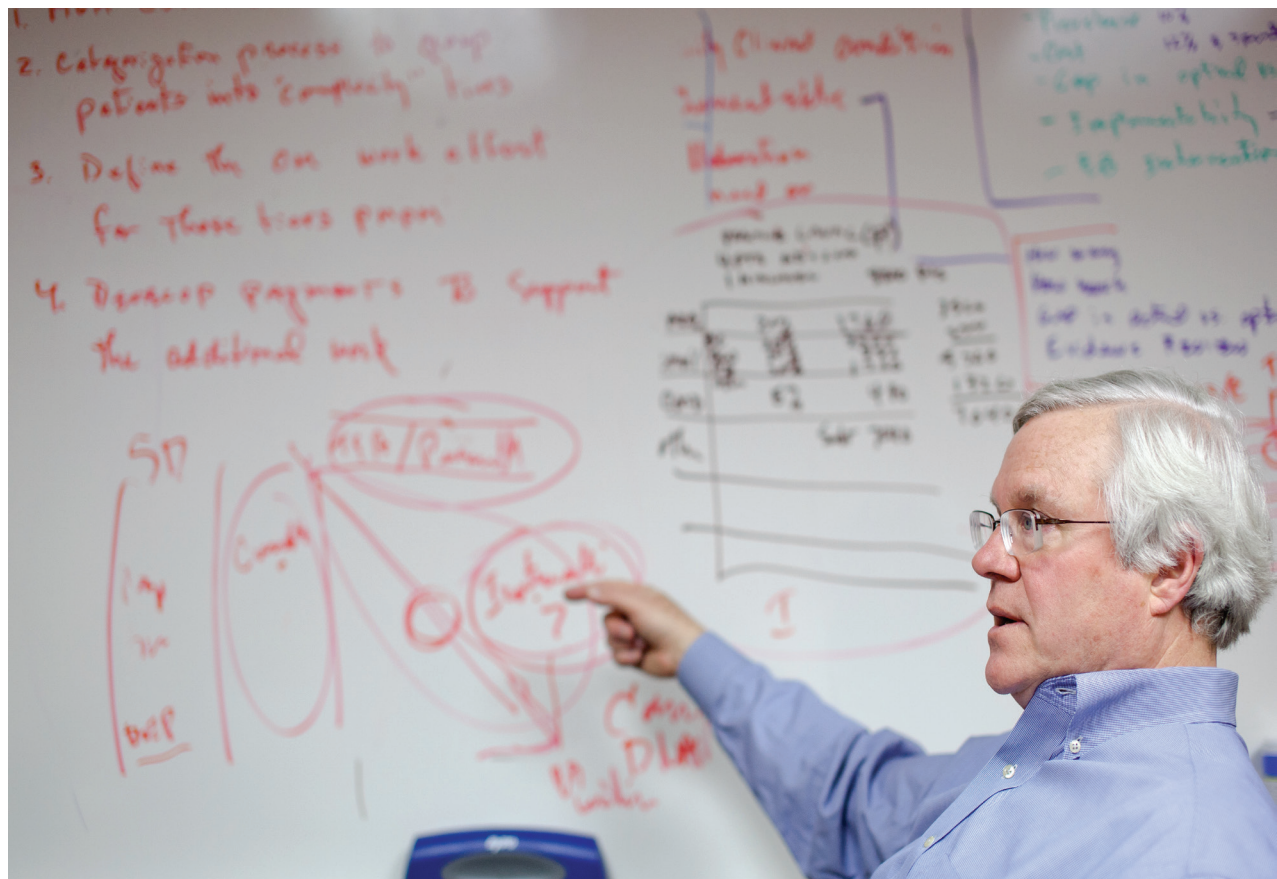
‘IT’S LIKE HAVING TO CHANGE THE WING ON AN AIRPLANE WHILE YOU’RE FLYING IT’

Mi-CCSI is also keyed in to another reason why the care management models may be particularly poised for success. In a 2011 physician survey by the Department of Community Health, psychiatry was identified by physicians as a specialty where they had the greatest difficulty getting timely referrals for patients. This lack of access is expected to grow as much as 19 percent in the next five years, and by 2020, nearly half of the population in need of a psychiatrist will be unable to access care.

Getting psychiatrists’ input and consultation through the programs’ systematic case review process is a way to deploy that scarce resource in a population-based way. It was also one of the reasons the physicians who are participating in COMPASS and



Family physician Gregory Gadbois, MD, speaks with Rebecca Raska, RN, care manager at their offices in Coopersville, Mich.



Steve Williams, executive director of the Michigan Center of Clinical Systems Improvement (Mi-CCSI), discusses primary care improvement at Mi-CCSI's Grand Rapids offices.

DIAMOND are so enthusiastic about the programs, Mi-CCSI and Alliance for Health leaders say.

"We have a fragile start on a common care management model for chronic illness across primary care systems in Western Michigan," Paul Brand, executive vice president at the Alliance for Health, says.

Van Winkle can see the potential for increased collaboration, especially in other shortage specialties, noting that in Muskegon, a town with a population of 120,000, there is not a single board-certified endocrinologist.

"These physicians enjoy the more complicated cases that challenge them and are interesting," Van Winkle says. "If they could partner more effectively with primary care physicians, their schedules wouldn't be clogged up with the more typical cases and they could spend their time on the more stimulating cases."

Still, challenges lie ahead. Brand says the primary care transformation underway in Western Michigan is critical, but is still difficult to implement given the current health care payment system, with incentives that often reward providers for high-volume care over high-value care. For example, a physician who cannot bill for the time spent in coaching heart disease patients on nutrition and lifestyle changes may instead opt to address the disease with a costly—and sometimes risky—procedure.

"We are just getting real traction at the practice and patient level after years of hard work," Brand says. "That is because we are constantly swimming upstream of the present payment model and financial incentives."

Williams acknowledges that the road the Alliance for Health and Mi-CCSI has chosen to travel is a difficult one, but won't be deterred by the challenge.

"We have to build a new system inside an already existing process," Williams says. "It's like having to change the wing on an airplane while you're flying it. But there is no other model that we've seen—and I've been reading the literature for 20 years—that even comes close to having the kind of impact that care management is showing."□

Alison Szot is a longtime health care policy writer whose work has appeared in *Modern Healthcare*. She holds a Master of Health Services Administration from the University of Michigan's School of Public Health and previously served as the senior editor and director of external partnerships for The Medicare NewsGroup.

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