Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

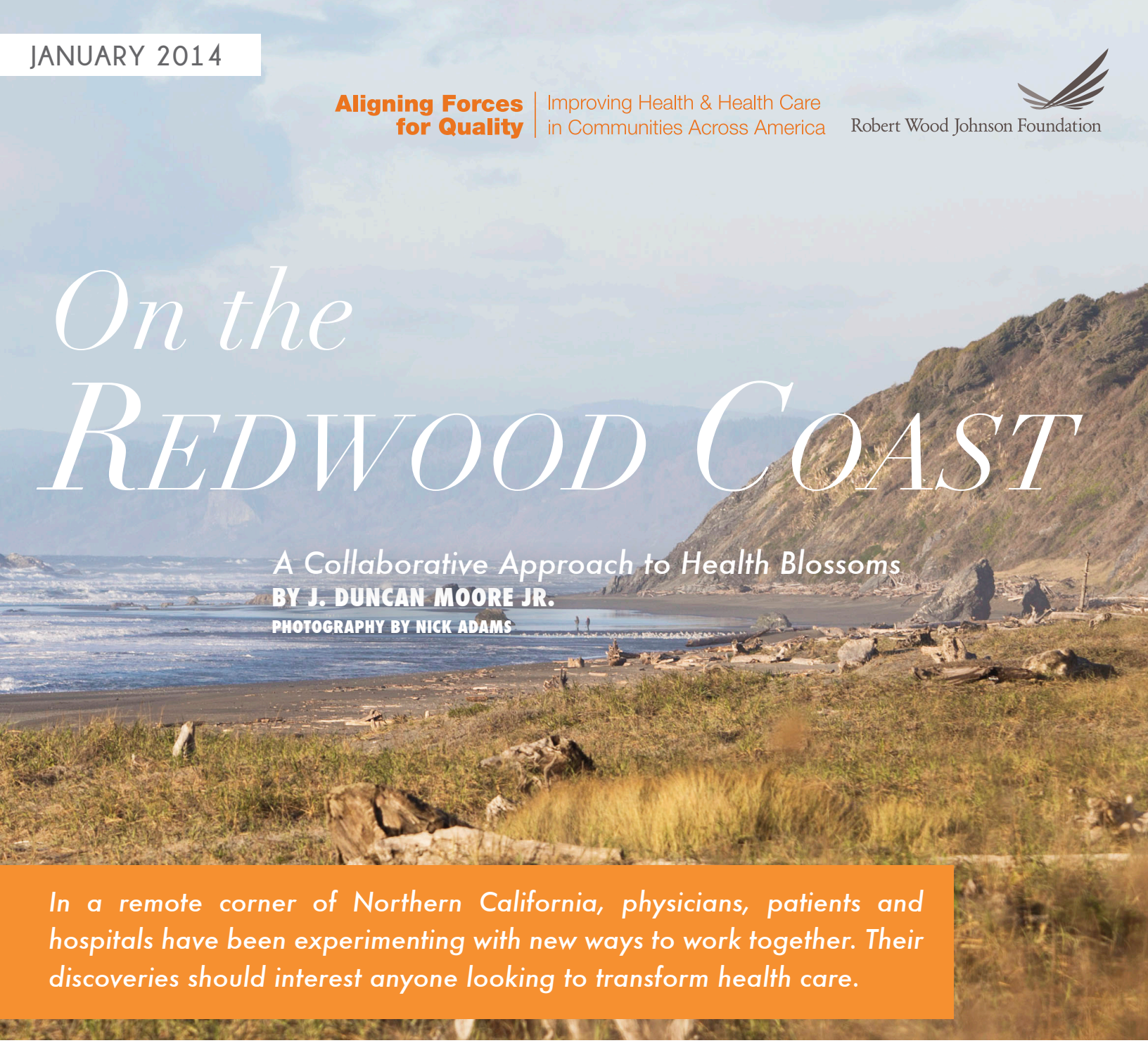
Robert Wood Johnson Foundation

On the Redwood Coast

A Collaborative Approach to Health Blossoms

BY J. DUNCAN MOORE JR.

PHOTOGRAPHY BY NICK ADAMS



In a remote corner of Northern California, physicians, patients and hospitals have been experimenting with new ways to work together. Their discoveries should interest anyone looking to transform health care.

Toni Martin has been thinking a lot lately about how one could make a primary care practice truly responsive to patient needs. She's 86 and has diabetes—"under control with diet and exercise"—and osteoporosis.

"I'm just aging. My doctor put it very well. He said, 'Toni, the parts are wearing out.'"

Her insight is that patients should get screened by another practice clinician before they see the actual doctor, so the caregiver can surface the real issues ahead of the patient's rushed, and sometimes intimidating, session with the authority figure.

"There's a nurturing thing that's missing," she muses.

Finally, she sat down and drafted a work sheet "to make your visit more satisfying and more productive," as she says. It consists of nine questions, starting with: "How are you feeling right now?" She hopes it will help patients learn to take a stronger role in managing their own care, as she has done over the past five years.

Martin has an unusual perspective from which to advance her views. She is one of two patient representatives participating in a process of "primary care renewal" at the office of Bruce Kessler, MD, in Eureka, California, near where she lives in Humboldt County on the foggy Redwood Coast.

Every two weeks Kessler hosts a brown bag lunch for his staff and the patient partners in his practice. Today, Martin introduces her work sheet and hands it around. The staff aren't immediately receptive to the idea—"I ask every one of my patients those questions every time," says Tonya Sauer, a medical assistant—but Kessler intercedes, saying, "Let's do a PDSA" (shorthand for Plan – Do – Study – Act, a tool for analyzing fast changes in procedures developed by the Institute for Healthcare Improvement).

This kind of patient suggestion-making and process improvement is a key element in Primary Care Renewal, a program intended to create medical offices that patients will want to engage with instead of just shuffle through.

"We're trying to think in terms of population management and best practices," Kessler says.

Primary Care Renewal (PCR) is one of the prongs of a wide-ranging patient care improvement initiative that the Humboldt

County medical community has launched with assistance from *Aligning Forces for Quality*, a national program organized and funded by the Robert Wood Johnson Foundation.

Other pieces of the program include the Surgical Rate Project, to understand why Humboldt County has higher rates of certain procedures than expected; the Care Transitions Program, to help patients discharged from the hospital manage their care more effectively; and Our Pathways to Health, a chronic disease self-management program to help patients better manage their own health. Outside of *Aligning Forces for Quality*, the Humboldt community is also engaged in the Priority Care Project, to ensure that patients get the right care in the right way as soon as possible.

Under the *Aligning Forces* framework, each program is designed to raise awareness to providers and the public of the importance of quality improvement; report data and analysis publicly; and engage patients and consumers in quality improvement.

This patient-centric focus includes various inducements for Humboldt residents to get screened for colon cancer, a disease with an unusually high incidence and mortality rate in Humboldt County.

In the five years that Humboldt has been working on these *Aligning Forces* initiatives, some things have gone well. Diabetes is better controlled, patients are more involved in their care, the health care community is more collaborative, and there's a greater awareness of the importance of cancer screenings.

There have been plenty of challenges: physicians distracted by the exigencies of running a practice and making payroll are not always favorably disposed to the latest quality process improvement imposed on them. Getting all community providers to share data can be tricky. Practitioners get worn out, retire, or move away.

Nevertheless, the local health care community continues to move forward, analyzing data, publishing reports, and applying process improvement techniques to see whether this or that incremental change might unlock some hidden insight that will hit the oft-cited "Triple Aim" promulgated by the Institute for Healthcare Improvement: to improve the patient experience of care, improve the health of populations, and reduce the cost of care.

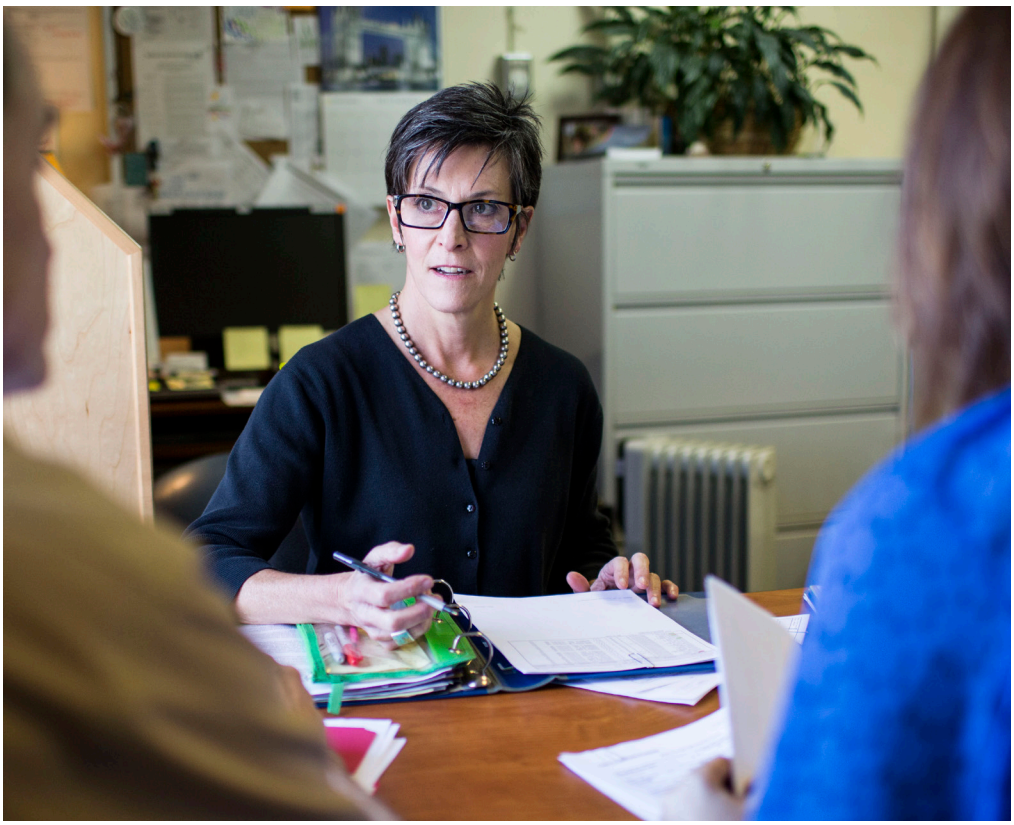
GETTING THE RIGHT PEOPLE IN THE ROOM

To get the health care system to change, lots of different forces need to be lined up.

"The various stakeholders who can make the difference are often local," says Elliott S. Fisher, MD, co-director of the Dartmouth Atlas, which surveys the differentials in utilization and cost across the country.

The federal government has a role to play, of course, as the largest payer and as author of the ACA. And states are important, as payers for Medicaid. But the stakeholders who can really put the pieces together—"the local medical society, hospital governing boards, businesses that might actually care about quality of care"—are local, Fisher says.

The people in Humboldt County are willing collaborators in this national endeavor.



Care Transitions Program Manager Sharon Hunter RN, PHN during a meeting in the Care Transitions Program office at St. Joseph Health's General Hospital Campus in Eureka.

MARTIN LOVE
CEO of the Humboldt Del Norte Independent Practice Association

For more than 10 years the local medical community has been on the system-, quality-, and cost-improvement bandwagon, and to a certain extent, they're the ideal testing ground for many of the innovations contained in the ACA and elsewhere.

"We've all been working together for quite some time," says Martin Love, 67, chief executive officer of the Humboldt-Del Norte Independent Practice Association (IPA) in Eureka and local philosopher-father behind the comprehensive quality improvement strategy. "There is quite some expertise in the team, and the team decides what to do and not to do."

The IPA has about 220 physician owners and an annual turnover of around $10 million. While the bulk of the commercial population is insured through PPO products, the IPA provides the local HMO structure, and is the convener on quality improvement.

Humboldt started working on improving access and quality in the 1990s, when community leaders noticed that it had an unusually high rate of diabetes, and that outcomes were worse than the state average. The IPA developed a diabetic registry and a point-of-care tool.

"Our care was not up to standard," recalls Rosemary Den Ouden, chief operating officer of the IPA and formerly a practice manager.

Starting in 2003, the community introduced a comprehensive diabetes care improvement regimen. Before then, only 32 percent of patients had received an eye exam in the past year; after the project, 68 percent had. Before, just 32 percent had had a foot exam; afterward, 72 percent had. The percentage of patients with HbA1c of less than 7.0 rose from 52 percent to 59 percent, while the percent of patients whose HbA1c was over 9.0 decreased from 5.9 percent to 5.2 percent. There were similar improvements in rates of hypertension and high cholesterol.

"You could say, medicine is getting better all over," says Alan Glaseroff, MD, one of the progenitors of the Humboldt quality project. "But the fact that it stayed the same statewide indicates that what we did in Humboldt made the difference."

"THE VARIOUS STAKEHOLDERS WHO CAN MAKE THE DIFFERENCE ARE OFTEN LOCAL,"

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Success in getting better control of diabetes provided the foundation to all of the endeavors since then.

RURAL HEALTH CHALLENGES IN A BEAUTIFUL, BUT REMOTE, SETTING

Though it's in California by climate, landscape, vegetation, and overall atmosphere, Humboldt County feels more like Puget Sound than San Francisco Bay. It is not merely rural; it is remote. To get there from "the City," you drive north through the wine country, then through gathering hills as you ascend the Coastal Range. Hours later, once past the crest, you slalom at 25 miles per hour on a two-lane blacktop between the primeval sequoias, shrouded in mist—this is the main road, mind you—until you emerge into the plain of the Eel River and Arcata Bay.

This remove has bred in the locals a sense of independence. "When we interact we keep that sense of autonomy," says Toni Martin. "Word of mouth is how we get things done."

Networks of acquaintanceship and social affiliation weave through the patient and provider communities. Janina Shayne, a patient representative in another practice, recounts that her first husband worked for Martin Love 30 years ago in the hospital lab. Everybody's children went to high school together.

Humboldt County is the only completely rural community of the 16 *Aligning Forces* pilot sites, and people there evince a strong sense that what they learn may be applicable elsewhere. Medical communities like this, characterized by associations of small practices in the absence of a large integrated delivery system, "are all over the nation," Den Ouden says.

The quality improvement team there has to address all the issues that come of not having seamless integrated systems: no single shared electronic medical record system, no IT support, no consistent administrative structure, and plenty of opportunities to either opt-in or opt-out.

DYING FROM 'DISEASES OF HOPELESSNESS'

Like rural communities across the country, Humboldt has endured a large portion of economic disruption, social disarray, and drug addiction in recent decades, and these have cast a pall over its public health statistics. While the county's ethnic makeup resembles the California of yesteryear—it's 84 percent white, 10 percent Hispanic or Latino, 6 percent Native American and 1 percent black—its health problems are decidedly present-day.

According to a draft community health assessment circulated in January 2013 by the county Department of Health and Human Services,

- The leading cause of premature death in Humboldt is acute and chronic effects of alcohol, drug, and tobacco use;
- Humboldt experiences drug-related death rates 300 percent higher than state and national averages;
- Non-white and American Indian/Alaska Native persons die 12 years sooner than whites.

People in Humboldt are dying from "diseases of hopelessness," in Connie Stewart's view. She's the executive director of the California Center for Rural Policy, the coordinating agency for the *Aligning Forces Humboldt* project.

"There's two different health outcomes: one for folks with substance abuse and another one for everybody else," she explains in her office at Humboldt State University, overlooking a redwood grove in Arcata, where she used to be mayor.

Since 1990 the county has lost 5,000 manufacturing jobs, mostly at sawmills. The consequence, as it plays out in population health, is a divide in outcomes between those with commercial insurance and those without. The county's rough topography complicates the problem. At a population density of 38 people per square mile, Humboldt comprises "very isolated communities," Stewart points out. That makes service delivery a critical issue.

OVERCOMING INERTIA TO IMPROVE HEALTH DELIVERY

While *Aligning Forces* may not be able to alter the social factors that contribute to the health of a community it can supply resources and intellectual capital to combat inertia in the health care delivery system, particular in specific interventions:

Care Transitions

Under the Affordable Care Act, hospitals are now being penalized if their Medicare 30-day readmission rates (resulting from failed care transitions) are higher than they should be.

Fragmentation—physicians not knowing when their patients are discharged, different physicians seeing the patient and not coordinating their efforts—has long been the main problem for health care quality in the U.S., says Fisher.

In Humboldt County, St. Joseph Hospital has led an effort to smooth out these handoffs. Sharon Hunter heads the Care Transitions Program at St. Joseph Hospital, the main acute-care provider in Eureka and a part of St. Joseph Health, sponsored by the Sisters of St. Joseph of Orange in Southern California.

"We are trying to de-silo our care and be a better partner to community providers," Hunter says. They have used the widely embraced Eric Coleman model, pioneered at the University of Colorado, to smooth the transition from hospital to home care. Part of that program coaches patients to think of themselves as active participants in their care instead of passive recipients.

The Humboldt team has concentrated on chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). For the third phase of *Aligning Forces* funding (2011 to 2013), Care Transitions has a goal of reducing readmission rates for chronic obstructive pulmonary disease and congestive heart failure by 20 percent of the baseline measurement, established in April 2010 through May 2011. To date, Care Transitions has reached the 20 percent reduction for enrollees with COPD, and is close to attaining the 20 percent reduction for those with CHF. Care Transitions has achieved a 23.5 percent decrease in ED utilization and a 44 percent decrease in hospital utilization among program enrollees.

Reducing Unnecessary Surgeries

In 2011 the California Health Care Foundation

PRIMARY CARE RENEWAL: PATIENT WORKSHEETS:

1. How are you feeling right now?
2. Are you tense and/or afraid? What about?
3. Are you handling any big problems at home right now?
4. What is your biggest worry?
5. What are your symptoms right now?
6. What have they been since your last visit?
7. Have you tried anything that seemed to help?
8. What do you want to ask that doesn't seem important?
9. What part of this do you want to share with _____?

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says Alan Glaseroff, M.D. one of the progenitors of the Humboldt quality project

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released a report by Stanford economist Laurence Baker that analyzed the rates of preference-sensitive elective surgeries, organized by hospital service area. Humboldt County's rates for six of the 13 procedures studied were surprisingly high—more than 150 percent of the state mean.

Of the six procedures, *Aligning Forces* and CHCF decided to focus on four: coronary artery bypass graft, hysterectomy, carotid endarterectomy, and cholecystectomy. The project leaders brought together key stakeholders to assess the problem and produce recommendations: primary care physicians, surgeons and specialists directly associated with the procedures and community members, representing patients, employers, government, labor, private and public organizations.

Part of the objective was to introduce the community group and the clinical community to shared decision-making, under the assumption that there should be a community view of how care is delivered.

In May 2013 the community group produced four deeply thought-through recommendations, among which was the suggestion "to adopt a clear process and nomenclature distinguishing the intent of a referral" that includes fully informing the patient.

The referral process is fundamentally flawed, the study group found. Referrals often work "like a game of whispering," Love says. A person with a lot of knowledge—the primary care physician—asks people with less knowledge—the office staff and the patient—to do something: say, see a specialist. A lot gets lost in translation. Many times the specialist has no idea why the referral has come in. The specialist asks the patient why he or she is there. Sometimes the patient knows, sometimes he or she doesn't.

Some primary care physicians think that if they send the patient to a surgeon, a procedure should follow. Others expect the surgeon to examine the patient, contribute his or her expertise, and return the patient to the PCP for decision-making. If the surgeon doesn't do a procedure, will the PCP be annoyed and stop referring to him or her? There's too much uncertainty in the process.

Patient Engagement

If there's a single through-line running across all the initiatives in Humboldt, it's putting the patient at the center of the reform and renewal process. In addition to the Primary Care Renewal program, those patient-centered efforts include Our Pathways to Health, a self-management initiative for patients with chronic illness, such as COPD, diabetes, and heart failure, based on a curriculum developed at Stanford by Kate Lorig.

At the same time, the Patient Partners concept was being launched, with assistance from *Aligning Forces*, by Betsy Stapleton, the Lead Consumer Representative, and Jessica Osborne-Stafsnes, Project Co-Director and Patient Engagement Specialist at *Aligning Forces Humboldt*.

"We said to practices, 'Come join our project,'" Osborne-Stafsnes says. "'Recruit a team from your office, and there must be a patient on your team. '"

Their framework has attracted wide interest from other *Aligning Forces* sites and the health reform community nationally.

"This is hard work," and you have to be prepared for it, says Janina Shayne, who was a patient partner in Alan Glaseroff's internal medicine practice before he moved to Stanford in 2011. "You have to try to breach the walls of the medical establishment. We're saying, 'Come out of your culture and look at ours—ours meaning patients!'"

The main things she's seen change since taking a seat at the table are "issues of tone and communication," with the result that frontline staff "became more human."

The first two years of the Primary Care Renewal project, 18 practices participated. At the end of the most recent funding cycle, only 11 did. To Shayne's dismay, the successor physicians in Glaseroff's practice decided not to continue with the program.

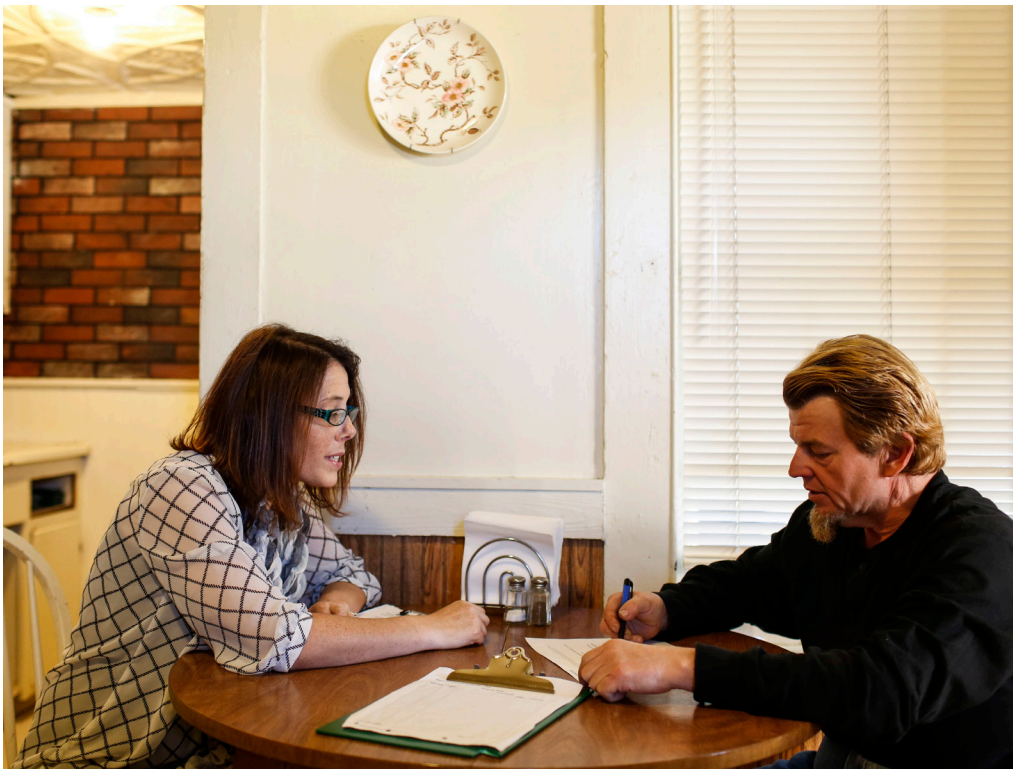
If having a patient at the table is so great, why are physicians walking away? In Bruce Kessler's view, it's because so many of them are overwhelmed trying to convert from paper charts to electronic medical record systems.

GETTING PATIENTS ON BOARD

Of course it could be something else. Dartmouth's Fisher notes that there are plenty of reasons why people take fright at the idea of being measured. "First, it's hard work. It's expensive. People get frustrated. They don't like being compared to each other, until they can be brought to the table and shown how it benefits them."

The resources provided by *Aligning Forces* have created an incentive for people to come together—for now. Unless the payment system changes, and providers see a business case for all this extra work, it's not likely to succeed in the long term, Fisher thinks. That's why payment reform models with aligned incentives, like accountable care organizations are necessary, he adds.

Still, it's not clear that the data being generated is being applied by the end users the way that theorists and academicians have anticipated. Some of the assumptions around



Social Work Coordinator Joy Victorine talks with patient Tony Domenico in Eureka.

MELISSA JONES
Project Director for
Aligning Forces Humboldt

data reporting made by *Aligning Forces* didn't pan out, Glaseroff says.

So the team leaders decided to pivot in the direction of patient activation. This emphasizes training patients to take independent actions to manage their health and care, and has been demonstrated to lead to better outcomes, according to a recent article by Judith H. Hibbard and Jessica Greene in *Health Affairs*.

When *Aligning Forces* said it wanted patient involvement, "I pushed really hard to use the Stanford program," known as the Chronic Disease Self-Management Program, Stapleton says. More than a support group, "it's a standardized developed curriculum" that teaches patients with chronic illness how to grapple with "loneliness, self doubt, how do you make decisions, good eating, exercise, setting reasonable goals given your new context."

By 2010 Humboldt had the highest number of graduates per capita of this course of any California county.

NEXT UP, SUSTAINABILITY

That raises the question whether the health delivery system can learn to self-manage as the patients have, and sustain the initiatives supported through *Aligning Forces* once the RWJF funding goes away, as it is scheduled to do on April 30, 2015.

The comprehensive program in Humboldt County "all sounds terrific," says Robert Wachter, MD, a professor of medicine at the University of California-San Francisco and a quality and safety expert. "The worry I have is, you can build something that is pretty impressive with a huge infusion of money and intellectual capital."

He is skeptical whether it will have traction, "unless the payment system changes and the culture changes to support this activity independent of what the Foundation is doing."

Melissa Jones, the project director for *Aligning Forces Humboldt*, says she thinks the community sees the value in sustaining most of the initiatives, "but we will undergo specific strategic planning and engagement with the broader community to determine more precisely what can be sustained and how."

The Humboldt team hopes that some initiatives will be absorbed by the organizations that operate them, while others may need to be supplemented by grant funding or support from insurers.

Whatever becomes of the specific programs, the Humboldt team holds out hope that some of the underlying gains may be rooted deeply enough to continue with their own, collaborative momentum. Den Ouden concedes that *Aligning Forces*' progress in reforming ambulatory care has been slow. But "in a community of independent practices you have to start from the beginning," she says.

The patient partners concept followed a similar trajectory. When patients stood up in the collaborative sessions and told how bad care coordination had affected them, "You could hear a pin drop. It was the patient partnerships that largely turned around the bad attitude among the doctors."

The major determinant of how long and how well the patient lives is the patient's own behavior, Den Ouden says.

"If we don't include the patient in the design of services," Den Ouden says, "we're not going to get it right. Patients determine the outcome, not doctors." □

J. Duncan Moore Jr. *is a nationally recognized health care policy writer whose work has appeared in the* Washington Post, *the* Los Angeles Times, Bloomberg News *and* Modern Healthcare. *Moore is also the co-founder of the Association for Health Care Journalists.*

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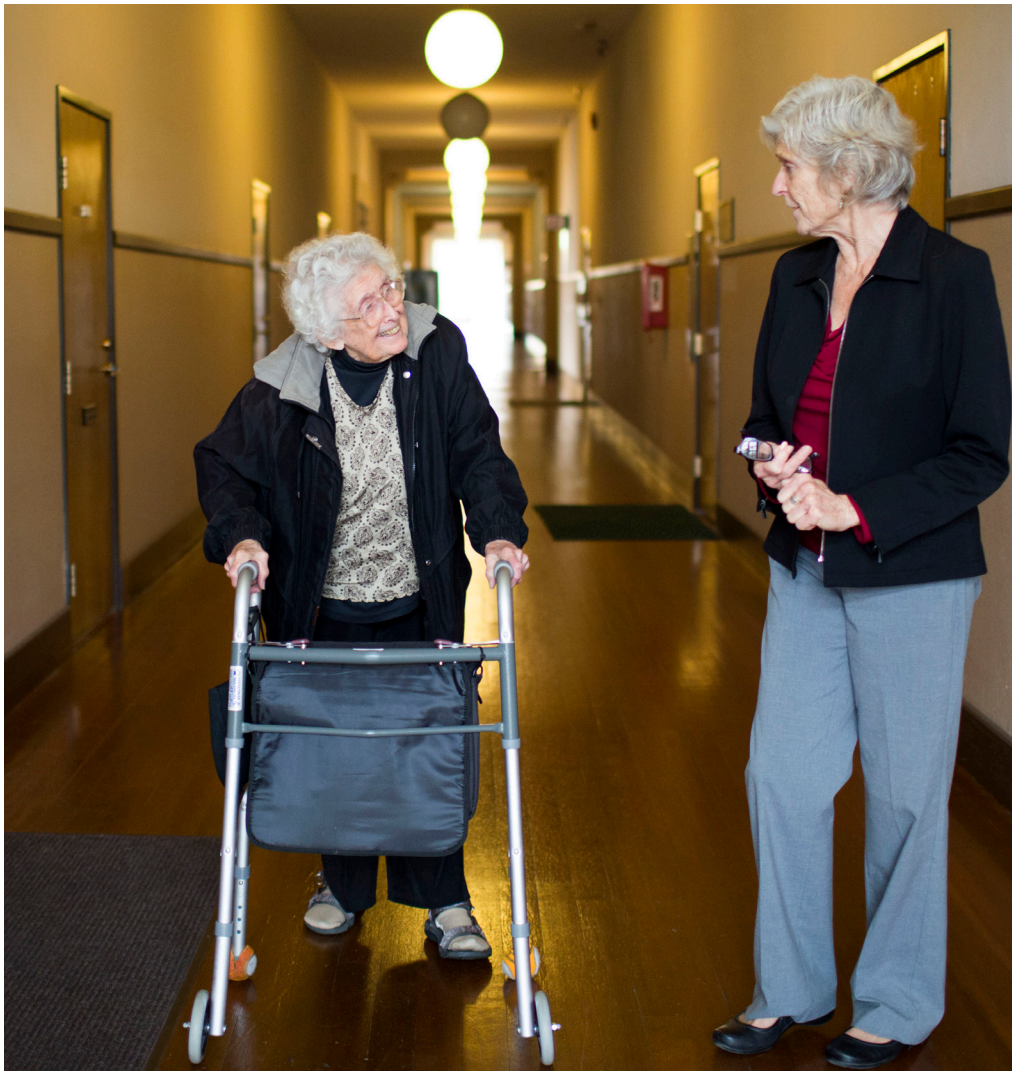

Pathways to Health Project Coordinator Judith Sears talks with Toni Martin at the Aligning Forces Humboldt *offices at the California Center for Rural Policy in Arcata.*