INTEGRATING PRIMARY AND SPECIALTY CARE:
The Integrated Care Neighborhood and Population Health Analytics

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Kenneth W. Kizer, MD, MPH
Distinguished Professor and Director,
Institute for Population Health Improvement
UC Davis Health System
Presentation Objectives

- Encourage you to think about how health care will be provided in the future and the changing roles of primary and specialty care providers
- Highlight the essentiality of integrating patient care generally and primary and specialty care specifically
- Review key characteristics or attributes of integrated patient care
- Provide an overview of the emerging evidence about ‘success factors’ in integrating primary-specialty care
- Discuss a strategic approach for identifying potential high-yield opportunities for integrating primary and specialty care based on population health analytics
What is the Institute for Population Health Improvement?
Established as a new independent operating unit in the UCDHS with no funding and 1 FTE in mid-2011

By Aug 2013, had developed a diverse portfolio of funded activities >$70 M and >115 FTE and consultants

Serves as a resource for:
- Health care reform
- Clinical quality improvement
- Health leadership development
- Creation of actionable clinical intelligence
- Health policy development, analysis and implementation

To date, has primarily focused on assisting health-related government agencies and philanthropies design, implement, manage and/or evaluate programs

Promotes understanding of the multiple determinants of health and of health outcomes being a function of the totality of one’s circumstances

New value-based health care payment models require that population health management be a core competency of health care provider organizations
Selected IPHI Activities

- Provide technical assistance and thought leadership in quality improvement to the state Department of Health Care Services for Medi-Cal (California’s $60B/yr Medicaid program)
  - Medi-Cal Quality Improvement Program
  - Evaluate CA’s Delivery System Reform Incentive Payments (DSRIP) Program
  - Design the CA-specific Evaluation of the California Medicare-Medicaid Dual Eligible Demonstration Program
- Manage operations of the California Cancer Registry
- Manage the California Health eQuality (CHeQ) Program - California’s ONC-funded Health Information Exchange Development Program
- Provide technical assistance and support for multiple CDPH statewide chronic disease prevention and surveillance programs
- Conduct a statewide assessment of surgical adverse events
- Conduct population health research projects
  - Approaches to prevention of prescription opioid use (with CHPR)
  - Use of the Oncotype Dx Assay in Medi-Cal beneficiaries with breast cancer
Selected IPHI Activities

- Investigate the feasibility of developing Community Paramedicine in California
- Manage the California Health Policy Forum
- Assist and support CDPH achieve national accreditation
- Develop basic QI training for all CDPH employees
- Support California Health & Human Services Agency in developing a CMMI-funded Payment Reform Model for the California
  - $2.3M 6-month planning grant received in Mar 2013
  - Anticipate submitting a $60M 3-year implementation proposal in early 2014
- IPHI asked to join the hACT for the new $1B HHS/CMS Health FFRDC managed by MITRE
- Establish a Center for Veterans and Military Health
- Develop an Integrative Medicine and nutritional genomics program
- Other
*Population health* refers to the net health status or outcomes of a defined group of people as a result of the many determinants of health, including health care, public health interventions, and social and environmental factors.
Population health management refers to purposeful actions taken to influence the health outcomes of a defined group of persons through coordination, integration and alignment of health care, public health interventions, and/or the social and environmental determinants of health.
THE ESSENTIALITY OF INTEGRATING PATIENT CARE
American health care provides some of the highest quality and most technologically sophisticated health care in the world, BUT -

- The rising cost of US health care is not sustainable
- Care is disjointed and fragmented
- Quality of care gaps abound, and receipt of high quality care is generally neither predictable nor consistent
- Many persons do not have adequate access to care, while others suffer adverse outcomes from too much care
- Inefficiency, waste and duplication of effort are glaring
- Specialists are highly utilized, but often for unclear purpose and resulting in little or no value
- Overall population health is largely stagnant or deteriorating
- There is growing dissatisfaction with health care because of cost, complexity, poor service and medical errors, among other reasons
The Need for Integrated Care

- The primary business of health care today is managing chronic conditions
  - Approximately 75% of all health care expenditures are for managing chronic conditions
  - 9 chronic ailments account for nearly 60% of the rise in Medicare spending in recent years
- A typical Medicare patient has 4 chronic conditions and will see 7 doctors (including 5 specialists) in 5 different practices in a year*
- 40% of Medicare patients have 7 or more chronic conditions and are likely to see 11 physicians in 7 different practices in a year (and it is not especially unusual for a patient to see 15-20 different doctors, along with other caregivers, in a year)*
- The cost of care is closely correlated with the number of chronic conditions

*NEJM 2007; 356:1130-1139
Figure 1: Average per capita spending by number of chronic conditions

Average per capita spending

$20,000

$15,000

$10,000

$5,000

$0

$994

$2,753

$5,062

$7,381

$10,091

$16,819

Number of chronic conditions

0

1

2

3

4

5+

$994

$2,753

$5,062

$7,381

$10,091

$16,819
The Need for Primary-Specialty Care Integration

- Most care that is provided today requires both primary care and medical specialist expertise.
- The continuing explosion of new bio-medical knowledge and technology is increasing the number of patients with complex, severe or uncommon health conditions, increasing the demand for both medical specialists and generalists who can interpret complex information, coordinate services and provide routine care.
- However, the primary care infrastructure of American health care has fractured in recent decades and the roles of primary care and specialty care providers have become less clear and less integrated.
- There is an urgent need to rethink and redesign the primary-specialty care relationship.
“Coordination of complex cancer care, using a common electronic health record, with treating specialists who jointly discuss the patient’s case and then confer with the patient about their recommendations, *is the exception and not the rule.*”

September 10, 2013
The evolving nature of American health care finance generally and the new value-based payment models specifically require that the delivery of services become more coordinated – or integrated - across the continuum of care.
What is Integrated Care?

- The converse of fragmented care
- Kodner, et al (2002) - “a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors.”
- WHO (2008) – “the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly; achieve the desired results and provide value for money”
- Singer, et al (2010) - “patient care that is coordinated across professionals, facilities, and support systems; continuous over time and between visits; tailored to the patients’ needs and preferences; and based on shared responsibility between patient and caregivers for optimizing health.”
Integrated patient care and integrated delivery system are not synonymous.

*Integrated delivery system* (IDS) is a generic term for a variety of organizational structures having varying degrees of administrative, financial and/or clinical integration; there is no standardized definition of what constitutes IDS.

Integrated delivery systems do not necessarily produce integrated patient care – e.g., VA early 1990s, DOD-MTFs.

No particular model of integrated care has been shown to be superior to others when certain core functionalities are present.
Defining Characteristics of Integrated Care

1. A common vision of health care service delivery
2. Shared and widely understood clinical objectives and goals
3. Information management tools and other infrastructure to monitor, analyze and affect clinical processes and outcomes
4. Policies and procedures for coordinating care across conditions, providers, settings and time
5. Team-based care
6. Methods of accountability, including a performance management system that consistently measures and monitors clinical performance by use of standardized performance measures
7. Strong clinical leadership
8. Aligned interests across providers, including shared financial risks and rewards for clinical outcomes
9. A patient-centric and population health focus
A model of integrated primary care that originated in the late 1960s

The PCMH is both a philosophical and an operational approach to care that seeks to provide comprehensive, ongoing and coordinated, “whole-person” care that improves care processes and outcomes, system efficiency, and both the patient and provider care experience.

Definitions of the PCMH vary widely, but all share certain core elements:

- Enhanced access to care through technology, people and process based on the concept of a ‘continuous healing relationship’
- Multi-disciplinary team-based care
- Patient-centeredness; support for self-care
- Active coordination of care across the health system and community
- Systems-based approach to the collection, analysis and use of data and the management of quality and safety
Patient-Centered Medical Home (PCMH)

- Is a centerpiece of health care reform; almost all states have adopted policies and programs to promote the development of medical homes
- While considered an especially promising approach for delivering higher quality, more cost effective care, current evidence is insufficient to determine its effects on clinical and most economic outcomes (Jackson, et al. *Ann Intern Med* 2013; 158: 169-178)
Specialty Care Medical Homes

- Has been attempted by cardiology, OB-GYN and endocrinology without notable success
- Oncology has had some successful early efforts and the model appears to be gaining traction
The ultimate success of the PCMH will depend in significant part on how well primary and specialty care are integrated and the resulting new relationships between PCPs and specialists, patients and specialists, patients and PCPs.
Primary-Specialty Integrated Care: Some Possible Guiding Principles

1. The patient is the center of the health care universe
2. Care should be viewed as a continuous caring relationship, and not defined by face-to-face office visits
3. Every provider should be working at the top of his/her skills and training
4. Every patient should have a personally tailored care plan and clinical goals
5. Processes of care should be evidence-based
6. Care should be actively coordinated so that transitions of care are seamless between providers and facilities and over time
Primary-Specialty Integrated Care: Some Possible Guiding Principles

7. Technology should be leveraged to enable and expand workforce capabilities and to make care more patient-centric

8. All processes of care should have associated performance measures and a systematic approach to quality improvement

9. Care must be cost-effective

10. Health care should be understood to be more than clinical; the role of social and environmental determinants of health must be recognized and incorporated into processes of care
Integrating Primary-Specialty Care: Many Efforts Under Way

- Project ECHO, VA’s SCAN-ECHO
- AHRQ Medical Neighborhood, Systems of Care/Patient-Centered Medical Homes Initiative
  - Primary Care-Specialty Care Compact, Colorado Health Foundation
  - HIV Integrated Care
- ACP Patient Centered Medical Home-Neighbor
- San Francisco General Hospital e-Referral Program
- Project Access of Durham County
- CHCF Complex Care Management Action Community and the California Improvement Network
- CMWF Access to Specialty Care and Medical Services in Community Health Centers
- Integrating Primary Care and Behavioral Health Initiatives
- RWJF The Synthesis Project
- California’s Specialty Care Safety Net Initiative
Specialty Care Safety Net Initiative

Integrating Telehealth In the Primary Care Setting

July 2013

SCSNI Partners

Open Door Community Health Ctrs
Del Norte Clinic
North Country Clinic
Teasdale Health and Visitor
Specialists Ctr

Redwoods Rural Health Ctrs

Ampla Health
Onco Family Health
Grizzly Family Health Ctr
Gorle Family Health Ctr

Colusa Indian Health

CommuniCare Health Ctrs
Peterson Clinic
Davis Community Clinic
Salud Clinic

UC Davis

UC San Francisco
Livingston Medical Group

UC San Diego

UC Irvine

UC Irvine Family Health Ctr

Tarzana Treatment Ctrs
Community Health Alliance of Pasaden
East Valley Community Health Ctr

UC Los Angeles

Santa Ana

St. John's Well Child & Family Ctr
At Magnolia Place
Dr. Lewis C. Fraser Health Ctr
Dr. Kenneth Williams Community Health Ctr
Compton Clinic W. M. Keck Foundation Community Health Ctr

Clinicas del Camino Real
Newbury Park
Fillmore Health Ctr
Cajon Valley Health Ctr
Ventura Health Ctr
Cedar Health Ctr

UC Irvine Family Health Ctr

Tarzana Treatment Ctrs
Community Health Alliance of Pasaden
East Valley Community Health Ctr

Southern Inyo Community Clinic

Tulare Community Health Clinic

Ridgway Regional Hospital

UC Irvine

Tarzana Treatment Ctrs
Community Health Alliance of Pasaden
East Valley Community Health Ctr

UC San Diego

UC Irvine

La Maestra Community Clinic
Mountain Health and Community Svc
Observations About Integrating Primary and Specialty Care

- Executive leadership support and strong clinical leadership are critical
- A comprehensive population health needs and organizational readiness assessment are necessary
- Designation of a dedicated specialty care coordinator
- Standardize service area processes associated with specialty care as much as reasonably possible – people, processes and systems must be in sync
- Secure active involvement of all participating providers
- Be selective in contracting for specialty care services; ensure there is a good fit with the PCPs
Observations About Integrating Primary-Specialty Care

- Must actively build understanding and appreciation of technology (e.g., telehealth); demystify it; enthusiasm for the technology follows demonstrated improvement in the quality and timeliness of care
- Anticipate and respond quickly and constructively to disruption of existing processes and systems
- Increasing the role of mid-level practitioners is an effective way to increase efficiency without impairing quality
- Current payment/reimbursement methods often are barriers for integrating care
- Data analytics and population health management are key
The optimal manner and methods of integrating primary and specialty care should be data-driven and based on analysis of population health needs.

For which patients is there the greatest opportunity for actionable interventions and return on investment for integrating care?
Figure 1. Distribution of health expenditures for the U.S. population by magnitude of expenditure and mean expenditures, 2010

Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2010

### Table 1: Distribution of Health Expenditures for The U.S. Non-Institutionalized Population, By Magnitude of Expenditures % Of U.S.

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<td>1996</td>
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Source: Derived from Berc & Monheit Health Care Trends

50% population accounts for 3% of expenditures
Distribution of per Person Aggregate Payments for 1606 non-Medicare FFS Medi-Cal Beneficiaries having >$250,000 Payment, Jul 2011-Jun 2012
(Preliminary Results, Updated 23Aug2013)
All suffered from complex chronic conditions; 20 episode diagnosis groups accounted for 62% costs
42% were 34 years or younger; average age - 38 yrs
53% male; 47% female
27% were deceased within approximately 1 year
9% hemophiliacs; average pharmaceutical cost per beneficiary = $507,557
24% had a primary diagnosis of diabetes
5% were newborns/NICU care
3% had a primary diagnosis of HIV AIDS
3% had a primary diagnosis of schizophrenia

*MCSS Statistical Brief, May 2005
Where on the cost curve do you get the most benefit and ROI for clinical population health management and/or for integrating primary and specialty care?
Figure 1: Population risk pyramid and average costs per tier

- **Top 1%:** Dominant chronic
- **Top 5%:** Severe significant multiple chronic conditions
- **Middle 14%:** Multiple chronic or severe chronic
- **Middle 30%:** Minor chronic
- **Bottom 50%:** Healthy

**Average monthly cost per risk tier**

- Mean

$0 $800 $1,600 $2,400 >$3,200

From A. Sengupta. Beyond Care, Inc
Figure 2: Population risk pyramid and distribution of costs per tier

From A. Sengupta. Beyond Care, Inc
Figure 3: Annual growth in medical costs after inpatient discharge, with increasing segmentation

From A. Sengupta. Beyond Care, Inc
The evolving nature of American health care finance generally and value-based payment models specifically require that primary care providers and specialist physicians collaborate and coordinate care to create seamless medical care neighborhoods built around primary care-based medical homes.

Creating such “integrated care neighborhoods” will necessitate, among other things, a shared vision and clear goals for health service delivery; collective accountability; expanded and innovative use of advanced telecommunications and information management technologies; and reshaped clinical care relationships between and among patients, PCPs and specialists.

Reshaping clinical care relationships must be informed by detailed and ongoing population health and service delivery assessments aimed at:

- optimally leveraging technology to enable and expand workforce capabilities and to make care more patient-centric and
- ensuring that providers work as much as possible at the top of their skills and experience.
The future is not what it used to be!
QUESTIONS?