New breed of primary care clinic helps patients tame chronic illness

February 10 2014, by Ruthann Richter

When Shelly Reynolds has a medical problem, she walks 500 yards from her office to a Stanford clinic where doctors know her by her first name and encourage her to call them any time—day or night—if she has a major concern.

The experience is not only refreshing, she said, but she has learned techniques at the clinic to manage her asthma and her chronic back pain so that she does not feel the need to go to the emergency room anymore and is feeling much better overall.

"They hold me accountable for my own health, which is great. Physically and emotionally, I'm healthier than I was before," said Reynolds, RN, who directs the catheterization-angiography laboratory at Stanford Hospital & Clinics.

Reynolds is a patient at Stanford Coordinated Care, a new breed of primary care clinic designed to be a national model for reducing health-care costs while improving people's health and experience with health care.

The clinic, which soon will celebrate its two-year anniversary, recognizes that people with chronic illnesses, such as diabetes, arthritis or heart problems, account for 80 percent of health-care spending in the United States. When their conditions are poorly managed, these patients are likely to wind up in the emergency room or the hospital, often at great cost.

The clinic helps patients gain control over their health in a number of ways, including a personalized approach by a team of caregivers who are available 24/7 and who give patients tools and support to deal effectively with their conditions at home.

"It's easy to make a diagnosis of diabetes, but it can be hard for a person to manage day to day," said Ann Lindsay, MD, a professor of medicine at Stanford. "We help patients in developing a plan. We support it, and we empower them along the way."

Lindsay co-directs the clinic with her husband, Alan Glaserof, MD, using an approach they tested successfully in Humboldt County.

What's important to patients

Glaseroff said the clinic's emphasis is on the patient's goals—what is important to them. With time, the staff develops trusting relationships with patients and can help them manage their own care, eat more healthy foods, be more physically active, or learn to live with less pain and stress. He cites a 2007 study by UC-San Francisco's Steven Schroeder, MD, chair of the National Commission on Physician Payment Reform, who noted in The *New England Journal of Medicine* that behavior is the single largest determinant of mortality, accounting for nearly 40 percent of all deaths in the United States. That was followed by genetics (30 percent), social circumstances (15 percent) inadequate health care (10 percent) and exposure to environmental factors (5 percent).

"We try to focus on the 40 percent," said Glaseroff, a professor of medicine. "It's an indictment of the health-care system because 90 percent of it is focused on diagnosis and treatment. There should be four times more focus on self-management and behavior. In American health care, that's an afterthought."

The clinic's approach thus far has proved to be cost-saving. Among the first 27 patients, it was able to save $420,000 in health-care costs in the first six months—a 39 percent decline over the previous six months, when the patients were enrolled elsewhere, Glaseroff said. Emergency room visits and hospital admissions both declined, while patient and staff satisfaction achieved a striking 100 percent. These are small numbers, and vigorous research is under way to help establish whether this model of care is effective on a larger scale in improving outcomes, promoting patient satisfaction and reducing costs, he said.

The clinic's approach was pioneered by Arnold Milstein, MD, a professor of medicine and renowned health-care innovator, who developed a concept he called the "ambulatory intensive caring unit," or ambulatory ICU. The idea was to intensify care up-front for chronically ill patients to reduce the frequency of health crises and avoid urgent hospitalizations, as well as minimize referrals to specialists. The model was tested among employees at Boeing Corp. in Seattle, among Atlantic City hotel workers and among CalPERS and PG&E employees in California.

"We invested more in primary care visits and medications because when you work more intensively with patients, they are much more likely to use their medications as prescribed and do other things patients can do to preserve their health, like exercise more, obtain treatment for mental health conditions and eat more healthfully," said Milstein, who directs the Clinical Excellence Research Center at Stanford.

Improved care

The approach proved enormously successful, saving money and improving care. Milstein wanted to test the program at Stanford and recruited Glaseroff and Lindsay, who had led an ambulatory ICU pilot site in Humboldt County. The Stanford program, currently limited to

university and hospital employees and their families, now has more than 200 patients.

Glaseroff said the clinic's personalized approach makes all the difference to patients. In Humboldt County, he conducted a study which found that when patients call a doctor's office with a problem and are told they will see someone other than their regular doctor, 75 percent hang up and head to the emergency room.

"If you can talk to somebody you trust and who knows you, you can just go back to bed," he said.

Both he and Lindsay give out their home phone number to patients, encouraging them to call on the weekend or during off hours if they need help. Patients call infrequently, but it gives them a sense of security to know help is there if they need it, he said.

Reynolds said she loves going to a clinic where people know her on a first-name basis and are well-acquainted with her medical history. Before, she said, "I always felt like a number—there was no personal relationship. … I just felt like I was never listened to."

Initially, she spent a lot of one-on-one time with Lindsay, developing a plan to manage her asthma. She now uses her inhaler twice a day, which helps her avoid the breathing crises of the past that sometimes sent her to the emergency room. They also devised a detailed exercise plan that was practical for Reynolds' lifestyle: walking the dog three times a week and riding her horse twice a week.

"She took an interest in me that no one had for a long time," Reynolds said of Lindsay. "For the first time in a long time, I felt that someone was looking out for me, advocating for me. It was such a relief."

In the course of her treatment, Reynolds also realized she had never fully recovered from the death of her brother more than a year before. She got counseling from a clinic social worker to deal with her grief. Mental health therapy is also included in the clinic's services, as patients who are anxious or depressed are likely to make greater use of the medical care system, Lindsay said.

Range of services

The clinic also focuses on primary care with the goal of making less use of costly specialists. For instance, one patient with Parkinson's disease had been seeing seven different specialists, though he rarely checked in with his primary care doctor, Lindsay said. Now, clinic caregivers are able to address most of his needs, so he spends far less time seeing specialists. And he is doing well: He had stopped running because he was afraid he would stumble and fall, but now he's running about a mile a day, she said.

The clinic has a patient advisory council, consisting of patients and their families, which meets regularly to offer suggestions and is involved in ongoing clinic improvement efforts. (Reynolds is a member of the council.)

The clinic staff includes three physicians, as well as three care coordinators—trained medical assistants who check in regularly with patients in their panel and who are always available to provide support and help solve problems. In addition, the clinic employs a licensed clinical social worker who provides mental health therapy, a clinical pharmacist who serves as a diabetes educator, and a dietician who helps patients with their nutritional goals. The staff continues to expand as the number of patients grows.

Because the care model is new, Milstein said it still faces the challenge

of being accepted by the general medical community.

"The main challenge has been that many primary care physicians understandably are reluctant to refer their patients to a new clinic with which they are not familiar and whose leaders are not well known to them," he said.

Milstein is working to change that by extending the model to a broader segment of the population. As medical director of the Pacific Business Group on Health, he helped the group obtain a $19 million grant from the U.S. Centers for Medicare and Medicaid Services to introduce the Humboldt version of the ambulatory ICU model in five states, with multiple sites in each state. Glaseroff and Lindsay are among the clinicians who are teaching and advising those implementing the plans.

"We see ourselves as an innovation clinic," Glaseroff said. "We're already spreading the model around the country."

Provided by Stanford University Medical Center

Citation: New breed of primary care clinic helps patients tame chronic illness (2014, February 10) retrieved 4 May 2024 from https://medicalxpress.com/news/2014-02-primary-clinic-patients-chronic-illness.html

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