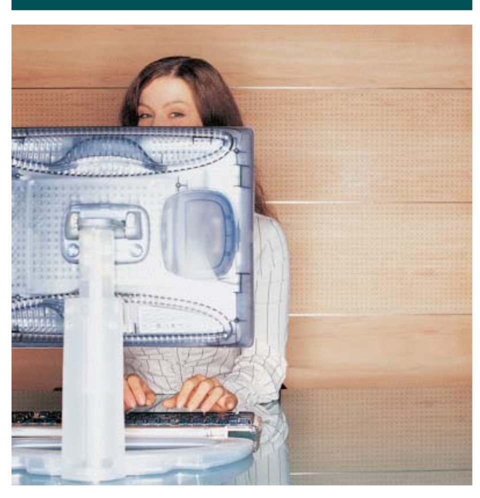
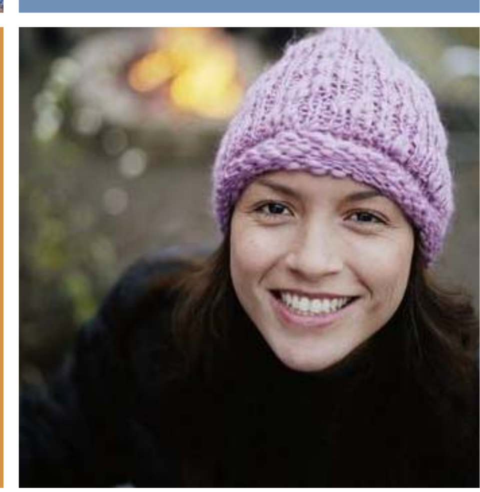



Group Health's Journey to Accountable Care

- **Robert Reid, MD PhD, Associate Investigator, Group Health Research Institute**
- **Michael Erikson, Vice President of Primary Care Services Group Health**

Medical Home Summit
March 14, 2011

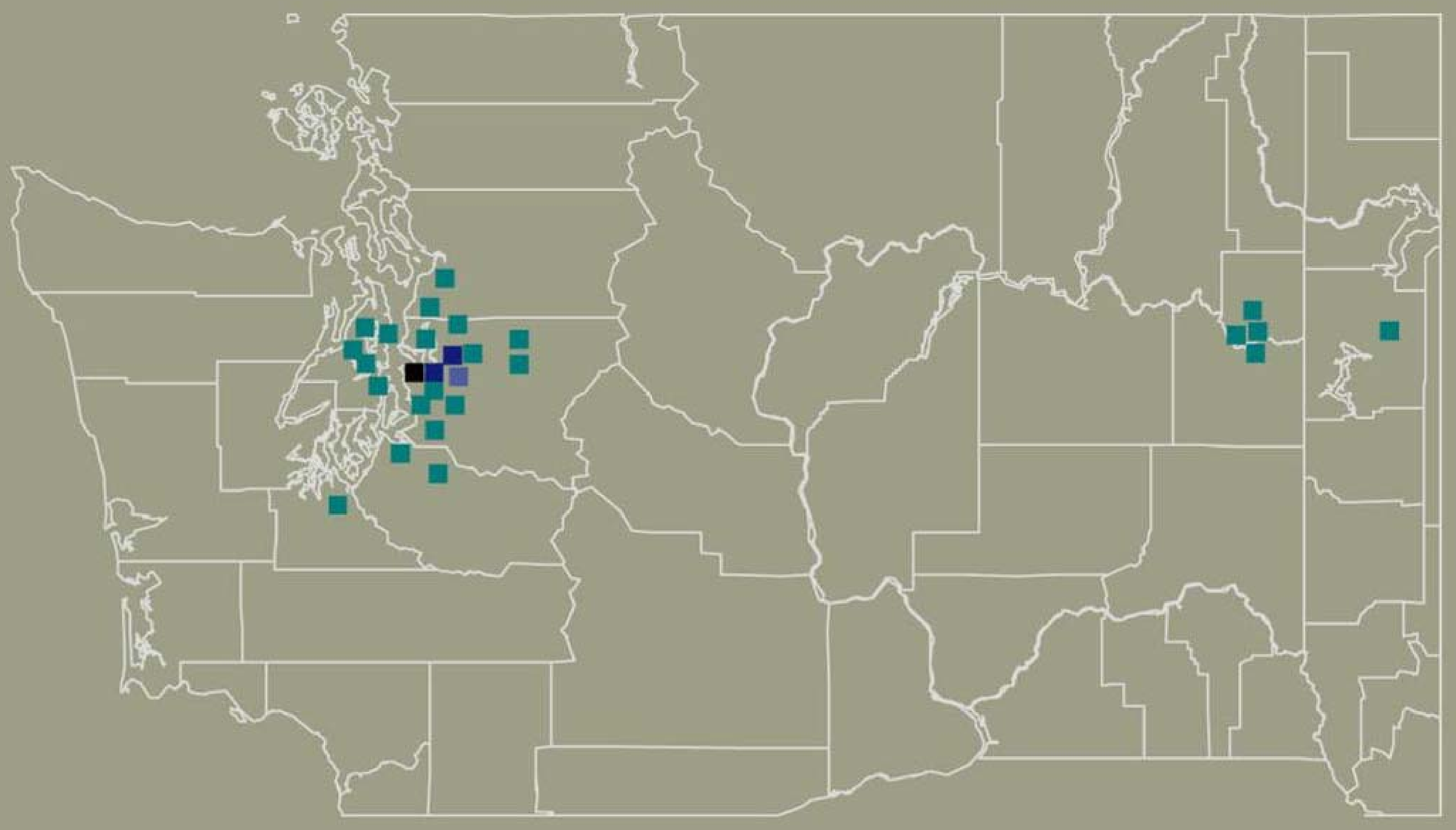
Who we are

- Integrated health delivery system
- Founded in 1946
- Consumer governed, non-profit
- Membership: 661,500   Staff: 9,365
- Revenues (2009): $3 billion

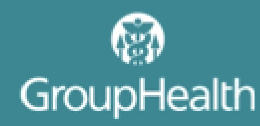
- Multispecialty Group Practice
  - 26 primary care medical centers
  - 6 specialty units, 1 maternity hospital
  - 985 physicians
- Contracted network
  - > 9,000 practitioners, 39 hospitals

- Group Health Research Institute
  - 34 investigators
  - 235 active grants, $39 million (2009)

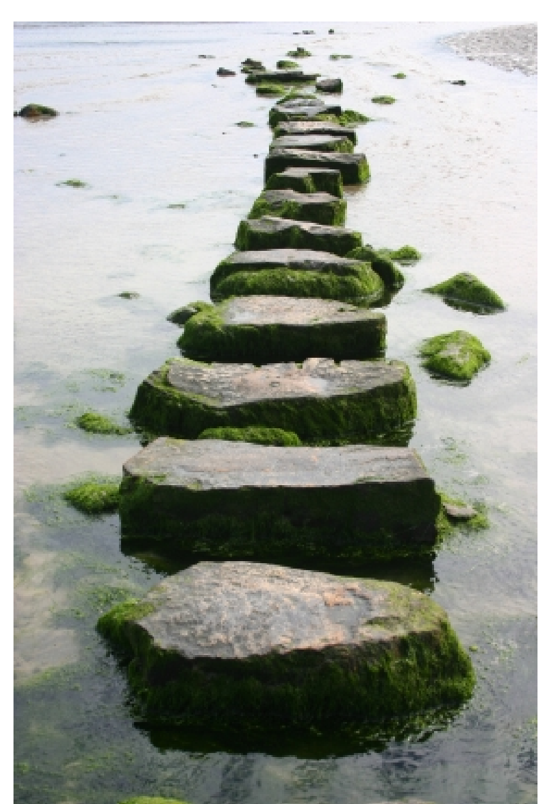
Group Health



Our Accountable Care Journey



- Building the Foundation: The Patient Centered Medical Home
- Extensions to Specialty Care and Hospital Transition
- ACO Moving the Care Model to Provider Partnerships



Medical Home Design Principles

The **relationship** between the clinician & patient is at our core. The entire delivery system will reorient to promote & sustain.

The primary care clinician will be a leader of the clinical team, responsible for **coordination** of services, and together with patients will create **collaborative care plans.**

Care will be **proactive** and **comprehensive**. Patients will be **actively informed** and encouraged to participate.

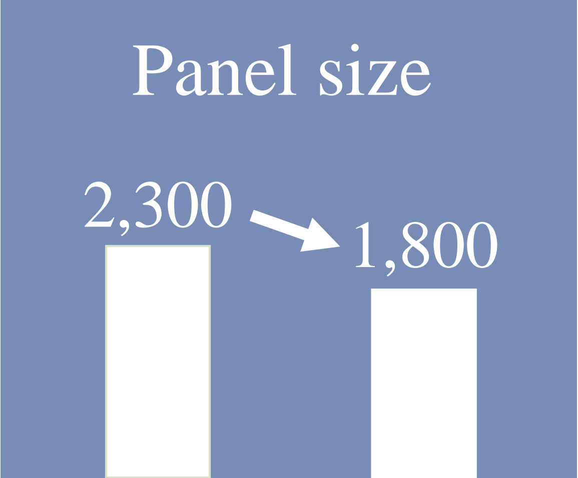
Access will be centered on patients needs, be available by various modes, and **maximize the use of technology.**

Our clinical and business systems are aligned to achieve the most **efficient, satisfying** and **effective** experiences.

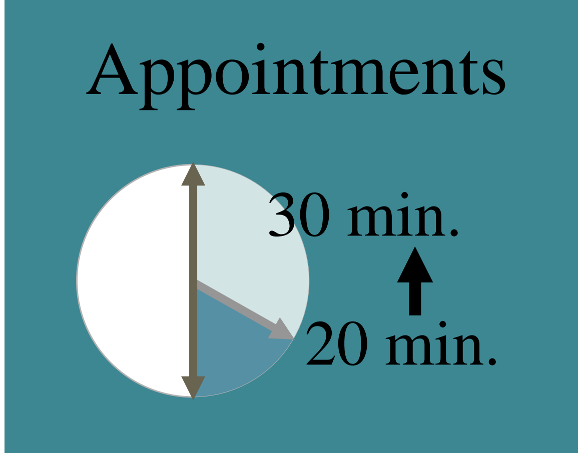
Medical Home Investments

PCMH design:

Panel size



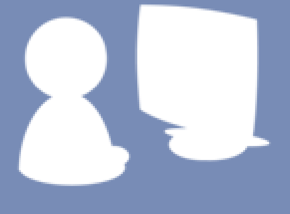
Appointments



Clinical teams

Desktop time

E-technology



MEDICAL HOMES: A SOLUTION?

By Robert J. Reid, Katie Coleman, Eric A. Johnson, Paul A. Fishman, Clarissa Hsu, Michael P. Soman, Claire E. Trescott, Michael Erikson, and Eric B. Larson

The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers

ABSTRACT As the patient-centered medical home model emerges as a vehicle to improve the quality of health care and to control costs, th[e] experience of Seattle-based Group Health Cooperative with its medic[al] home pilot takes on added importance. This paper examines the effe[cts] of the medical home prototype on patients' experiences, quality, burn[out] of clinicians, and total costs at twenty-one to twenty-four months afte[r] implementation. The results show improvements in patients' experien[ce], quality, and clinician burnout through two years. Compared to other Group Health clinics, patients in the medical home experienced 29 percent fewer emergency visits and 6 percent fewer hospitalizations. We estimate total savings of $10.3 per patient per month twenty-one months into the pilot. We offer an operational blueprint and policy recommendations for adoption in other health care settings.

COMMENTARY

The Patient-Centered Medical Home Movement

Why Now?

MANAGERIAL

Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation

Robert J. Reid, MD, PhD; Paul A. Fishman, PhD; Onchee Yu, MS; Tyler R. Ross, MA; James T. Tufano, MHA, PhD; Michael P. Soman, MD, MPH; and Eric B. Larson, MD, MPH

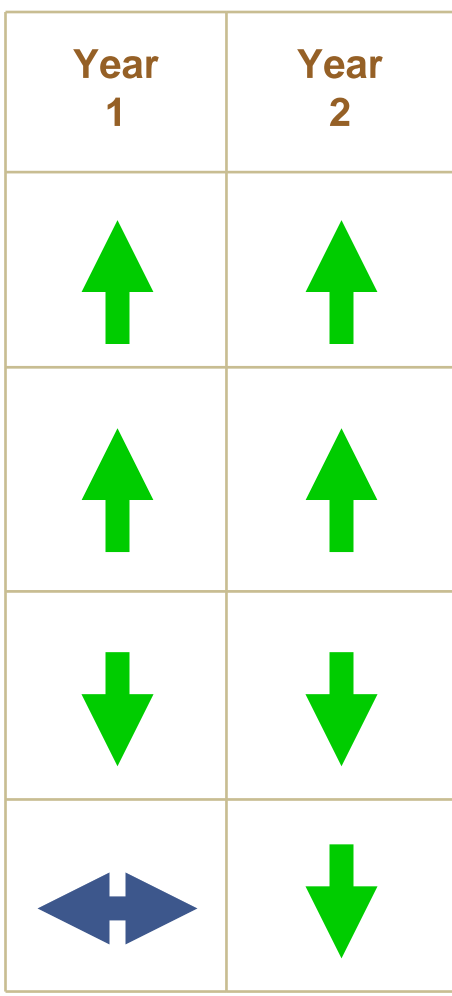
Reid RJ et al, Health Affairs 2010;29(5):835-43

Larson EB et al, JAMA 2010; 306(16):1644-45

Reid RJ et al, Am J Manag Care 2009;15(9):e71-87

Medical Home 1 & 2 Year Pilot Outcomes

Group Health Research Institute



QUALITY (HEDIS)

- Year 1: Rate of rise, 2x that of control clinics
- Year 2: Rate of rise continued to be 20 – 30% greater in 3 of 4 composites

PATIENT/STAFF SATISFACTION

- Year 1: Patient satisfaction – 5% increase in patient activation/goal setting; Practitioners - *substantially less burn-out with significantly reduced emotional exhaustion & depersonalization
- Year 2: Scores continued to improve at Medical Home; controls were slightly worse

ED/UC UTILIZATION

- Year 1: 29% fewer ER visits, 11% fewer preventable hospitalizations, 6% fewer but longer in-person visits
- Year 2: Significant changes persisted

COST

- Year 1: Cost is neutral
- Year 2: Overall patient care costs lower at Medical Home (~$10 PMPM)

Source: Health Affairs 29:5 May 2010

Spreading the Medical Home

1. Staged spread of practice change modules

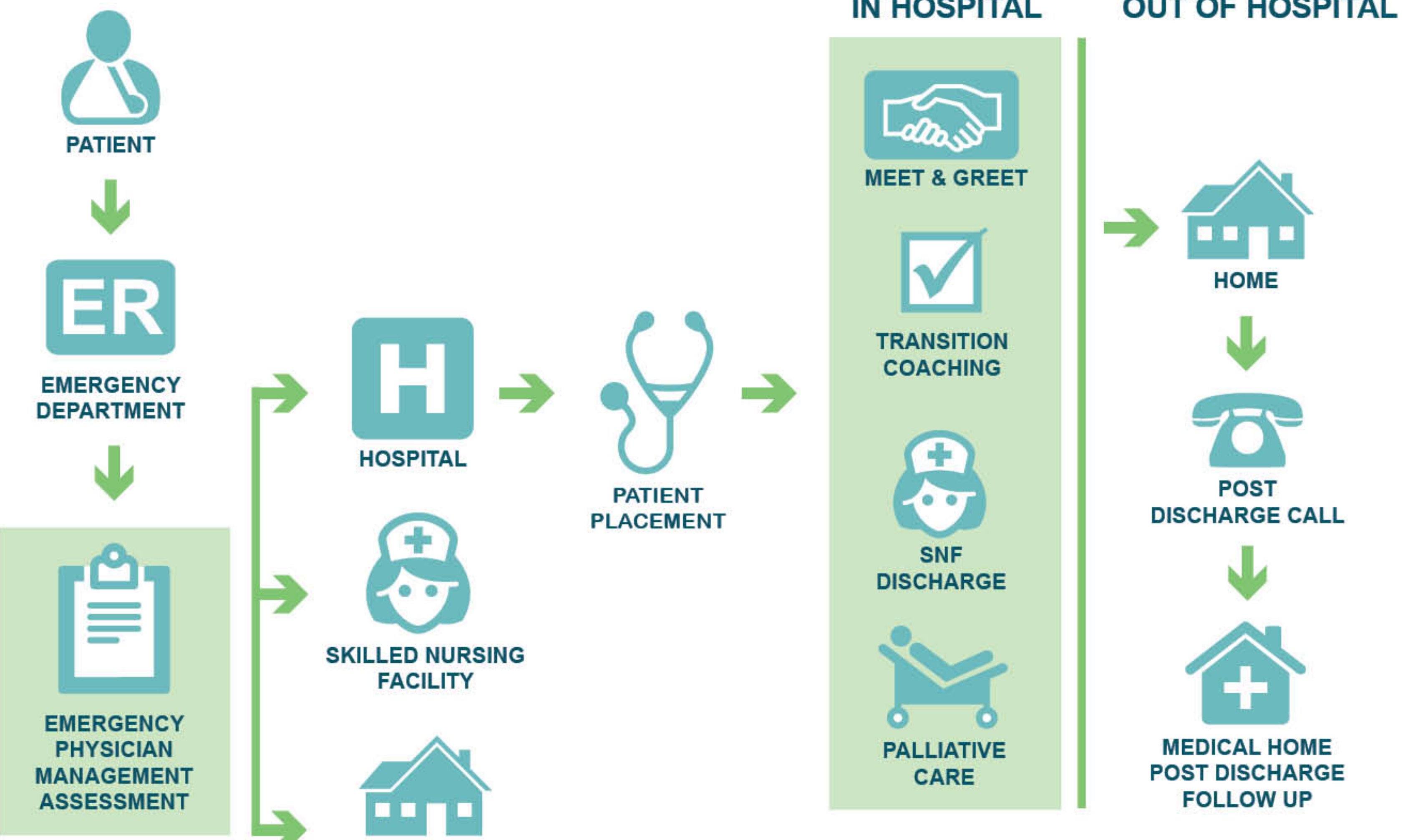
- Virtual Medicine
- Disease Management
- Visit Preparation
- Patient Outreach

2. Supported by changes to mgmt & staffing

- Call Management
- Team Huddles
- Standard Mgmt Practices
- Enhanced Staffing Model
- Value-based MD Payment Model

Standardization & Spread using LEAN methods

GROUP HEALTH EDHI CLINICAL INTEGRATION



WHAT IS **ACCOUNTABLE CARE?**

“We’d like to start out being very involved with you but eventually be drawn away to much more interesting cases down the hall.”

Accountable Care

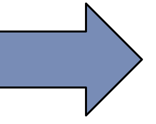
- **PROVIDER ORGANIZATIONS WORK TOGETHER TO CONTROL COSTS AND ENSURE QUALITY BY INCREASING COOPERATION**

Organizing Principles

- **Manage a full continuum of care in an integrated, local delivery system**
- **Focus on improving care and lowering costs**
- **Establish specific spending levels and shared savings under fee-for-service or increasing degrees of capitation**
- **Select Partners with these as part of shared values and principles**

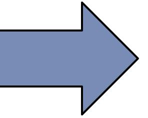
Attributes

Physician-Led



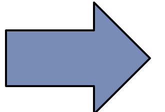
The ACO should be led by physicians (however, partnerships with hospitals and health plans are critical)

Patient-Centric



Managing a patient population requires patient engagement and personalized care

Shared Rewards



The cost savings and rewards need to be shared among all key stakeholders

ESSENTIALS OF BUILDING AN ACO

Care Delivery Essentials

ONE | The system is truly patient-centered

- Patients are active, engaged participants in their care
- Processes serve patients, not doctors, nurses or insurance companies
- Patients have access to electronic records, shared decision-making

TWO | Medical practices are structured to manage care and promote health—not just provide services

THREE | Providers share a common approach to care

- Common clinical guidelines based on evidence
- Shared medical culture
- Clinical leadership, transparency, consequences for not performing

FOUR | Information systems support health

- **Electronic medical records are more than tools for doctors**
- **Health risk assessment tools**
- **Population prevention & chronic disease tracking**
- **Embedded evidence-based protocols**

FIVE | Payment structures encourage better health

- **Payment structures used to support new care delivery model**
- **For Group Health, this means pre-payment, focused on overall health**
- **Tying provider pay to service and quality incentives**
- **Shared savings model as a transitional payment structure to partial or full capitation**

SIX | Care systems are part of the broader community

- **Care providers contribute a relatively small amount to better health of communities—need to collaborate with government agencies, social services, community organizations.**

TWO EXAMPLES: Our Starting points

Group Health

GROUP HEALTH
Medicare Advantage

The Everett Clinic
Medical Centers

Group Health
Medical Centers

GH Health Plan+ 2 Delivery Systems:

- Selected respected multiple specialty medical group practice as partner in delivering care to a defined Medicare Advantage population organized by our GH Health Plan.
- Patient's have choice between Group Health and The Everett Clinic clinical practices

  Year 1: Traditional contracting (2011)

  Year 2: Shared gain and risk arrangement and agree on quality and utilization metrics for this population (2012)

Eastern Washington

Delivery System play:

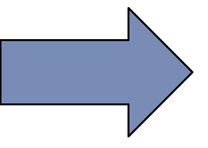
Select Hospital Partner: Providence Hospital

Partner with sub-specialities practices

- Define larger population of Patients to care for between these medical practices and work with multiple payers including Group Health the health plan.

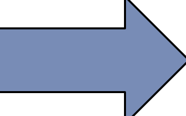
Summary

It is the Best of Times



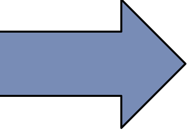
Advances in biomedical knowledge and technological innovation offer the promise of marked improvements in health

It is the Worst of Times



- Coverage
- Cost
- Quality

The Solution



Delivery System Reform: Accountable Care Organizations

Keys to Success

Engage Patients

Lower Costs

Improve Outcomes

Share in Savings & Rewards

Win/Win

Our learnings so far

- Accountable care starts with a stable primary care base
- Approach should be patient-centered & population based
- Need agreement on shared values & common model of care
- Physician leadership is essential with focused attention on care transitions (primary care, specialty care, hospital care)
- Payment incentives & shared rewards can support care model