

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



GroupHealth

Who we are

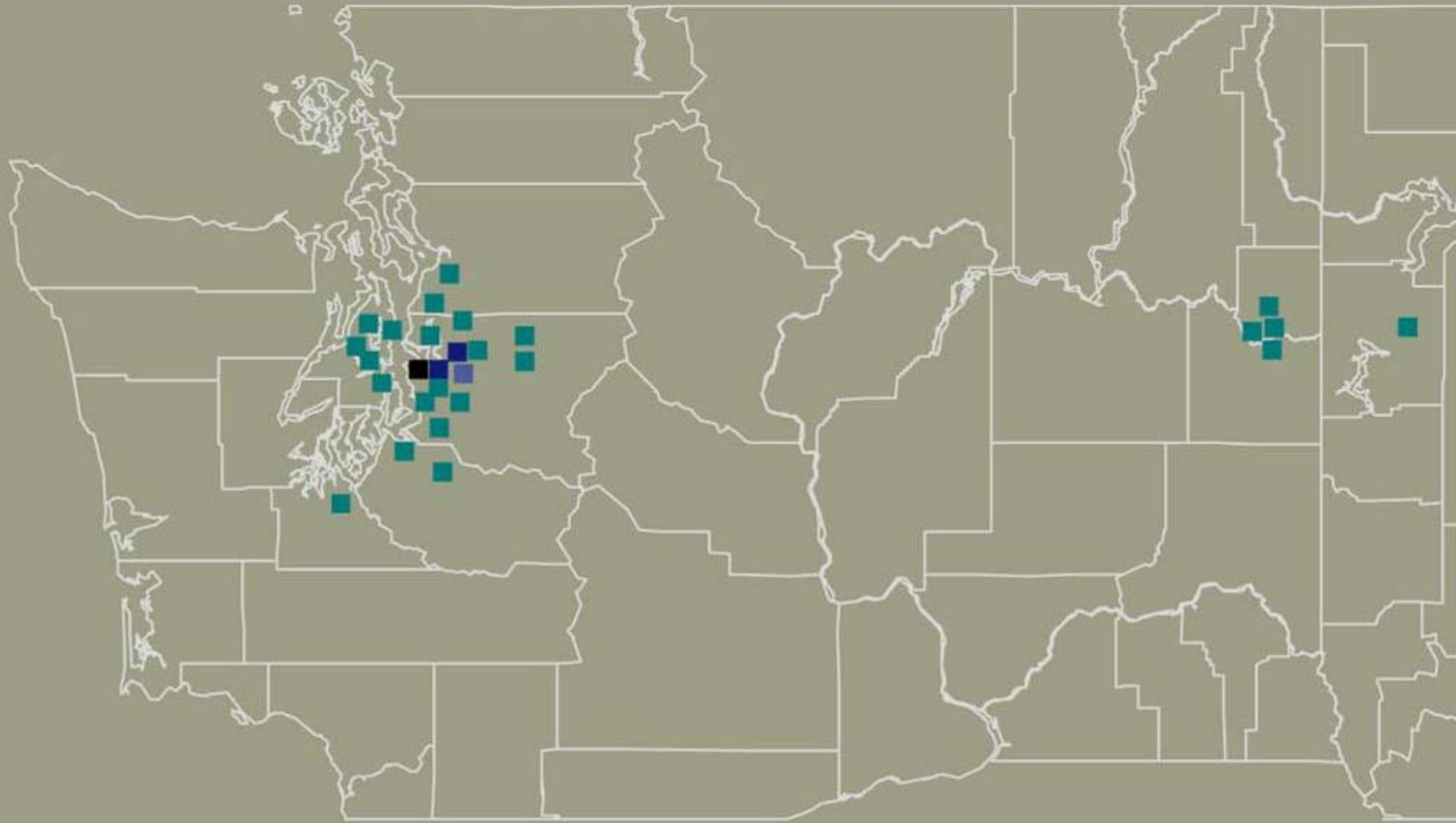
- Integrated health delivery system
- Founded in 1946
- Consumer governed, non-profit
- Membership: 661,500 Staff: 9,365
- Revenues (2009): \$3 billion

- 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)

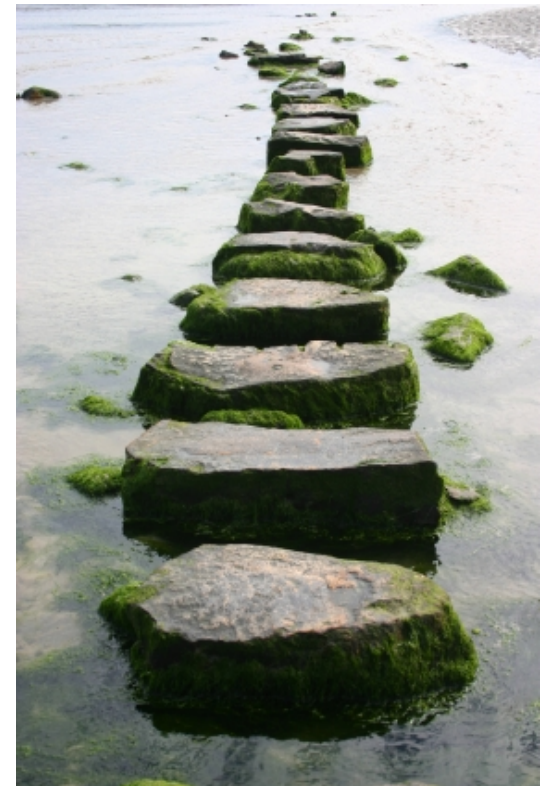


Group Health



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

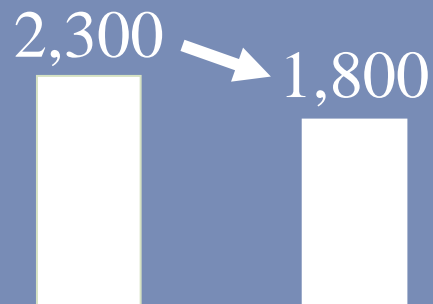


Medical Home Design Principles

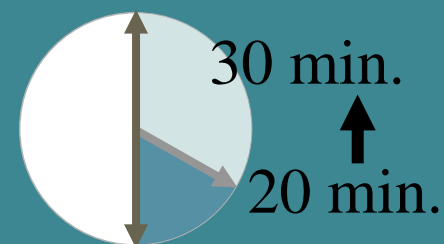
- ✓ The **relationship** between the clinician & patient is at our core. The entire delivery system will reorient to promote & sustain.
- ✓ The primary care clinician will be a leader of the clinical team, responsible for **coordination** of services, and together with patients will create **collaborative 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.

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

DOI: 10.1377/jlma.2010.018
HEALTH AFFAIRS 29,
NO. 5 (2010): 835-843
©2010 Project HOPE—
The People to People Health
Foundation, Inc.

ABSTRACT As the patient-centered medical home model emerges as a vehicle to improve the quality of health care and to control costs, the experience of Seattle-based Group Health Cooperative with its medical home pilot takes on added importance. This paper examines the effect of the medical home prototype on patients' experiences, quality, burnout of clinicians, and total costs at twenty-one to twenty-four months after implementation. The results show improvements in patients' experience, 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 month twenty-one months into the pilot. We offer an operational blueprint and policy recommendations for adoption in other health care settings.

The patient-centered medical home has emerged rapidly as the main policy vehicle to reinvigorate U.S. primary care. The widely endorsed 2007 joint principles of the patient-centered medical home, developed by a coalition of professional organizations, emphasize the attributes of primary care. These include access to care, long-term relationships with health care providers, and comprehensiveness and coordination of care. The principles also embrace a health professional team orientation grounded in quality improvement.

staffing, key electronic health record features, and optimal methods for transformation to this new practice model.

Several questions about medical homes remain unanswered. These include how quickly the anticipated improvements emerge and how operational definitions apply to practices with different settings, patient mixes, and cultures.

Since 2006, Group Health Cooperative, a nonprofit, consumer-governed, integrated health insurance and care delivery system based in Seattle, Washington, has pioneered a medical home redesign that relies on its existing electronic health record technology. The one-year

Improving the delivery of primary care is high on the healthcare reform agenda in the United States and other industrialized nations. Evidence shows that when health systems emphasize primary care, patients achieve better outcomes at lower cost.¹ Compared with other countries, US healthcare costs significantly more² and has large gaps in coverage, wide variation in quality, and poorer patient experiences.³ Primary care physicians leave the workforce sooner than specialists⁴ and complain of a hectic work environment,^{5,6} and fewer medical trainees choose primary care careers.⁷

The patient-centered medical home (PCMH), a new model of primary care, is widely regarded as a potential solution to these problems.⁸ This model of practice redesign emphasizes the core attributes of primary care (access, longitudinal relationships, comprehensiveness, and coordination), promotes the chronic care model, maximizes the use of advanced information technology, and aligns reimbursement methods with improved patient access and outcomes.⁹ Despite growing enthusiasm and desire that the PCMH be fast-tracked, more information on its performance is needed.¹⁰ Based on early experiences from a national demonstration project, Nutting and colleagues caution that "wholesale practice transformation is required, even in highly motivated practices, along with significant resource investment."¹¹ We describe a multifaceted PCMH demonstration at Group Health Cooperative, a large, nonprofit integrated delivery system, and the changes observed in its first year.

COMMENTARY

The Patient-Centered Medical Home Movement Why Now?

Eric B. Larson, MD, MPH

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

Background: A patient-centered medical home (PCMH) demonstration was undertaken at a healthcare system, with the goals of improving patient experience, lessening staff burnout, improving quality, and reducing downstream costs. Five design principles guided development of the PCMH changes to staffing, scheduling, point-of-care, outreach, and management.

Objective: To report differences in patient experience, staff burnout, quality, utilization, and costs in the first year of the PCMH demonstration.

Study Design: Prospective before and after evaluation.

Methods: Baseline (2006) and 12-month (2007) measures were compared using surveys from a random sample of patients and all staff at the PCMH and 2 control clinics. Automated data were used to measure and compare change in patients' quality, utilization, and costs for PCMH practices versus controls at 19 other clinics. Analyses included multivariate regressions for the different outcomes to account for baseline case mix.

Results: After adjusting for baseline, PCMH patients reported higher ratings than controls on 6 of 7 patient experience scales. For staff burnout, 10% of PCMH staff reported high emotional exhaustion at 12 months compared with 30% of controls, despite similar rates at baseline. PCMH patients also had gains in composite quality of care, despite 12% and 1.6% greater than those of controls, and specialist visits, but fewer emergency phone and specialist visits. There were no significant differences in overall costs.









Conclusions: A PCMH redesign can be associated with improvements in patient experience, staff burnout, and quality without increasing

in primary care. However, according to the Institute of Medicine's (IOM's) "Quality Chasm" reports,¹² US care is increasingly fragmented and moving away from primary care and chronic care management, and the effectiveness of their effectiveness.

Integrated delivery systems—termed "accountable organizations"¹³ and credited with providing better, less fragmented care—are often challenged to provide high-quality, affordable primary care. Group Health Cooperative, a nonprofit health insurance and care organization that has always been primary care-focused, is an example. In response to market forces and the desire to provide ready access to physicians and other clinicians, it was a problem in traditionally managed integrated delivery organizations. Group Health in 2002 initiated a primary care redesign. Elements included open access to specialists, and an integrated record with a secure Web site that enabled their physicians and view their records. The redesign also established new standards and reimbursement changes (Table 1).

Patients' expectations for improved primary care met patient expectations for improved primary care. Moreover, primary care redesign had no negative effects on their quality of life, and primary care redesign had no negative effects on their quality of life, and primary care redesign had no negative effects on their quality of life. Thus, even in an integrated delivery system, primary care redesign can be successful. This study was part of a larger effort to redesign primary care at Group Health Cooperative, which was the Chronic Care Model, the result of which was not being realized. This study was part of a larger effort to redesign primary care at Group Health Cooperative, which was the Chronic Care Model, the result of which was not being realized. This study was part of a larger effort to redesign primary care at Group Health Cooperative, which was the Chronic Care Model, the result of which was not being realized.

Group Health Research Institute

Year 1	Year 2
	
	
	
	

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)

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

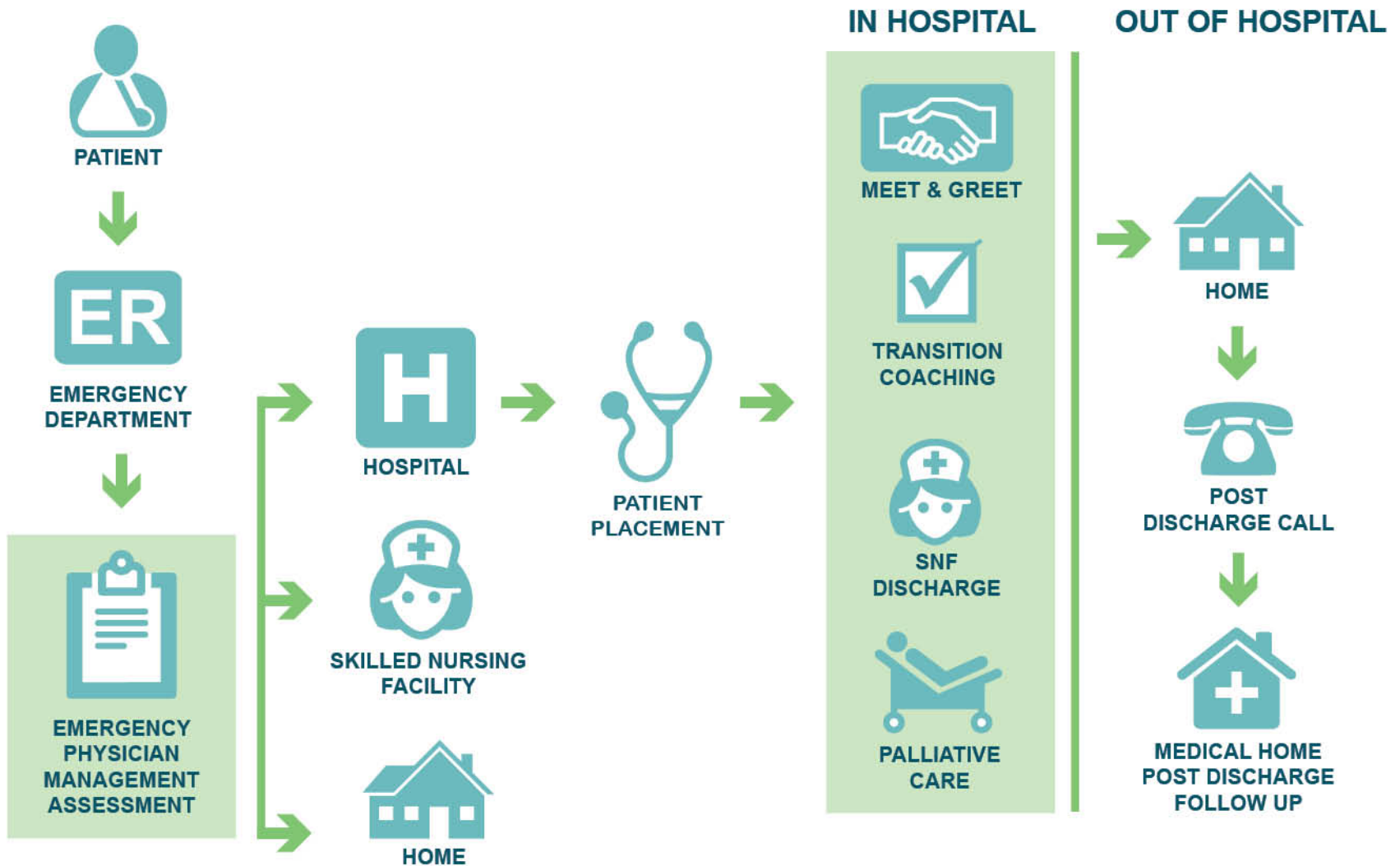
Standard Mgmt Practices

Enhanced Staffing Model

Value-based MD Payment Model

Standardization & Spread using LEAN methods

GROUP HEALTH EDHI CLINICAL INTEGRATION





WHAT IS ACCOUNTABLE CARE?

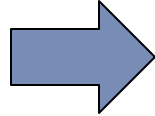


“We’d like to start out being very involved with you but eventually be drawn away to much more interesting cases down the hall.”

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

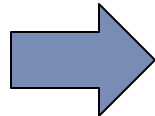
- **Manage a full continuum of care in an integrated, local delivery system**
- **Focus on improving care and lowering costs**
- **Establish specific spending levels and shared savings under fee-for-service or increasing degrees of capitation**
- **Select Partners with these as part of shared values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

Physician-Led



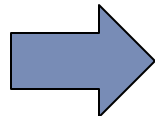
The ACO should be led by physicians (however, partnerships with hospitals and health plans are critical)

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

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**

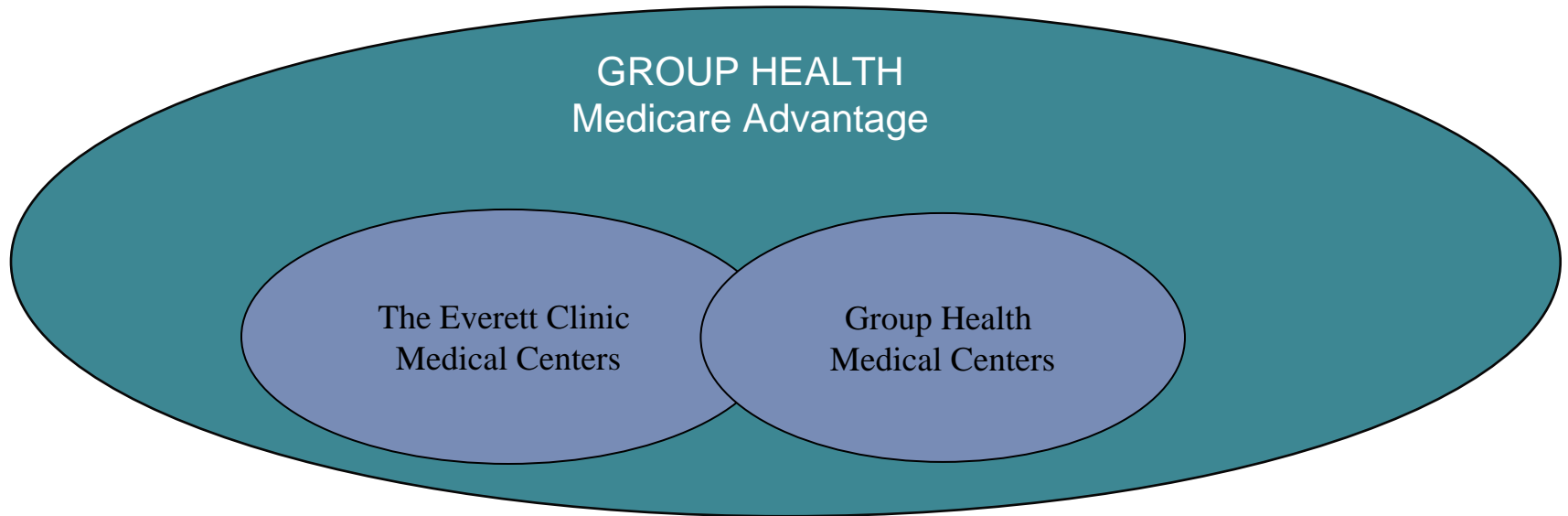
FIVE | Payment structures encourage better health

- **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



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**

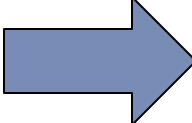
Year 1: Traditional contracting (2011)

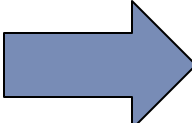
Year 2: Shared gain and risk arrangement and agree on quality and utilization metrics for this population (2012)

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.

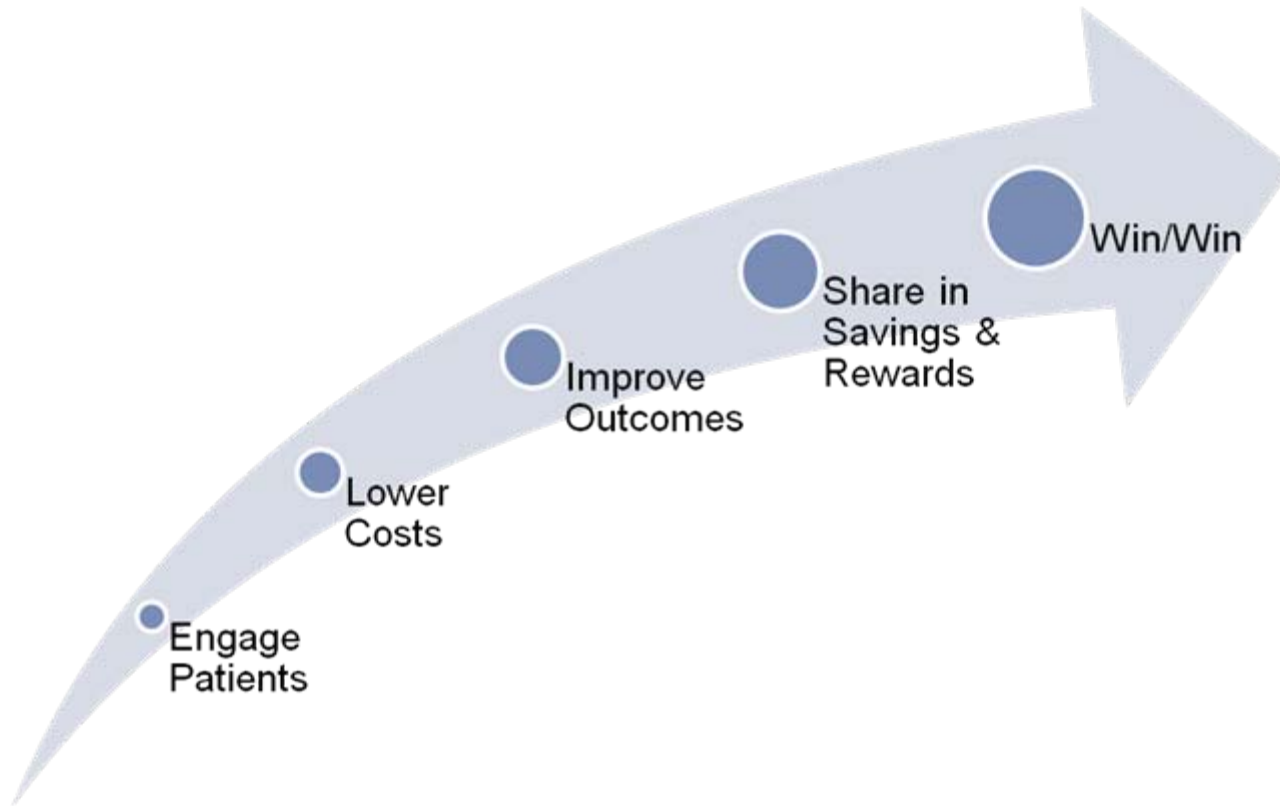
It is the Best of Times  Advances in biomedical knowledge and technological innovation offer the promise of marked improvements in health

It is the Worst of Times 

- Coverage
- Cost
- Quality

The Solution  Delivery System Reform:
Accountable Care Organizations

Keys to Success



- ⑩ **Accountable care starts with a stable primary care base**
- ⑩ **Approach should be patient-centered & population based**
- ⑩ **Need agreement on shared values & common model of care**
- ⑩ **Physician leadership is essential with focused attention on care transitions (primary care, specialty care, hospital care)**
- ⑩ **Payment incentives & shared rewards can support care model**

