Medical Home at Group Health
Health Reform Implementation, Joint Legislative Select Committee

September 15, 2010   Paul Fletcher MD

Assistant Medical Director, Primary Care

Why is medical home at Group Health demonstrating results?

Context of Medical Home at Group Health: What environmental factors contribute to success?

Medical Home: What is it? What are the elements? How is it different from good primary care?

Proven results: expenses, quality, patient satisfaction

o **Health Affairs documents the methods and the results**
The Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction and Less Burnout for Providers. Health Affairs 29:5, May 2010.

o **Annals of Family Medicine suggests GH's accomplishments may be unique to date**
Initial Lessons From the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home. Annals of Family Medicine 7:3, May/June 2009

o **AMGA Acclaim award application gives details of the context for the medical home**

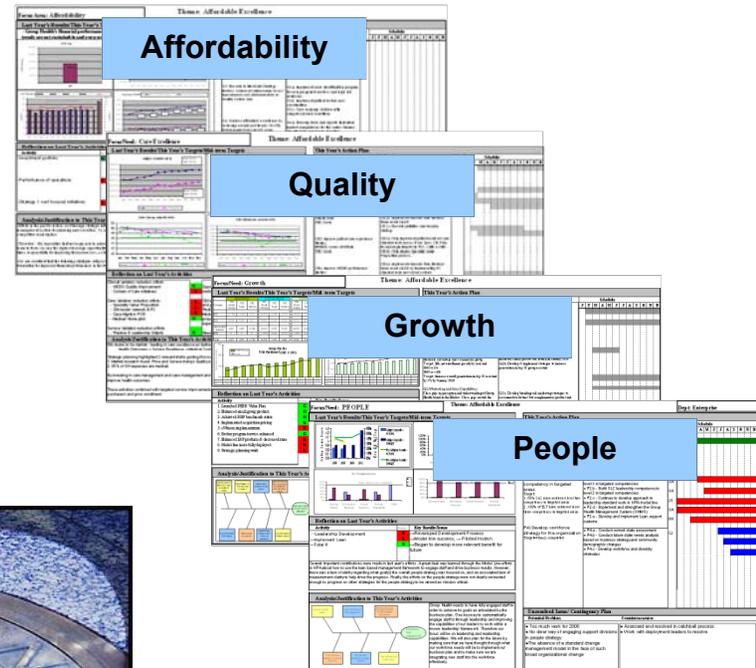GroupHealth.

Group Health Cooperative

A consumer governed organization with multiple health plans and an exclusive arrangement with Group Health Physicians. Serving 628,000 patients, 9,300 employees, operating revenue $2.8 billion

Bulk of enrollees and ambulatory services through "owned and operated" facilities. 1,200 clinicians working in 25 clinics in Washington; 1.4 million encounters, 30% through virtual medicine.

Over half the medical expenses in contracted hospitals and physicians; 6,000 community based physicians, and 7 contracted hospitals

GroupHealth.

True North: Affordable Excellence

Affordability

Quality

Growth

People

GroupHealth.

Results of Our Efforts

GroupHealth.

Context for success of the Medical Home

o We are on a mission to demonstrate a better way to deliver health care.

o We are organized around the patients and motivated to keep them healthy. The Medical Home is one part of our strategy, one part of our improvement work.

o The Medical Home is organized around principles of bringing value to the patient and building the patient –pcp relationship.

o No single strategy works alone.   The Commonwealth Fund Commission identified Six Attributes of an Ideal Health Delivery System. We are working on each of these attributes.

Six attributes of Success

1. **Clinically Relevant patient information widely available, enhanced by a unified system**

   o A robust and sophisticated electronic health record used by all clinicians in our system

   o Many patients access their personal records- test results, visit summaries and care plans

   o Patients obtain medical advice via secured messaging and 24/7 consulting nurse/MD advice line who are looking at the medical record

   o Patients schedule visits and refill prescriptions on line and have direct access to a wealth of reviewed high quality medical information

Six Attributes of Success

2. **Patient Care is coordinated and transitions of care are actively managed**

- o Dedicated hospitalists and nursing home rounding and hospice physicians provide focused attention on fragile patients

- o Case managers work with patients at times of transitions in and out of the hospital, and with those with new or unstable chronic disease

- o Patient care in emergency room is actively reviewed and managed in real time by GH physicians

- o Coordination across the continuum is facilitated by the personal physician and team

Six Attributes of Success

3. **Care team members accountable to each other, collaborate to deliver high quality and high value care**

   o Visual display for processes and outcomes at each level of the organization

   o Daily huddles at the team level include process performance and outcomes

   o Complete medical record visible to all specialties showing medical decision making at each step. Care plans visible in the medical record so all clinicians can contribute to the care of the patient

   o Physician 360 evaluations include input from nursing, peers across the specialties, and performance in the areas prioritized by the organization including patient satisfaction

   o Robust patient complaint response system, patient safety review, unusual occurrence reporting to collect and learn from defects across the system

Six Attributes of Success

4. **Patients have multiple points of entry and easy access to care from clinicians who are culturally competent and responsive**

  o Patients choose secure on-line messaging, face-to-face visits, telephone consults with nurse or personal physician, local walk-in urgent services.

  o Patients with chronic diseases have care plans printed on take home visit summaries that make the next steps clear.

  o Multiple outreach activities to patients: chronic conditions, ER/UC or hospital visits, unmet prevention needs such as pap smears.

  o Physician training in communication starts with orientation and continues with directed training for those with low patient satisfaction surveys or multiple complaints.

Six Attributes of Success

5. Clear Accountability for the total care of patients

- o Vertical integration of financing and delivery of care is built into our DNA. We coordinate care in all settings and transitions. Our revenue is primarily capitated, some risk adjusted and medical expense liabilities are for all levels of care.

- o Quality and cost measures are published at the level of patient population

- o We align incentives via our compensation at the individual and group level

- o Primary care physicians given data for their panel, care and outcomes for the population served. Outcomes include ED/UC and hospitalization rates as well as HEDIS and patient satisfaction.

GroupHealth.

Six Attributes of Success

6.   The system is continuously innovating and learning

o   Removing affordability as a barrier for our patients has required a relentless focus on our systems and our processes to reduce waste and increase value.

o   Our management system has been fundamentally reformed and rebuilt on Lean principles. Innovations are developed with front line workers, piloted and spread across the organization. Work place rounding -the routine work of leaders- is to ensure standard work is spread and followed. Local teams are trained to make continuous improvement in their local processes.

Why Medical Home? The Burning Platform

GroupHealth.

Why did GH adopt Medical Home?
"Enhanced Primary Care"

o 2003- 2006 basic elements of "medical home" in place- patients paneled with primary care physicians accountable for population outcomes, same day appointments, direct access to specialty, electronic medical record and on-line portal for our patients and 24/7 consulting nurse service.

o But, results not what we expected: Low morale, early retirement, flat quality indicators, increasing medical costs, little growth.

o Established a small pilot, established powerful design principles and tried everything we could think of from Jan 07-Dec 08. Notably we lowered the paneled count by 15% but more importantly we changed the nature of the work. We were able to demonstrate results within 12 months and continued the rigorous controlled study for 24 months.

o AT 12 months we decoded what made the difference compared to our usual primary care. Reverse engineering, design, pilot and implementation with our new lens of lean management principles.

Medical Home Results after 1 Year

- QUALITY (HEDIS)
  - Rate of rise, 2x that of control clinics

- PATIENT/STAFF SATISFACTION
  - Patient satisfaction – 5% increase in patient activation/goal setting
  - Practitioners - *substantially less burn-out with significantly reduced emotional exhaustion & depersonalization

- SPECIALTY VISITS (8%)
  - Medical

- SPECIALTY REFERRALS (5%)
  - Total referrals, all medical and surgical

- ED/UC UTILIZATION (29% reduction)

- AMBULATORY SENSITIVE ADMISSION (11%)

- COST NEUTRAL AT 1 YEAR!

Peer reviewed: September 2009, American Journal of Managed Care

15

GroupHealth.

Mapping the Medical Home Value Stream

Primary Care Future State Map
August 19 – 21, 2008
Medical Home Model

LEGEND

PREREQ
Prerequisite for individual clinic before going live

Improvement work

Medical Home element to be spread

PREREQ Define Facility Assessment Needs/Strategy

PREREQ Panel Size = 1800 adjusted

Standard Work for Moving Panel - Includes Strategies for Hard to Recruit clinics

Determine Medical Home Applicability to Pediatrics - Panel, Visit levels, Peds RNs

Other Demand

Patient

Design Heijunka Format & Rules

Strategies & Tools for Increasing Use of Virtual Medicine

Standard Work for Managers/ Leaders

Heijunka Box to Level Work

XOXO

(Increase Use of) Virtual Medicine (Call Management & Secure Messaging)

Consistent Use of Visual Systems

Outreach Workcell

Includes:
1. ED/UC outreach
2. Hospital/SNF discharge outreach
3. Complex Case Management outreach
4. Disease Management outreach
5. Chronic Care outreach (Doc & Coding)
6. HEDIS outreach
7. Lipid Mgmt outreach
8. TRIP outreach, Pharmacy outreach

Appoint Patient

Prep for Visit

Provide Care

Follow Up

Outreach Cell Development
- Who/Roles
- Work Rules
- Virtual or Physical
- Standard Work for Outreach
- Outreach Prioritization Criteria

Define M-F Template Variation

Standard Work for Huddles & Pre-visit Prep

Consistent pre-visit prep work (MD and flowstaff)
- Team Huddles (everyone attends)
- Dyad Huddles

PREREQ Visit Length = 30 minutes
-More holistic care/ opportunistic care

PREREQ 1:1 MD/Flow Staffing (consistent each day if possible)

PREREQ Co-Location of Team Members

Standard Work for Chronic Disease Mgmt - Meet regulatory requirements, build reporting

Consistent AVS usage

Select Standard Tools/AVS Content

Decoding the Medical Home at Factoria

- Enrollment Costs

- Outcomes // Patient & Staff Satisfaction

Outreach

Standard Work

Prepared for the Visit

MORE TIME

Call Management

MHM
Advancing Primary Care

Virtual Medicine
- Phone, Secured Messaging

Disease Management

Decrease Panels
e.g. 1,800

Access : Visit Demand

MORE TIME

GroupHealth.

Medical Home

Basic requirements in place, circa 2005

- Patients paneled, salaried/ capitated primary care

- Appointing center for those patients wanting routine appointments

- Good access for primary care and 24/7 consulting nurse service

- Multi-disciplinary team: lpn, RN, clinical pharmacist

Ready for Enhanced Medical Home

- Lower panel count, adequate staffing

- Teaming- co-location of multiple disciplines

- Huddles with effective communication

Enhanced Elements

1. Call Management

o Answer the phones and resolve the patient question. No message machines and few call backs.

o "Press 4 to speak to your care team"; new technology so medical record number directs the call to the pcp office

o Phone answered by MD (!), lpn, Rn, pa or medical assistant

o Co-location of the lpn and the RN and close proximity to the physician makes it easier to resolve issues in real time.

o Visual display of time to answer, % calls answered, and first call resolution

Decreased rework and messaging created room for more clinical work, better preparing for visits. Removed large dis-satisfier for patients.

Enhanced Elements

2. Virtual Medicine

o <u>All</u> physicians communicate with patients via email and phones

o Easy for patients to send secured email message directly to pcp or specialist recently seen

o Visible targets and performance on percent of "touches" via virtual medicine

Face to face visits decreased naturally to 14 per day creating room for more virtual visits and longer face to face visits, and pulling more work into the team via outreach

Enhanced Elements

3. Chronic Disease Management

o   Focus on 5 chronic diseases (and now Opioids)

o   Patients leave the visit with clear diagnosis, goal of treatment, medication plan, and follow up steps. Care plan visible to clinicians across the system- consulting nurse to urgent care.

o   Referral to RN or clinical pharmacist for intensive personal intervention for those unstable or new diagnosis. They will get education, titration of medications, sick day plans, screening for depression, and frequent monitoring.

o   Visual display of care plans completed everyday

New way for team to communicate with each other and with the patient regarding the specific targets and plan for these potentially high risk patients. Our "ambulatory care sensitive conditions" admission rates are lowest in the country; we intend to improve our performance.

Enhanced Elements

4. Visit Preparation

- o Medical assistant reviews chart and patient registries for care needs including lab monitoring

- o Patients needing care plans are identified based on diagnosis and presence of up to date care plan

- o Opportunistic preventive care done every visit every time not saved up for "physicals" or "annual preventive care visits"

- o Visual display of ability to prepare the charts for the next day and the ability of the clinician to perform or schedule the needed care

Most of our patients with care needs come into the office during the year and opportunistic care is a powerful way to improve our performance. No longer are we dependent on a rushed physician doing heroics to recognize that a patient coming in with an acute problem might also need immunization or a lab test or mammogram.

Enhanced Elements

5. **Daily Access Management daily huddles**

   o Routine work to level supply of clinicians, (leave request process, locums coverage)

   o Adjustments to scheduling yearly, monthly and weekly

   o Daily huddles to maximize continuity, fish for opportunities to convert face to face visits to virtual visits

   o Visual display of percent of appointments made within 36 hours

   Good access is critical to everything we do. Everything goes better when the supply matches demand and the work is leveled. Most demand is predictable. Trend toward fewer rules in place for appointing. Some limited opportunity to fine tune access on the day.
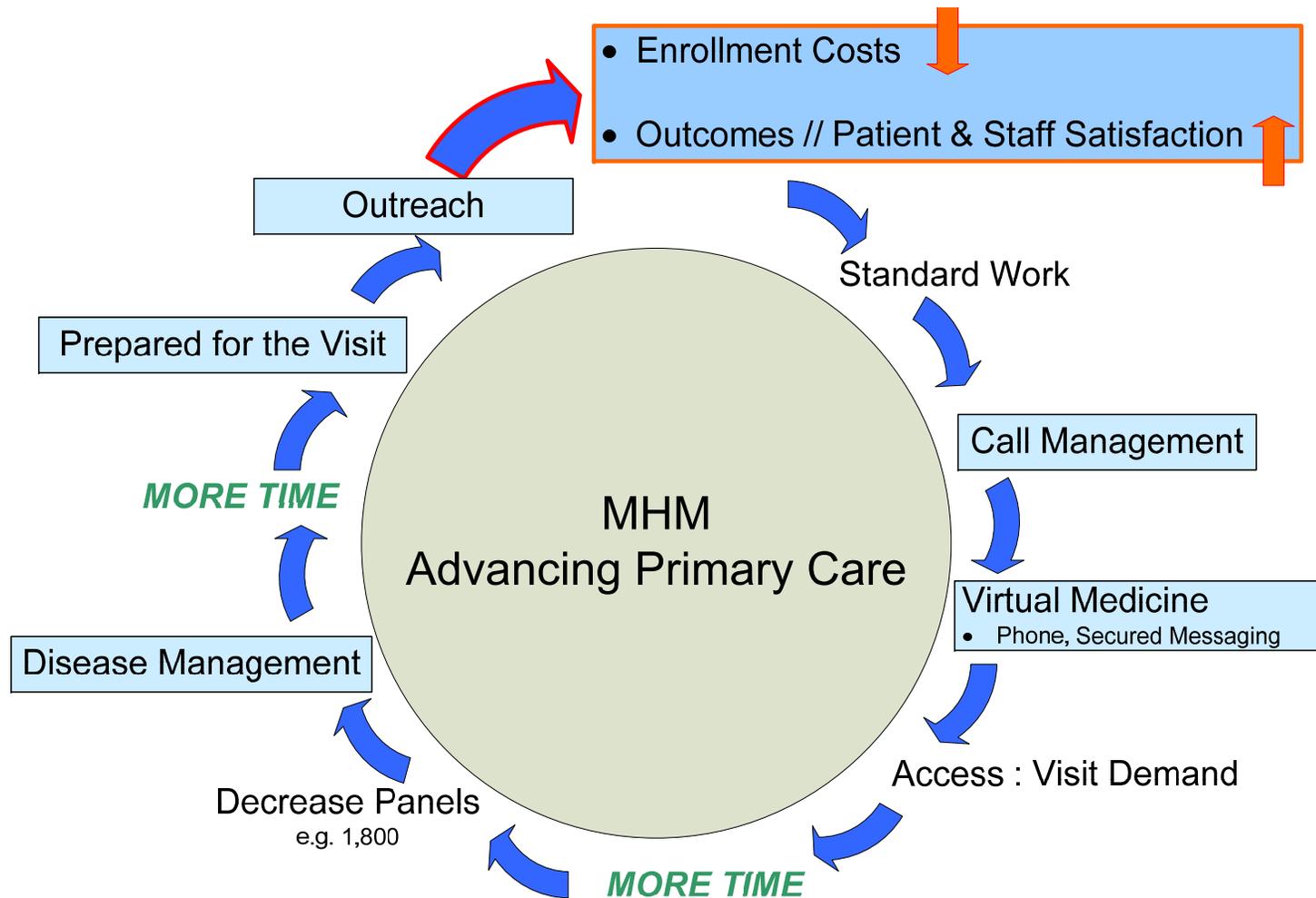
GroupHealth.

Enhanced Elements

6. **Outreach- contacting patients who did not call in**
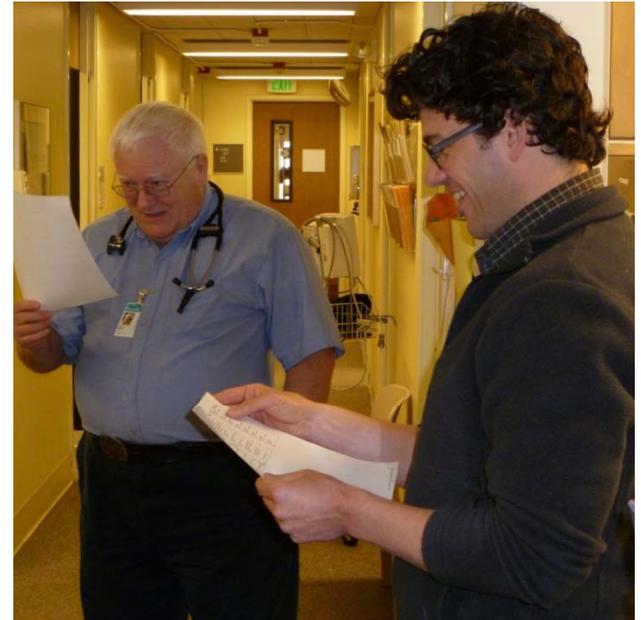
    o   With care needs identified from electronic record or billing information (to schedule labs, studies or appointments)

    o   With chronic conditions who have not been evaluated for that problem within the year (to schedule appointments)

    o   Who visited an ER or urgent care within the last 24 hours (to check on health status, inform of our ambulatory hours, to ensure correct follow up)

    o   Discharged from hospital (to ensure medications correct, follow up plans are understood and in place)

    o   Visible display of contacts needed and made every work day

    Powerful tool for making significant progress on our performance goals- HEDIS, utilization, billing and coding accuracy, patient satisfaction. Pulling in significant amount of work for the teams 2-3 of the 14 face to face visits per day.

Decoding the Medical Home at Factoria

- Enrollment Costs

- Outcomes // Patient & Staff Satisfaction

Outreach

Prepared for the Visit

MORE TIME

Disease Management

Decrease Panels
e.g. 1,800

MHM
Advancing Primary Care

Standard Work

Call Management

Virtual Medicine
- Phone, Secured Messaging

Access : Visit Demand

MORE TIME

GroupHealth.

The Group Health Management System is our secret sauce…

Enhanced Elements

7. Manager Standard Work

    o   Required daily and weekly rounds

    o   Required shadowing watching actual work

    o   Knowing, teaching and reinforcing standard work

Changing the management work and culture is the most important element. Belief in standard work as the foundation for learning together. Attention to process and making problems visible are essential to our strategy of continuous improvement.

Changing Role of Leaders

GroupHealth.

Are Doctors Compatible with Lean?

≠

Standardized Work, reduced variation

Virtual medicine, proactive chronic care

Delegation to team members

No barriers to access and pulling work

GroupHealth.

Results at two years

o Pilot clinic compared to control clinics

o Costs: overall pmpm $10 better

o $1.50 more in primary care

o $5.00 more in specialty care

o Reductions in emergency room, urgent care, and admissions.

o Continued improvement in quality, patient satisfaction and staff morale

Summary

Vertical integration of finance and delivery of care. Aligned incentives consistent with an accountable health care organization: physician group predominately on salary with incentives for quality.

Horizontal integration of care with physician group providing care at critical points of care: primary care, specialty, urgent care, hospital care, nursing home and home health.

Robust electronic medical records and web portal for patients allowing rapid sharing of information.

Design of services to provide value to the patients. New Group Health management system based on Lean principles ensures a new level of reliability and consistency across the organization.

Questions?

GroupHealth.