



# Health Plan Innovations in Patient-Centered Care

## Strengthening Primary Care for Patients





Health Plan Innovations in Patient-Centered Care:  
**Strengthening Primary Care for Patients**

A publication of the Alliance of Community Health Plans

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# LETTER FROM ACHP's CEO

Dear Colleagues,

Our nation's community-based health plans know that successful, sustainable, scalable primary care transformation benefits consumers, their communities and our entire health care system. By positioning primary care providers and their practices as the backbone of health care, primary care can organize our fragmented health system and coordinate patients' care across the "medical neighborhood" of multiple providers and health agencies. Putting patients – and their needs – at the center of such transformation ensures that this adds value to patients' health care experience.

The Alliance of Community Health Plans (ACHP) and our members came together in 2008 to consider how community health plans could best achieve a new form of primary care: one that serves the patient. The Primary Care Innovation (PCI) Collaborative met regularly from the fall of 2008 through the spring of 2011 and developed a Primary Care Sustainability Model. At the core of the model are four standards that the collaborative identified as essential components of accountable primary care: patient-centered care and coordination, support of care integration, value-based practice reimbursement and outcomes measurement. As the participants in the collaborative refined their strategies to help practices redesign primary care to meet patients' needs, health plan investments directed at supporting these standards and improving outcomes were a key component of success.

Strengthening Primary Care for Patients profiles 17 ACHP members involved in the PCI Collaborative and offers encouraging examples of plans' successes, including:

- Increased quality care, lowered costs and/or improved patient or provider experience in all 17 organizations. Many had positive outcomes in all three categories, demonstrating that health plans and provider groups do not have to sacrifice quality and patient experience for cost.
- Increased patient confidence in their ability to manage and control their health.
- Increased patient and provider satisfaction.
- Reduced hospital admissions and readmissions.

Strengthening Primary Care for Patients is the third publication in the ACHP "Health Plan Innovations in Patient-Centered Care" series, which focuses on members' initiatives to achieve improved population health, enhanced patient experience and more affordable costs. **Our goal is to contribute to the increasingly urgent discussion on how to deliver high-value care by focusing on quality, patient satisfaction, the best clinical outcomes and a health care cost curve that bends down.**

We hope that Strengthening Primary Care for Patients will serve as a useful resource to a variety of stakeholders, including health plans, providers and policymakers who are looking to transform primary care so that it plays the central role in health care delivery that we believe it should.

Patricia Smith



President & CEO  
Alliance of Community Health Plans

# EXECUTIVE SUMMARY

This publication, the third in a series on health plan innovations in patient-centered care, describes the role of health plans in primary care transformation. It examines the essential elements of plan-provider partnerships, drawing on the experience of 17 members of the Alliance of Community Health Plans, a national leadership organization of high-performing plans and plan-affiliated provider groups. Their decades of experience bringing about patient-centered models of care provide valuable insight for health plans and provider groups seeking to implement such reforms.

Health plans can be invaluable partners to practices that aim to transform their delivery of primary care as well as improve health outcomes, patient and provider satisfaction and financial viability. The case studies in this report demonstrate how plans provided infrastructure grants to support investments in health information technology and new staff; convened practice collaboratives to spread innovations and best practices; engaged consultants to facilitate provider-led change; and developed new payment and reimbursement models that rewarded comprehensive care.

More important than specific details on how plans facilitated primary care transformation among their partner practices appears to be the focus of health plans and plan-affiliated provider groups on three core elements. All organizations featured in this brief:

- Worked closely with providers through the entire design and implementation process.
- Provided physicians with tools and resources to support primary care transformation.
- Adapted their models to the unique culture of the plan, providers and community.

Each of the three core elements is described through examples from Alliance of Community Health Plans members in the Essential Elements section. In Promising Results, the paper outlines outcomes they have achieved in the areas of care quality, affordability and patient experience. The discussion section summarizes how the featured plans and provider organizations have been able to successfully implement reforms, sustain them over time and scale them to additional practices, as well as how these lessons can be applied to other organizations. Finally, Section V contains longer case studies on each organization featured in this publication.

# I. Introduction

## Sections

About ACHP

Challenges Facing Primary Care

Importance of Primary Care  
Transformation

The Health Plan Role in Transformation

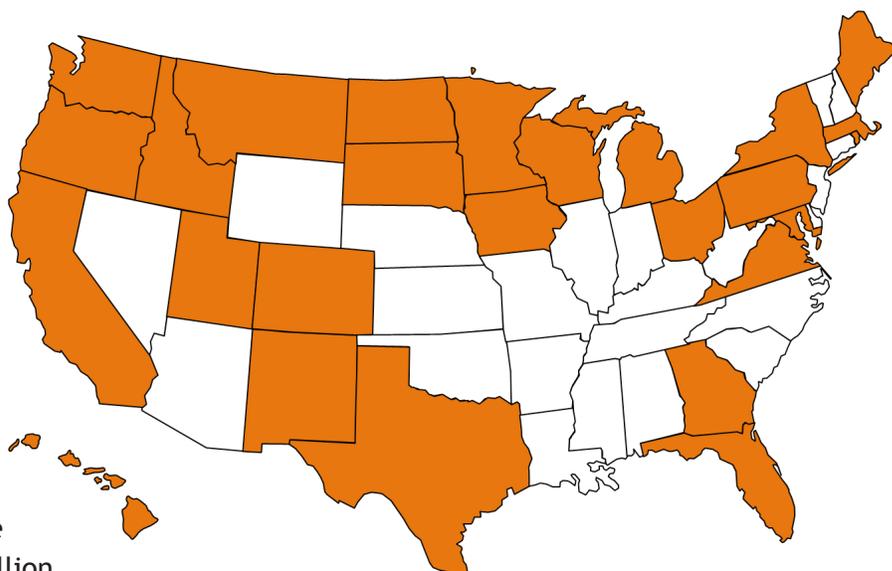
ACHP Members: Decades of Experience

About the ACHP Innovation Series

## ABOUT ACHP

The Alliance of Community Health Plans (ACHP) is a national leadership organization bringing together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care.

The community-based and regional health plans and provider organizations from across the country that make up ACHP's membership provide coverage and care for approximately 16 million Americans. These 22 organizations focus on improving the health of the communities they serve and are on the leading edge of innovations in affordability and the quality of care.



*Figure 1: States containing at least one ACHP plan*

## CHALLENGES FACING PRIMARY CARE

Strong primary care that provides patient-centered and ongoing care and support, and which functions as the first point of contact for patients with health and wellness needs, can improve health outcomes, reduce health disparities across a population and lower costs.<sup>1</sup> Recognizing the importance of such care, the Patient Protection and Affordable Care Act (ACA) set aside resources for strengthening the primary care workforce through training support and financial incentives<sup>2</sup> and doubled the capacity of community health centers.<sup>3</sup> The Comprehensive Primary Care (CPC) initiative, a multi-payer demonstration project sponsored by the Center for Medicare and Medicaid

Innovation, will offer incentive payments to primary care physicians who coordinate care for their Medicare patients.<sup>4</sup>

Even with the enhancements of the ACA and initiatives being piloted by the Centers for Medicare and Medicaid Services (CMS), primary care continues to face multiple challenges, including limited access to timely care, poor reimbursement rates,<sup>5</sup> fragmentation and lack of coordination among providers.<sup>6</sup> It would take a primary care physician 18 hours per day, on average, to provide the necessary preventive and chronic care services to a typical patient panel.<sup>7</sup>

# IMPORTANCE OF PRIMARY CARE TRANSFORMATION

In order to maintain financial viability while ensuring the delivery of high-quality care, primary care practices will have to adapt to the reality of larger patient panels with increasingly serious illnesses.<sup>8</sup> To succeed and thrive in this new environment, practices will have to transform the way they deliver care by investing in health information technology, instituting team-based care to maximize the value of each provider's time, improving care coordination and expanding hours to improve access. Simultaneously, since fee-for-service fails to reimburse for activities such as communicating with specialists or providing care by phone, revised payment models will enable practices to succeed financially in light of their redesigned work flows and expanded services.

This brief uses the phrase “primary care transformation” as an umbrella term to describe changes made at the practice level combined with payment reform (described as “comprehensive payment for comprehensive care”<sup>9</sup>) to improve the delivery and experience of primary care. Patient-centered medical homes (PCMH) are one manifestation of primary care transformation; however, the focus of transformation is not simply to implement PCMH elements to comply with national guidelines. The ultimate goal of primary care transformation is to implement reforms that fundamentally change the delivery and experience of primary care in a community, with a focus on ensuring sustainability over time.

# THE HEALTH PLAN ROLE IN TRANSFORMATION

Mixed-payer primary care practices often lack the capabilities to fundamentally transform without outside help.<sup>8,10</sup> The National Demonstration Project evaluation of 36 practices that underwent transformation found that practices needed financial assistance in purchasing health information technology, such as electronic medical record (EMR) capabilities; external facilitation to help staff build foundations of high-performing practices; and peer learning and support.<sup>11</sup> The success of medical home initiatives also requires staff and workforce training, monitoring of patient outcomes and ongoing enhanced reimbursement.<sup>12</sup>

Health plans can facilitate transformation due to their access to capital, experience in managing financial risk, experience in examining

process flows and possession of advanced information technology infrastructures that allow them to collect, integrate and analyze data from multiple sites.<sup>13</sup> For example, plans can offer grants for practice transformation and

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reimbursement for care coordination, engage external consultants to implement revised work flows, embed plan-funded case managers at practices and convene collaboratives to facilitate conversation among practices. Health plans can group multiple small practices together to share resources for transformation, such as in Geisinger Health System, creating conditions under which practice transformation can occur.<sup>8</sup>

Even when providers can afford some practice transformation elements, technical assistance from plans enhances their ability to make the most of reforms. For example, among a group of small physician practices in New York, implementation of EMRs combined with technical assistance resulted in improved care quality; practices that received no or moderate assistance did not see improved quality, even after two years of use.<sup>14</sup>

## ACHP MEMBERS: DECADES OF EXPERIENCE

The Patient-Centered Primary Care Coalition (PCPCC) has identified more than 90 commercial insurance plans that have become involved in PCMH initiatives, many within the past two or three years.<sup>15</sup> Members of the Alliance of Community Health Plans (ACHP), an association of 22 not-for-profit, community-based health plans and plan-affiliated provider organizations, stand out as early initiators of work to transform primary care.

ACHP members are committed to ensuring patient-centered, affordable and high-quality care for their members, and have historically close relationships with their provider partners. Member plans recognize the importance of strong primary care in improving the health of their communities and reducing cost of care, as well as the challenges providers face in changing the way they deliver care. For years, therefore, they have been investing in primary care transformation, using their own resources and staff time to implement patient-centered reforms and improve the care experience for both patients and providers.

By the 1990s, Kaiser Permanente — an integrated, group-model health care organization — was already developing care teams consisting of physicians, nurse practitioners, nurses and educators, as well as coordinating care between primary care physicians and specialists.<sup>16</sup> The organization’s Emergency Prospective Review/Critical Care Transport program in San Diego was developed to channel patients with urgent or emergent conditions to their “medical home” through a 24-hour triage phone line.<sup>17</sup> By 2000, the Permanente Medical Groups were setting performance expectations for providers and adopting evidence-based care standards, and rolled out a system-wide EMR by 2005.

HealthPartners of Minnesota began primary care transformation work in 2001; Capital Health Plan in Florida created a primary care center for chronically ill members in 2003; and the launch of Geisinger Health Plan’s ProvenHealth Navigator® in 2005 continued to pave the way for other commercial payers to support primary care transformation. Their efforts predate the official introduction of the term “patient-centered medical home” in 2007,<sup>18</sup> but would now be considered standard in a PCMH.

# ABOUT THE ACHP INNOVATION SERIES

ACHP's Health Plan Innovations in Patient-Centered Care is a series of publications profiling the roles health plans can play in advancing care.

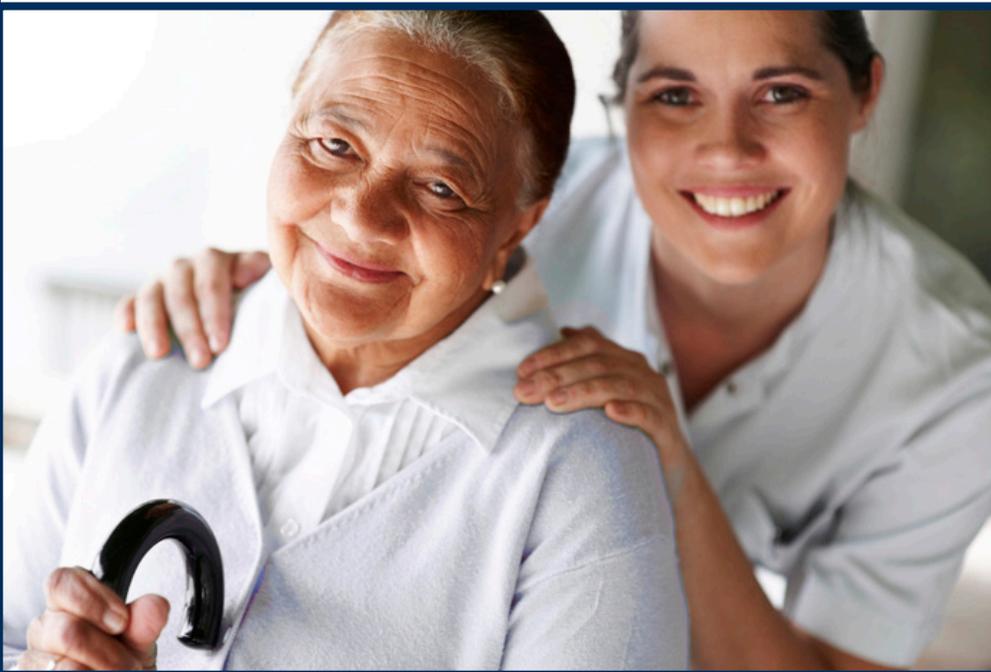
The first publication in the series, on care management strategies and the role of care management nurses, examines the exceptional work being done by ACHP plans to manage care of high-risk, chronically ill patients with complex needs.

The second publication explores a variety of approaches these plans are using to effectively transition patients from acute care settings to home. ACHP members are leaders in the health care industry and in developing care transitions programs that improve delivery system quality and the health of patients. These strategies

also have the potential to help address costs for enrollees and health care markets.

This third installment examines the vital role health plans can play in transforming primary care, and how these new models of care can create better health, better health care, improve experience and satisfaction for both patients and providers and lower costs. Section II describes the components of health plan facilitation of primary care innovations, while the detailed summaries in Section V provide deeper insight into each organization's initiatives and efforts to ensure sustainability.

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*The Health Plan Innovations in Patient-Centered Care series looks at the role health plans can play in care management, transitions of care and primary care transformation.*

# II. Essential Elements of Payer Facilitation of Primary Care Transformation

## Sections

Overview

Collaborating Toward Mutual Goals

Sharing Tools and Resources

Building on Plan, Provider and  
Community Culture

# OVERVIEW

This brief profiles the experiences of 17 diverse members of the Alliance of Community Health Plans in facilitating primary care transformation. These organizations range from 50,000 to over a million insured members, from Florida to Seattle to Hawaii. A few health plans have an entirely contracted network of physicians, whereby each provider is independent from the plan with wholly separate governance structures. Others are part of integrated systems, in which a majority of members get care from plan-employed or associated physicians.

Because they vary so widely, the organizations facilitated primary care transformation in unique ways. However, three elements stand out as commonalities among all their initiatives:

- Collaborating toward mutual goals, including close cooperation between and among plans and providers through all stages of the transformation process: from relationship-building to design, implementation and evaluation.
- Sharing of tools and resources with practices, including financial support and enhanced reimbursement, data and health information technology, access to health plan staff and opportunities to work with experts and consultants.
- Building on existing cultures and characteristics of the health plan, providers and community to develop a customized care delivery and payment model that delivers the best results in a particular market.

Every plan focused on all three components, but the ways that plans chose to incorporate these elements into their primary care transformation initiatives were largely independent of their delivery models. For example, Independent Health, a fully networked plan that does not employ any physicians, and Group Health Cooperative of South Central Wisconsin, which contracts almost entirely with plan-affiliated primary care providers, are highlighted for their close plan-payer collaboration. Priority Health, a network-model health plan, and Kaiser Permanente Hawaii, a group-model organization whose medical group is affiliated with the national Kaiser Foundation Health Plan, attributed their models' successful implementation to the culture of both their own organizations and that of their physician partners.

Each element is described in greater detail in the following sections, with examples from ACHP members. One-page case studies for each organization can be found in Section V.

## COLLABORATING TOWARD MUTUAL GOALS

Previous literature has identified that the success of initiatives in transforming the delivery of primary care “depends on the quality of collaboration between providers and payers.”<sup>13</sup> ACHP member plans partner closely with both network and plan-affiliated providers in the development and implementation of new care models, supporting and engaging them through work groups, collaboratives, site visits and sharing of best practices.

Health plans are able to convene multiple practices that would not typically share resources and ideas and spread lessons learned from one initiative throughout an entire network. Further, by co-creating both practice transformation elements and new payment models with providers, plans can maximize the chance of successful adoption and implementation of these new elements.

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**CareOregon** in Portland, Ore., and **Independent Health** in Buffalo, N.Y., both fully networked health care organizations, aimed to support primary care providers financially and logistically, in order to allow physicians to succeed in increasingly resource-limited and fragmented settings. Both plans trusted primary care providers to advocate for reforms that would increase provider and patient satisfaction with care delivery.

CareOregon, a non-profit health services organization providing health plan services, education and community building support to its partners and their members, led the development of its Primary Care Renewal initiative and co-created specific elements with providers. Plan-funded consultants provided change management and leadership training and convened steering committee meetings with each site to exchange ideas and best practices. A reimbursement model includes incentives based on reporting, improving or meeting Triple Aim outcomes of improving the patient experience of care, improving health of populations and reducing the per capita cost of health care. The initiative has reduced emergency department (ED) and urgent care use, hospital admissions, inpatient days and specialty care use.

Physicians within the Independent Health contracted network have significant latitude to implement elements of its PCMH model. In addition to grant money and a refined reimbursement model, Independent Health supports practices through a quarterly dashboard containing information about performance and areas of opportunity, monthly learning collaboratives and health plan consultants. It has seen reductions in ED use, improvements in quality and overall staff satisfaction and savings of \$2.9 million.

Collaboration also occurred between providers and between organizations. **Group Health Cooperative of South Central Wisconsin**, most of whose members seek care at plan-affiliated primary care clinics, improved communication among clinical staff through a collaboratively developed initiative that drew on provider and member input. The plan supported the development of care teams, embedded care managers in practices, improved medical information documentation in its EMR, implemented evidence-based clinical reminders and began sending practices quarterly dashboards

### Patient Story: Plan-Provider Collaboration

Sandra C., an Independent Health member for more than 20 years, visited her primary care physician, David Pawlowski, M.D., after suffering a cat bite. When an injection of antibiotics did not clear up the swelling and redness, it was determined that Sandra needed inpatient treatment for the infection. Independent Health Practice Care Coordinator Susan Schuler, R.N., who was employed by the plan and embedded in Independent Health-affiliated PCMH practices, arranged for Sandra to be admitted to Northgate Healthcare Facility rather than a hospital. Located in a suburb of Buffalo, N.Y., Northgate is a comprehensive inpatient and outpatient facility offering rehabilitation programs and therapy to patients after injury or illness. As Sandra recalls, “within an hour, I had the medicine and I was on my way to getting better.”

At Northgate, Sandra received IV antibiotics under close supervision of an infectious disease specialist, along with rehabilitation in a less acute setting, which helped her avoid a more costly hospital stay. In addition to prompt and efficient care, Sandra was pleased that the care coordinator found a care option that was close to her home. She commends the team effort among her doctor’s office, Independent Health and Northgate, and says she feels confident in the coordination of care and the attention she received.

“There is always a high level of care given from Dr. Pawlowski and his office, but I think this brings another level to your care,” says Sandra. “You know that there’s Independent Health and the doctor working together, and it really relaxes me to know I have that there. It made a big difference.”



When they collaborate with each other and other professionals, doctors are able to provide the best care for their patients. Independent Health is able to foster better coordination by providing doctors’ offices with practice care coordinators like Susan. With all health care professionals working in unison, patients receive quality, cost-effective and appropriate care.

*Collaboration among physicians, nurses and other health professionals increases care quality*

on each practice's performance on Triple Aim outcomes. This initiative has improved patient, provider and staff satisfaction as well as continuity of care and access.

Taking a different approach, the **Southern California and Colorado regions of Kaiser Permanente** each developed separate initiatives to bolster patient-centeredness, then shared these best practices with each other. Once a year, Kaiser Permanente – an integrated health care delivery system – hosts a national meeting of primary care leaders to share best medical home practices. Kaiser Permanente regions also cooperate through monthly meetings, information partnerships and emails. The proactive office encounter initiative, developed by the Southern California Permanente Medical Group (SCPMG), ensures that every time a member accesses the health care system, SCPMG staff can view his or her care gaps and address them during that same visit, reducing the need for referrals and significantly increasing screening rates.

The Colorado Permanente Medical Group (CPMG) adopted the proactive office encounter initiative from SCPMG, and shared with Southern California its panel management initiative. Under panel management, patients are more likely to see their primary care physician or that provider's "secondary practice partner" during each visit, rather than any physician available in the practice, thereby improving continuity of care. The percentage of routine visits with each patient's personal primary care provider increased substantially after implementation of the panel management initiative.

UCare in Minneapolis, Minn., provides coverage exclusively to patients eligible for state- and federally funded insurance through a network of contracted physicians. The plan reimburses state-recognized health care homes for care coordination services; its care coordinators train practice staff and support them with decision-making processes, provide care management software with risk stratification and share cost

and outcomes data with practices. While data on all of UCare's partners is not yet available, one clinic with which UCare has worked since 2008 has reported significant decreases in cost of care and admissions.

**Rocky Mountain Health Plans**, a network-model health plan in Grand Junction, Colo., has applied its experiences with community-based collaborations to successive practice transformation efforts. As a lead grantee in the Colorado Beacon Consortium, an initiative funded by the Department of Health and Human Services to strengthen local health information technology infrastructure, the plan piloted the use of Quality Improvement Advisors (QIA) to bring about practice transformation. It has since deployed these QIAs to practices involved in the Colorado Comprehensive Primary Care initiative, a Center for Medicare and Medicaid Innovation-funded effort and other practices throughout the community.

Collaborative relationships are further strengthened when plans share tools and resources with practices and acknowledge both the community's characteristics and challenges facing providers and patients. For example, Group Health Cooperative of South Central Wisconsin, the Kaiser Permanente regions and UCare all share quality dashboards with providers. UCare and CareOregon, which exclusively manage care for beneficiaries of state- and federally funded health plans (such as Medicaid and Medicare), have to contend with rapidly changing, high-risk populations and providers who are being reimbursed at rates lower than those for privately insured members.

In spite of their significant differences in member populations, payment models and degree of payer/provider integration, ACHP members demonstrate that a collaborative relationship that includes payers and providers working together from the outset and communicating frequently can be an effective tool in supporting primary care transformation.

# SHARING TOOLS AND RESOURCES

All member plans interviewed for this publication referenced the importance of tools and resources provided to practices in four main categories: payment (including grants and enhanced reimbursement), data (such as identification of high-risk patients, quality dashboards and EMR support), human resources (such as embedded care managers and health plan-based support staff) and expertise (including practice transformation consultants and chronic care experts).

On their own, practices often lack the resources and data capabilities to fully transform the way they deliver care; ACHP members recognize the benefits practice transformation brings to patients and practices and are willing to invest staff time and resources toward the successful implementation of these initiatives.

The specific ways that plans share these resources depend largely on how involved providers are in the design and implementation of the initiative, as well as the culture of the health plan and its relationship with provider partners. For example, **Capital District Physicians' Health Plan, Inc. (CDPHP)**, a fully networked plan in Albany, N.Y., transitions providers in its Enhanced Primary Care (EPC) initiative from fee-for-service to full capitation with opportunities to increase their revenue by 40 percent. The plan funds practices' year-long transformation process through grants, consulting support, plan-based staff resources and data dashboards. CDPHP's EPC practices have seen reduced cost trends, decreased utilization, decreased preventable hospital admissions, improvement in outcome measures and high provider satisfaction.

**UPMC Health Plan** in Pittsburgh, Pa., where approximately 70 percent of members receive care outside its affiliated provider group, leverages significant health plan-based human resources to

support providers, in addition to performance-based incentives. The plan embeds practice-based care managers, who are supported by a health plan-based multidisciplinary support team, at its PCMH sites. It also pays for process improvement specialists to consult with practices and gives them population-level claims data, helping them determine areas of improvement. UPMC Health Plan has reported reductions in readmissions and costs, totaling a return on investment of 160 percent, and increases in quality and efficiency among its PCMH practices.

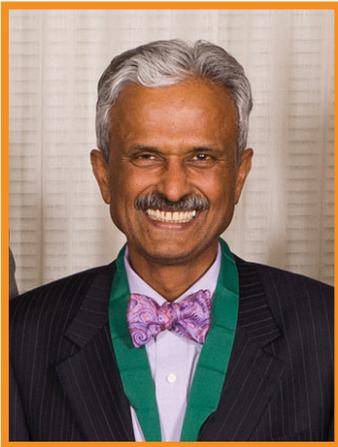
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**Geisinger Health Plan's ProvenHealth Navigator® (PHN)** initiative involves staff, financial and health information technology support, and is designed to facilitate rapid changes to the model. Geisinger Health Plan, which is based in Danville, Pa., and provides less than half of its care through an affiliated provider group, supports all PHN practices through enhanced EMR capability, monthly dashboards and practice-based care managers. The plan offers financial support through stipends and performance and incentive bonuses. Its "rapid-cycle innovation" process continuously monitors data, quickly pilots changes and rapidly disseminates them throughout the entire medical home system. PHN implementation was associated with reductions in hospital admissions and readmissions and \$3.7 million in net savings, for a return on investment of more than 2-to-1.

## Provider Story: Practice Transformation

The chief medical officer of Whitney M. Young, Jr. Health Services in Albany, N.Y., can tell you that change is not easy. In fact, when Kallanna Manjunath, M.D., embarked on a journey to change the way his practice did business, he was met with skepticism, doubt and even resistance. Two years later, the practice and its clinicians are seeing the fruits of their labor.

In 2010, Whitney Young began the process of practice transformation as part of Capital District Physicians' Health Plan's (CDPHP) Enhanced Primary Care (EPC) model. Within one year, Dr. Manjunath began noticing tangible results.



*Kallanna Manjunath, M.D.,  
at the CDPHP Physicians'  
Academy™ awards, 2012*

“We were stunned by the progress being made in the area of diabetes management,” says Manjunath. “Specifically, we were able to significantly decrease no-show rates and increase adherence to medical and diet management.” Pre-visit planning and care coordination allowed the practice to decrease no-show rates among diabetes patients by nearly 60 percent.

But the rewards extend far beyond statistics. Dr. Manjunath, who has been practicing medicine for 30 years, says being a physician now has new meaning for him. “Yes, I’m working harder but I’m more satisfied and excited about the renewed opportunity to engage with my patients,” he says. “As a provider of an underserved and uninsured community, I have a unique set of challenges, but I believe those challenges create a greater opportunity for change.”

“The EPC program has really provided us with significant opportunities to implement long-lasting changes to improve access to quality health care for our patients,” says Manjunath. “On a personal level, this is the most exciting and rewarding work I’ve done in my three decades as a physician.”

At **Martin’s Point Health Care** in Portland, Maine, most members receive care through contracted network providers. One of the main ways the plan has facilitated change at the practice level is by adopting Lean methodology, a management philosophy based on improving quality and reducing waste,<sup>19</sup> for the entire organization and applying it to the practice transformation effort. The plan developed provider reporting programs for medical expense data, tools to manage medical expenses and a platform to identify gaps in care. Outcomes in blood pressure and hypertension have improved, and patients are more confident that they can manage and control their health problems.

**Presbyterian Health Plan, Inc.** in Albuquerque, N.M., a majority-contracted network plan, offers a variety of services to assist primary care practices in PCMH transformation and improve access to care for patients. Plan- and practice-based care managers reach out to high-risk members, while its Pres Online service streamlines administrative tasks for providers. Patients have access to alternate venues of care, including website portals, phone calls and group visits. Grants, incentives for PCMH accreditation and shared savings encourage quality outcome performance and population management. PCMH pilot sites have reduced ED utilization, hospital admissions and improved quality outcomes.

## II. Essential Elements

Health plans can increase the chance of both sustainability and spread of primary care transformation initiatives by sharing resources with practices. Support through grants, EMRs, change management consultants, care managers and other resources prepares practices to be successful under new payment models, in turn enabling them to maintain changes over time. At the same time, new practices, particularly those with limited funds, are more likely to join

such an initiative when they know that the plan will support them throughout the transformation process. What appears to be essential – rather than each organization’s delivery model or the specific resources that are shared – is customization of tools based on each practice’s abilities and priorities, constant communication with practices about their readiness to accept change and a clearly stated mission to improve both patient and provider experience.

### Patient Story: Compassionate Care

Dale, a healthy Martin’s Point Health Care member in his 70s, was vacationing in Florida with his wife Lucille when he noticed blood in his urine. Tests revealed a large vascular tumor in his kidney, later discovered as malignant, that needed to be addressed immediately. The following week, Dale went to Brigham and Women’s Hospital in Boston to have his kidney removed, after which he returned home to Newburgh, Maine, to recuperate.

Throughout this process, Dale had been in communication with his primary care physician in Maine, Charles Burger, M.D., at the Martin’s Point Bangor Health Care Center. All medical records, results and concerns were constantly being transmitted to Dr. Burger so he could stay updated on Dale’s progress. He saw that Dale had been diagnosed with chronic kidney disease and had several hospital stays due to complications; Linda Mullen, a specialty nurse on Dr. Burger’s care team, decided to get in touch with Dale to see how he was doing.

“It was amazing to hear from Linda,” said Dale. “All of a sudden I had this wonderful person reaching out to me to check in and ask how my wife and I were holding up. She had been reviewing all the medical records that Dr. Burger had been receiving and based on all the complications she saw, she thought we might need some help.”

“It was great having someone to ask questions,” he said, “to reassure us and to just be there, letting us know we had someone to lean on through this tough time.”

Dale is now doing very well and is once again participating in many healthy activities that he enjoyed before his kidney issues. “Life is different now,” he says, “but we will always remember Linda’s act of kindness that helped pull us out of that dark time. She really demonstrated the values and caring of Martin’s Point, treating us with warmth and concern. And none of it would have been possible without the fact that Dr. Burger and his team insisted on getting all my medical records, and then really took the time to review them and make sure they were up to speed on how I was doing and what I might need.”

## BUILDING ON PLAN, PROVIDER AND COMMUNITY CULTURE

The culture of providers and physician groups, internal health plan dynamics and characteristics of patient populations can all influence implementation of medical home models and other changes to care delivery. Certain characteristics and cultural elements of primary care practices, including authoritative leadership behavior and lack of common vision or communication, can act as barriers to transformation.<sup>20</sup> At the same time, a history of close cooperation among physicians and between the payer and providers can – when combined with shared resources and collaboration in development and implementation of these new care models – increase the chances of successful and sustainable transformation.

ACHP members' experiences demonstrate how familiarity between the payer and providers with each other's strengths and weaknesses, and a willingness to adapt the elements of the primary care transformation initiative to the culture of each, can positively impact implementation. In particular, culture can influence the level of standardization built into the model.

At **Group Health Cooperative** in Seattle, Wash., and **HealthPartners** of Minneapolis, Minn., both of which provide care to about 60 percent of their members through contracted network providers, practice transformation was standardized through Lean management processes and other performance improvement methods<sup>21</sup> to ensure consistency in the delivery of care and prevent regression to previous care practices. Sustainability for these plans was defined as successful maintenance of the new processes over time.

By implementing a Lean management system for its PCMH pilot, in conjunction with \$600,000 in funding for new staff and health information

technology, Group Health Cooperative reduced waste through collaborative redesign, improved processes and standardized work flows. Clinical teams at pilot sites designed “standard work” for each element of the model, which was then refined and spread throughout Group Health’s entire system, with some elements adopted across all sites and others unique to local areas. By standardizing certain care delivery elements, Group Health reduced waste, giving providers more freedom and time with patients.<sup>22</sup> Group Health has seen a return on investment of 1.5-to-1 for total medical home costs and has significantly reduced provider burnout.

*ACHP members' experiences demonstrate how familiarity between the payer and providers with each other's strengths and weaknesses, and a willingness to adapt the elements of the primary care transformation initiative to the culture of each, can positively impact implementation.*

HealthPartners' Care Model Process<sup>®</sup> (CMP) redesigned care team work flows to ensure standardized and scripted care delivery for a consistent clinical experience for patients. For over a year and a half, the leadership team and doctors discussed cultural shifts that were necessary to implement the new processes. As a result of these concerted efforts to bring about greater trust and respect, the two parties developed a partnership agreement that paved the way for standardization, emphasizing reliable quality while maintaining customized care based on patients' needs.<sup>23</sup> Care Model Process implementation has led to

## II. Essential Elements

reduced ED utilization and hospital admissions, improvement in diabetes outcomes and below-average costs.

On the other end of the spectrum, **Capital Health Plan** and **Priority Health** gave providers significant latitude in determining how to transform their practices, understanding that among their particular physician populations, provider-led initiatives would be more likely maintained in the long term due to physician involvement and investment in the model.

In 2003, Capital Health Plan, a staff-model plan in Tallahassee, Fla., launched its Center for Chronic Care, a primary care center for members with severe health risks. Two full-time physicians manage 400 patients with a focus on self-management, offering same-day visits and intensive care coordination. The plan has spent years nurturing a high-efficiency, high-quality physician group through its selectiveness in hiring, provider education efforts and use of mostly non-financial incentives. Due to the close relationship and mutual trust between the plan and providers, physicians drive changes in care delivery. While the plan is prescriptive about its expected outcomes, providers themselves make changes to the model to achieve these outcomes.

Recognizing that practices vary significantly with regard to physicians' workloads, focus, priorities and interest, Priority Health, a fully networked plan in Grand Rapids, Mich., allowed its PCMH pilot practices to direct their transformation independently by providing \$2 million in up-front funding with few stipulations on how the money should be used. Most practices hired health coaches and care coordinators; Priority Health supported them through health information technology, quality measure dashboards and access to consultants. Pilot practices showed improvement in quality of care measures and patient and staff experience, and a reduction in ED use compared to matched control groups.

For the **Hawaii Permanente Medical Group**, practice transformation was seen as a way to formalize, standardize and improve the care delivery processes that were already in place, as well as improve communication across the medical group. Acknowledging concerns about standardization infringing on providers' independence, the medical group made population management easier for practitioners. This was achieved through collaborative case management support, patient risk stratification upon discharge and monthly data dashboards, encouraging practitioners to shift to a more proactive model of care. Due to its relatively small size, the provider group can quickly adopt best practices from other Kaiser Permanente regions and adapt them to its unique environment.

*"PCMH helped validate what we were doing and really put it on paper and made it just a little more standard so that everyone's doing it."*

*- Registered nurse, Kaiser  
Permanente Hawaii*

Neither standardization nor provider-driven customization is, in itself, better than the other. Transformation of care processes cannot occur in a vacuum, separate from personal and organizational characteristics and traits; what makes ACHP members' interventions successful, sustainable and scalable is each stakeholder's ability to understand the others' distinct cultures and modify its processes accordingly. At the same time, understanding culture cannot alone ensure practice transformation; collaboration and sharing of resources are also crucial to the success of these initiatives.

# III. Promising Results

## Sections

Care Quality

Affordability and Utilization

Patient and Provider Experience

NCQA Accreditation

### III. Promising Results

Every ACHP plan featured in this brief saw improvements in care quality, affordability and/or patient experience in practices that underwent primary care transformation. Many plans had positive outcomes in all three categories, demonstrating that it is not necessary to sacrifice quality and patient experience for cost, and improvements in access to care do not necessarily increase utilization.

These initiatives can take two or three years to demonstrate results;<sup>24</sup> many of the outcomes shared here are preliminary, particularly since the plans are continuing to adapt to and improve on the models themselves, as well as refine ways to measure meaningful outcomes.

## CARE QUALITY

ACHP member plans' efforts to transform primary care have improved the quality of care that members receive, including improvement in both process and outcome measures.

Between 2004 and 2012, colorectal and breast cancer screenings at the **Southern California Permanente Medical Group** increased 36 percent and 11 percent, respectively; blood pressure control increased 43.5 percent; tobacco counseling increased 17 percent; and glucose control in diabetics increased 13.5 percent. Leadership estimates that the medical group's rigorous program for PAP smears may have saved at least 100,000 office visits in 2012; overall, the care delivery transformations are estimated to save more than 15,000 lives over ten years.<sup>25</sup>

Over four years, the **Hawaii Permanente Medical Group** improved its scores on disease management, LDL cholesterol level, blood pressure control and breast cancer screening Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) measures from the 50th to the 90th percentile.

At **Priority Health**, pilot practices, in comparison to matched control groups, showed significant improvements in overall quality of care measures, overall composite diabetes measures and individual diabetes measures, which included improvements in monitoring for diabetic nephropathy and retinopathy, and controlling cholesterol levels. Similarly, The

**HealthPartners** Research Foundation reported significant quality improvements measured over four years for HealthPartners Medical Group patients, including a 129 percent increase in patients receiving optimal diabetes care.<sup>26</sup>

At **Martin's Point Health Care**, practice transformation reduced uncontrolled hypertension from 43 percent of patients with elevated blood pressure to 14 percent between 2007 and 2010 in one clinic. In addition, Martin's Point has been able to increase patients' confidence in their ability to manage and control their health problems, and keep the medical expense trend lower than the national average.

At **Capital Health Plan**, patients who receive their care at the Center for Chronic Care are, on average, seen by their new primary care physician three-and-a-half times more often than before. In comparison to baseline assessments, the center has decreased patient mortality rates from 6.5 percent to 4 percent.

**Geisinger Health Plan** members who receive care in ProvenHealth Navigator<sup>®</sup> sites are likely to have statistically significant better results in HEDIS<sup>®</sup> measures such as immunization rates, diabetes and lipid and hypertension control, as well as appropriate therapies for COPD and asthma. **Independent Health** Primary Connection sites saw an 8 to 10 percent improvement in their measures of quality related to preventive services and acute and chronic conditions.

## Patient Story: Focus on Preventive Care

Before she embarked on a new exercise program, Mattie of Long Beach, Calif. wanted to ensure she was in good health. Vanessa Gavin-Headen, M.D., a family medicine physician at Kaiser Permanente Long Beach Medical Offices, had ordered a colonoscopy for Mattie when she turned 50, but her patient had not followed up. “It’s important for everyone to have at least one colonoscopy in their life,” said Dr. Gavin-Headen, “to see if anything [is] there that shouldn’t be there.”

Dr. Gavin-Headen’s reminder prompted Mattie to undergo the procedure. Mattie was surprised to learn that she had colon cancer. “I didn’t want to take the test, but I did anyway and I’m glad I did,” said Mattie. Her cancer was detected at an early and treatable stage. She underwent a successful surgery and is now cancer free.

Mattie, a member of Kaiser Permanente for more than 30 years, now tells everyone she knows about the importance of getting a colonoscopy at age 50. “You need to go get it done right away,” she tells her friends. “We want you to be here, be my friend later, so I stay on ‘em about it.”



*Mattie, a patient at Kaiser Permanente of Southern California, was thankful for her doctor’s urgings to undergo a colonoscopy.*

See more stories like Mattie’s on the Kaiser Permanente Care Stories blog at <http://www.kp.org/carestories>.

## AFFORDABILITY AND UTILIZATION

In the long run, cost savings are essential to the sustainability of these initiatives: to ensure that payers and providers can continue to fund practice transformation and improvement efforts, maintain enhanced reimbursement rates and eventually pass cost savings along to consumers. Decreases in utilization of high-cost services, such as ED and hospital admissions, can be predictors of decreased cost trends in cases where return on investment is difficult to measure.

In the first year of its pilot, **UPMC Health Plan (UPMCHP)** reported a decline of 12.5 percent in post-hospital readmissions and total medical and pharmacy costs that were 4 percent lower at pilot practices than in non-PCMH primary care practices.<sup>26</sup> UPMCHP calculated its cost avoidance at \$15.84 per member per month (PMPM), for a return on investment of 160 percent,<sup>27</sup> in addition to increases in quality and efficiency measures.

At **Geisinger Health Plan**, implementation of its ProvenHealth Navigator<sup>®</sup> model was associated with an 18 percent reduction in hospital admissions, 36 percent reduction in hospital readmissions and 7 percent reduction in cumulative spending.<sup>28</sup> An August 2009 review of its pilot PHN practices reported an estimated \$3.7 million net savings, for a return on investment of greater than 2-to-1.<sup>30</sup> Continued evaluation of the first 21 PHN sites shows sustainable and reproducible changes and statistically significant reduction in total costs of care.<sup>29</sup>

Between 2008 and 2011, **Independent Health PCMH** pilot practices had 15 percent lower costs associated with ED utilization than their non-PCMH counterparts. In addition, they demonstrated a 19 percent increase in generic statin prescribing. Overall, the 18 pilot practices saw a 10 percent decrease in overall cost, corresponding to \$2.9 million in savings.<sup>26</sup>

Even though hospital admissions in the clinics chosen for **CareOregon's** Primary Care Renewal (PCR) initiative were initially almost 1.5 times higher – and rising at a faster rate – than in non-PCR clinics, the launch of the model reversed these trends. After the one-year implementation period, hospital admissions began decreasing more rapidly in PCR than non-PCR clinics, and as of April 2011 had decreased to the non-PCR rate.

Similarly, **HealthPartners** reported a 39 percent reduction in emergency room utilization, a 24 percent reduction in hospital admissions, 40 percent fewer re-hospitalizations than community norms and 8 percent lower total costs than the Minnesota average. HealthPartners Medical Group practices with higher performance on outcome measures significantly reduced outpatient costs (by \$1282 per person) for patients using 11 or more medications.

Two peer-reviewed studies of the **Group Health Cooperative (GHC)** PCMH pilot site found that PMPM upfront investment costs were recouped in full after 12 months, primarily because of \$54 PMPM savings from a decrease in ED utilization.<sup>31</sup> GHC has seen an overall return on investment of 1.5-to-1 for total medical home costs. Possibly as a result of publicity stemming from the medical home pilot, the health plan noted a 20 percent increase in residency applications in 2010.

For Medicare, Medicaid and dual-eligible patients in **UCare's** care coordination program at Lakewood Health System, the plan reported a 37 percent decrease in the total cost of care and an 18 percent decrease in inpatient admissions. One of **Presbyterian Health Plan's** PCMH groups reduced ED visits for Medicaid members by more than 11 percent. At **Priority Health**, PCMH implementation was similarly associated with a reduction of 52.1 visits per 1,000 members in ED utilization.<sup>26</sup>

**Capital District Physicians' Health Plan** has seen lower cost trends in its Enhanced Primary Care (EPC) practices than in non-EPC practices. An independent analysis of the pilot program found \$8 PMPM cost savings, a 15 percent reduction in hospital inpatient admissions and a 9 percent reduction in emergency department visits, along with fewer advanced imaging tests and decreases in admissions for ambulatory care sensitive conditions.<sup>26</sup>

At its Center for Chronic Care, **Capital Health Plan**, in comparison to baseline assessments, decreased days spent in inpatient care by 40 percent, ED utilization by 37 percent and

claims costs by 18 percent. PMPM costs for its initial patients were reduced by 21 percent in 2004, while in 2005, for a second cohort of patients, PMPM costs were reduced by 65 percent.<sup>26</sup> Average actual costs for commercial and Medicare members receiving care at the center were \$3,388 and \$2,200 lower in 2011 than predicted, respectively, for a return on investment of 1.6-to-1.<sup>32</sup>

At **Colorado Permanente Medical Group**, the 30-day readmission rate is between 12 and 14 percent and the average length of hospital admission is between 3.4 and 3.9 days, far below the national average.

## PATIENT AND PROVIDER EXPERIENCE

Primary care transformation should ultimately improve not only the quality and affordability of care, but also the patient experience, with an emphasis on engagement, access and satisfaction.<sup>24</sup> ACHP members recognize that patient experience is closely linked to provider satisfaction, and many plans have undertaken improvement of these metrics for physicians and staff as well.

**Group Health Cooperative of South Central Wisconsin** noted improvement in 17 of 18 measures across five domains related to patient, provider and staff satisfaction as well as in outcome measures like continuity of care and access. Similarly, at **Independent Health**, already high patient satisfaction numbers increased slightly with large jumps in overall staff satisfaction at PCMH pilot practices.

**Group Health Cooperative** decreased staff burnout (as measured by the Maslach Burnout Inventory\*) and improved provider satisfaction, while improving patient care coordination, access, involvement and goal setting over the course of its PCMH pilot.<sup>31</sup> **CDPHP** also saw high

provider satisfaction from its Enhanced Primary Care initiative, while documenting improvement in 15 of 18 reported HEDIS® outcome measures.<sup>26</sup> One federally qualified health center that was part of **CareOregon's** Primary Care Renewal initiative reduced waiting days for appointments from four in February 2009 to one in February 2011, in addition to improving patient satisfaction with diabetes and behavioral health care.<sup>23</sup>

**Priority Health** conducted Primary Care Assessment Tool (PCAT) surveys, completed by physicians, staff and patients, at baseline and twice during transformation; these surveys measured the perceptions that different groups had related to the delivery of care changes and revealed significant overall improvements in patient and clinical staff experience at seven- and 15-month follow-up evaluations.

The **Hawaii Permanente Medical Group** has reported consistently high levels (greater than 90 percent) of patient and provider satisfaction, and a decrease in abandoned calls following standardization of care processes.

\* The Maslach Burnout Inventory measures how emotionally exhausted and overextended staff feel due to work; depersonalization (meaning a lack of feeling toward recipients of services, care treatment or instruction); and a lack of personal accomplishment, competence and achievement.

## NCQA ACCREDITATION

The National Committee for Quality Assurance (NCQA) released its first assessment tool for PCMH activities in 2008 and is currently the main organization that provides PCMH recognition.<sup>24,33</sup> Six “must-pass” elements in its 2011 criteria are considered essential to each PCMH and are required of all practices that wish to gain recognition. These include access during office hours, use of data for population management, care management, support of self-care processes, referral tracking and follow-up and implementation of continuous quality improvement.<sup>34</sup> Practices’ success at implementing each of these elements determine the tier into which they are placed, with Level 3 demonstrating the highest adherence to optimal PCMH practices. Many health plans have chosen to pursue NCQA PCMH accreditation for their affiliated practices and have achieved

recognition at the highest level; some, like Priority Health, offer financial incentives to practices to achieve recognition, while others support practices through training and non-financial assistance.

All of Hawaii Permanente Medical Group and Independent Health’s PCMH practices, Geisinger Health System’s primary care sites and HealthPartners’ Care Model Process sites have achieved Level 3 NCQA PCMH recognition. Four Care Model Transformation pilot sites at Martin’s Point Health Care received Level 3 recognition in 2010 and the remaining five were planning to apply by the end of 2013. At Presbyterian Health Plan, 10 sites had Level 3 accreditation, as well as 20 at the Colorado Permanente Medical Group and nine at the Southern California Permanente Medical Group.

*Care teams can improve the quality of care delivered, increase coordination among providers and enhance patient experience of care. Alain Montegut, M.D., vice president of primary care development and practicing physician at Martin’s Point Health Care, reviews patient information with his care team.*



# IV. Discussion

## Sections

What Makes ACHP Primary Care  
Transformation Initiatives Successful?

Applying These Lessons

Future Steps

# What Makes ACHP Primary Care Transformation Initiatives Successful?

Health plans can play a crucial role in promoting, developing, implementing and measuring outcomes of initiatives to transform the delivery of primary care in collaboration with their provider partners. Many ACHP members have increased the quality of care delivered, improved patient and provider satisfaction, lowered health care costs, reduced care fragmentation and improved access to care. It is not enough, however, that they are successful in achieving these outcomes in the short term, leading to temporary improvements. In order to truly have an impact on the health care system, interventions must also be sustainable and scalable – able to spread to additional sites of care or be expanded in scope among the existing cohort of practices.

From interviews conducted with ACHP members on their experiences with primary care transformation, the following factors appear to be the most significant in ensuring the success, sustainability and scalability of these initiatives.

## Collaborating, sharing resources and building on culture

First, and most important, each organization profiled in this publication combined three essential elements in its initiatives: collaboration toward mutual goals; sharing of tools and resources with practices; and building on existing cultures and characteristics of the health plan, providers and community. ACHP members provided the necessary input for sustainable transformation in a way that fostered plan-provider trust, through collaborative processes that took into account the unique and distinct cultures and characteristics of each stakeholder.

Each element on its own is not sufficient for transformation. A plan that gives tools and resources to practices but fails to include providers in the design of its initiative may be wasting time and money on tools that are irrelevant to those physicians. Likewise, collaboration that does not take into account the culture of the physician group and the comfort of providers with standardized protocols may create tension among stakeholders.

These three core elements were applied differently in every ACHP plan, demonstrating that there is no single “correct” plan-payer relationship that will facilitate successful transformation of primary care. Instead, this brief suggests that a focus on the three elements, tailored to the unique needs and characteristics of provider partners, appears to be more important and influential than the specifics of how each element was implemented.

## Continuous evaluation and improvement

Another factor that appeared to facilitate success, sustainability and scalability of these initiatives among ACHP plans was the creation of “learning health systems” that engage providers, data analysts and other stakeholders to frequently evaluate necessary changes and rapidly adapt the care delivery and payment models to changing circumstances. Health plans worked with individual practices, brought together practices to facilitate cross-site learning and created an assessment tool against which plans could benchmark their progress.

Member plans noted the importance of continuously monitoring outcomes to identify areas of improvement and gaps in care and sharing that information with practices. Plans

and practices worked together to determine appropriate interventions given the unique perspective each has on the issue: Practices can view the problem through the perspective of front-line staff, while health plans may have previous experience with similar issues at other practices, or can provide the data resources necessary to further pinpoint the specific issue.

ACHP members solicited feedback from physicians, patients and practice staff on a regular basis. This information was vetted and incorporated throughout the entire system, and/or shared with other practices in learning collaboratives to encourage self-directed transformation. By conveying to patients and providers that their feedback was both valuable and actionable, plans simultaneously improved the practice transformation and payment models and fostered a sense of collaboration and mutual accountability.

In addition to learning from their own initiatives, member plans shared their experiences with each other through the ACHP Primary Care Innovation Collaborative, which met regularly between 2008 and 2011. Collaborative members discussed strategies and common challenges, solicited feedback and developed a tool to assess health plan innovation in primary care. As a medical director from Priority Health noted, “ACHP is a learning organization, so these forums provided us with the opportunity to share what we know and to be the recipient of information from our colleagues who work with other high-functioning health plans.”<sup>26</sup>

## Focusing on the mission

ACHP and its members are all driven by a mission: “to improve the health of the communities [they] serve and actively lead the transformation of health care to promote high-quality, affordable care and superior consumer experience.”<sup>35</sup> The ability to convey that mission to clinicians proved to be crucial for many

health plans facilitating efforts to improve the delivery of primary care.

By building relationships around a shared mission of improving health and health care, ACHP plans foster mutual trust and respect with their provider partners, overcoming what can often be historical barriers to close cooperation. Payer involvement in care delivery is sometimes viewed with suspicion by providers who question the motives of the payer; in a fee-for-service system, initiatives that purport to make care more efficient simultaneously reduce the profit margin of providers (by decreasing utilization and billable services) and increase health plan profit (by reducing the amount paid for claims). Health plans that truly strive to transform care on Triple Aim measures can overcome this suspicion and mistrust by demonstrating their commitment, through words and actions, to mutually agreed-upon goals.

*Each organization profiled in this publication combined three essential elements in its initiatives: collaboration toward mutual goals; sharing of tools and resources with practices; and building on existing cultures and characteristics of the health plan, providers and community.*

ACHP plans have long histories of working closely with providers and community-based organizations. They further convey their good intentions by involving providers in every stage of the design process, frequently soliciting feedback and buy-in, demonstrating their understanding of the financial and time pressures that primary care providers face and offering enhanced reimbursement and other resources to providers to prove the plans’ long-term commitment to the initiatives.

## Applying These Lessons

The ACHP case studies demonstrate that both fully integrated and fully networked plans can lead and facilitate successful primary care transformation initiatives. At CDPHP, CareOregon, Independent Health, Priority Health and UCare, more than 95 percent of members receive care from independent, contracted network providers. Group Health Cooperative of South Central Wisconsin and Kaiser Permanente, on the other hand, are more integrated, with only 15-20 percent of members receiving care from providers not affiliated with the health plan. In spite of significant variation in delivery model, size and geography, every plan managed to achieve outcomes related to care quality, affordability, patient experience, provider satisfaction and/or access to care.

*Health plans and providers can draw from ACHP plans' years of work on transforming primary care for ideas on how to successfully implement these innovative care models.*

As the U.S. health system continues to look to PCMHs and accountable care organizations as effective models of care, health plans and providers can draw from ACHP plans' years of work on transforming primary care for ideas on how to successfully implement these innovative care models.

The experiences of ACHP plans demonstrate the importance of creating long-lasting relationships with providers based on the pursuit of common goals. Even payers without extensive histories of cooperation can increase their chances of success by partnering with provider groups

whose priorities are aligned with the plan, showing their commitment to improving Triple Aim outcomes and pledging to stay involved in the community in the long term (for example, by establishing linkages with community-based organizations). By understanding providers' motivations, wants and needs from the outset, the health plan will increase the chances of provider buy-in during implementation.

Although it is important that providers trust the health plan, the plan must in turn trust providers by soliciting their feedback and incorporating it into the design of the care delivery and payment models. National payers must understand that there is no "one-size-fits-all" approach to implementing primary care transformation; trying to copy an existing initiative without customizing it based on the specific characteristics and culture of the group may alienate physicians who would prefer a different approach.

Second, given the complex nature of primary care transformation and the multiple components that must be in place to ensure sustainability of the changes, health plans must be prepared to assist practices across several dimensions. ACHP members support practices with grants and new types of reimbursement models, data and quality dashboards, health information technology (such as online portals and EMR implementation), care managers, health plan-based support staff and practice transformation consultants and by conducting patient outreach. For many practices, meaningful use and federal and state funding are "wholly inadequate,"<sup>36</sup> as costs are so high — reaching over \$90,000 per physician per year in one study of 26 PCMH demonstrations.<sup>37</sup> All health plans must therefore be prepared to provide a significant percentage of the

resources required for practice transformation, and to commit to a long-term relationship that includes ongoing financial and non-financial support.

Third, health plans can be most effective when they are aware of the community resources that are available to members and patients and when they establish relationships with community-based organizations and non-primary care providers, including nursing homes

and specialists. PCMHs, accountable care organizations and other practices that take on responsibility for their patient panels cannot operate in isolation from the rest of the health care system; awareness of resources available in the “medical neighborhood”<sup>38</sup> is crucial when launching an effort to transform primary care. Additionally, understanding the community context of care can provide health plans with an important awareness of the environment in which providers and patients are delivering and seeking care.



*Health plans can create long-lasting relationships with providers based on the pursuit of goals, assisting them across several dimensions to ensure the success and sustainability of initiatives to facilitate primary care transformation.*

## Future Steps

ACHP plans' efforts to transform primary care in their communities have been valuable in strengthening infrastructure at the local level, but challenges remain in scaling these new models of care across broader physician networks. Practices may be reluctant to transform with the support of only a single payer, particularly when faced with the prospect of decreased utilization among – and therefore reimbursement for – all patients; health plans, on the other hand, may lack sufficient funding to expand their pilots to their entire networks. A number of policy changes and payment reforms could better align incentives from public and private payers to support such models of care. These would include coordination of up-front funding from multiple payers, investments in care management and development of standardized outcomes measures.<sup>39</sup>

Support for patient-centered care, coordination and integration is necessary in the form of up-front funding for infrastructure, ranging from high-tech needs such as patient registries and population management tools to low-tech organizational changes like appointment reminders. Payment changes that encourage health plans and providers to decrease unnecessary readmissions or reduce preventable emergency department visits for patients who could be treated in an outpatient setting would promote greater management of care transitions and other processes to support coordination across providers and settings, as well as support the role of primary care. Public policy can also encourage linkages between primary care practices and community services, which are crucial to managing the health of a population.

Due to their close relationships with providers and knowledge of local health systems, community health plans are well positioned to function as what the Institute for Healthcare Improvement

calls “macro-integrators.”<sup>40</sup> Such entities pull together the resources of numerous organizations into a virtual system that strengthens care for a defined population. Innovation grants, regional information exchanges, payment reforms and, if necessary, regulatory changes could promote this integrative function. One precedent for such an initiative, the Department of Health and Human Services' Beacon Community Cooperative Agreement Program, provides funds for 17 communities to build and strengthen their health information technology infrastructure.<sup>41</sup>

Health care must move away from payment that encourages fragmentation and rewards volume; payment models should instead reward coordinated, high-quality and efficient care. Bundled payments (a single payment for a defined episode of care), global payments (payment for all services a patient may receive over a fixed period of time), payments tied to quality metrics and/or shared savings goals and the CMS Comprehensive Primary Care Initiative represent efforts to realign payment incentives. Policy should support value-based reimbursement models that tie payment to quality and outcomes, add payment components to cover care management and coordination expenses and reward efficiency through shared savings.

Finally, organizations should promote the development and widespread use of outcomes measures that reflect the goals of lower cost, improved population health, higher quality health care and superior patient experience. This may require the application of similar measures to all public and private health plans, including fee-for-service Medicare and Medicaid and health plans offered in federally facilitated or state-based exchanges, along with transparency requirements that would make it easy for consumers to compare choices across the commercial and public sectors.

# V. Profiles of Primary Care Transformation Initiatives

## Sections

Capital District Physicians' Health Plan  
Capital Health Plan  
CareOregon  
Geisinger Health Plan  
Group Health Cooperative  
Group Health Cooperative of South Central Wisconsin  
HealthPartners  
Independent Health  
Kaiser Permanente of Hawaii  
Kaiser Permanente of Colorado and Southern California  
Martin's Point Health Care  
Presbyterian Health Plan  
Priority Health  
Rocky Mountain Health Plans  
UCare  
UPMC Health Plan

## COMPREHENSIVE PAYMENT FOR COMPREHENSIVE CARE: CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC. (ALBANY, N.Y.)

Capital District Physicians' Health Plan, Inc. (CDPHP) launched its Enhanced Primary Care (EPC) initiative in 2008 with a three-practice pilot and a goal of providing "comprehensive payment reform to support comprehensive care"<sup>26</sup> to its contracted primary care providers. The model allows primary care physicians to enhance their revenue by 40 percent while providing them with the tools necessary to transform their practice. Since its inception, the EPC has undergone four expansions and currently covers 160 practices and more than 181,000 patients.

A core component of the EPC model is practices' transition from fee-for-service reimbursement to a fully risk-adjusted capitation model, which holds primary care physicians responsible for services they provide and includes opportunities for substantial performance-based bonuses: Providers can earn up to \$5.32 PMPM by meeting efficiency, quality and patient experience measures.

CDPHP realizes that in order for its new payment model to be effective, providers have to transform the way they delivered care; in turn, transformation enhances providers' ability to succeed under the new payment model, and larger performance-based bonuses further drive transformation. Therefore, before the payment model is put in place, sites have twelve months to undergo practice transformation, supported by a \$20,000 infrastructure grant from the health plan.

CDPHP further supports practices at the administrative and clinical levels by contracting with an outside vendor that provides consulting services for primary care practices aiming to transform care delivery, and by leveraging CDPHP's internal resources.

Initiative: Enhanced Primary Care

Start date: 2008

Practices: 160

Physicians: 723

Covered lives: 181,012

CDPHP offers each practice consulting resources, assistance with meaningful use of EMRs and access to health plan pharmacists, behavioral health specialists and practice-embedded health plan case managers. The plan provides practices Medical Intelligence, a risk-adjusted predictive modeling tool that provides quality and utilization data, including information on gaps in care, potential emergency department or inpatient admissions and high-utilizing patients. CDPHP also supplies them with pharmacy drill-down data, which includes detailed information on prescribing patterns, cost comparisons and generic prescribing opportunities, and faxes daily patient discharge reports to the practices.

The plan has seen lower cost trends in EPC than in non-EPC practices, fewer emergency department visits and hospital admissions, decreased admissions for ambulatory care sensitive conditions and improvement in 15 of 18 reported HEDIS outcomes measures, in addition to high provider satisfaction.<sup>26</sup>

The rapid growth of the EPC model, which increased by more than 60 new practices between 2009 and 2012, speaks to its sustainability and scalability. Currently in its fourth phase with 723 clinicians, EPC demonstrates how practice transformation and enhanced reimbursement can mutually reinforce each other, improving the quality and affordability of care while increasing patient satisfaction.

## FOCUS ON OUTCOMES, NOT PROCESSES: CAPITAL HEALTH PLAN (TALLAHASSEE, FLA.)

Initiative: Center for Chronic Care

Start date: 2003

Practices: 1

Physicians: 2

Patients: 550

In 2003, Capital Health Plan launched its Center for Chronic Care, a primary care center for health plan members with severe health risks. Initially, the center consisted of 250 patients, a single gerontologist, two nurses and a clerical support staff member. As of 2012, Capital Health Plan was able to maintain two full-time physicians at the center who, together with their support staff, manage a panel of approximately 400 patients.

The Center for Chronic Care aims to address the whole patient at every visit, with a focus on self-management. New patients take part in a detailed intake process, which includes a multidisciplinary review of medications and diet as well as their baseline physical, emotional and social well-being. In conjunction with the patient's medical history and weekly goals, this information is used to create a care plan that is updated regularly. The center also offers open access with same-day visits that take as long as necessary.

Capital Health Plan has spent years nurturing a high-efficiency, high-quality physician group and culture through its selectiveness in hiring, provider education efforts and use of incentives, most of which are non-monetary. Due to the close relationship and mutual trust between the health plan and providers, physicians drive changes in care delivery and new staff physicians who join the Physician Group of Capital Health Plan can implement and spread their own unique approaches.

Capital Health Plan does not prescribe how physicians should practice in the center, nor has it adopted the PCMH model of the National Center for Quality Assurance; instead, it takes advantage of the diversity, personality and training of providers to tweak the center's care model. As a small clinic, the center can rapidly test, adopt and spread new practices. By giving providers initiative to improve on the model, Capital Health Plan gains physician buy-in, increasing the chance of long-term sustainability.

The health plan, however, is very prescriptive about desired outcomes, and relies on physicians and their teams to figure out how to achieve those outcomes and share resulting best practices with each other. Capital Health Plan has found that this process reliably leads to simultaneous improvements in quality of care and provider efficiency. It supports these improvement projects by supplying center providers with a clinical dashboard, which reports on quality, efficiency and access measures, such as HEDIS measures, hospital readmissions and ED use.

Patients who receive their care at the Center for Chronic Care are, on average, seen by their new primary care physician three-and-a-half times more often than before switching to the center. In comparison to baseline assessments, the center has decreased: days spent in inpatient care by 40 percent, emergency department utilization by 37 percent, claims costs by 18 percent and patient mortality rate from 6.5 percent to 4 percent. PMPM costs for its initial patients were reduced by 21 percent in 2004 and in 2005, for a second cohort of patients, by 65 percent.<sup>26</sup> Average actual costs for commercial and Medicare members receiving care at the center were \$3,388 and \$2,200 lower in 2011 than predicted, respectively, for a return on investment of 1.6-to-1.<sup>32</sup>

## CREATING A COMMON VISION: CAREOREGON (PORTLAND, ORE.)

For almost a decade, CareOregon has partnered with its affiliated practices to deliver high-quality care. Recognizing that many providers have meager funds with which to invest in practice transformation, CareOregon launched its CareSupport and System Innovation program in 2005 to fund improvement projects in network provider organizations, allocating between \$75,000 to \$125,000 a year in seed money to practices.<sup>23</sup>

CareOregon realized, however, that its impact was limited as long as it only paid claims and provided the occasional grant. Inspired by work being done by the Alaska Southcentral Foundation, it launched its Primary Care Renewal (PCR) initiative to comprehensively redesign and transform its clinics.

The principles of CareOregon's PCR work include creating a common vision with providers through collaborative learning sessions; building technical and adaptive skills to support delivery system transformation; realigning incentives; co-designing with constant dialogue and feedback from providers; and viewing system redesign through needs of patients, not providers. Practice staff received change management and leadership training from a CareOregon-funded consultant and guided implementation of PCR in their practices. It held monthly steering committee meetings with each practice, in addition to one-on-one coaching sessions, regular phone calls and site visits.

In 2009, based on mutual understanding that fee-for-service payment was not adequate to support PCR work, CareOregon and participating practices developed a payment model based on quality measures. Under the model, PCR practices are eligible for up to \$5 PMPM enhanced reimbursement based on reporting, improving or meeting targets on Triple Aim outcomes.

**Initiatives:** Primary Care Renewal (PCR) and Patient and Population Centered Primary Care (PC<sup>3</sup>)

**Start date:** 2007

**Practices:** 53

**Providers:** Over 330

**Covered lives:** 81,000

Even though hospital admissions in PCR clinics were initially almost 1.5 times higher – and rising at a faster rate – than in non-PCR sites, the launch of the model reversed these trends. After one year, hospital admissions began decreasing more rapidly in PCR than non-PCR clinics, and as of April 2011 had decreased to the non-PCR rate. One federally qualified health center reduced waiting days for appointments from four in February 2009 to only one in February 2011, in addition to improving patient satisfaction with diabetes and behavioral health care.<sup>23</sup>

Based on feedback from its practices, CareOregon has developed a curriculum for the future spread of its PCR program, called PC<sup>3</sup>: Patient and Population Centered Primary Care. Not only have existing clinics been retrofitted to support the new care delivery design, but new clinics are also being designed around supporting PCR work in line with this curriculum. As of fall 2012, CareOregon was transforming its PCR and PC<sup>3</sup> initiatives into a train-the-trainer model, in which local resources are invested in the primary care transformation while building community capacity for this work to facilitate sustainability and future spread of the model to new clinics.

With the rise of Community Care Organizations in Oregon – which combine local systems of care to encourage accountability and coordination of care – CareOregon will increasingly be working with community groups, local neighborhoods of providers and new self-governing organizations to provide infrastructure and data support.

## USING DATA FOR RAPID-CYCLE INNOVATION: GEISINGER HEALTH PLAN (DANVILLE, PA)

Initiative: ProvenHealth Navigator®

Start date: 2006

Practices: 86

Physicians: 718

Covered lives: Over 300,000

Geisinger Health Plan's (GHP) ProvenHealth Navigator® (PHN) initiative involves staff, financial and health information technology support with an emphasis on adaptability and responsiveness to change.

Practice-embedded health plan case managers perform multiple tasks, including patient outreach, post-hospital discharge follow-up, medication reconciliation and assessments of patients' social support at home. They also coordinate care by alerting practice care teams to patients likely to require additional care and creating links with local resources, such as nursing homes or rehabilitation centers, on behalf of primary care practices. Automated home IVR (interactive voice response) phone calls and in-home wireless devices monitor high-risk and post-discharge patients.

GHP supports all PHN practices through enhanced EMR capability, including decision support and best practice alerts. The health plan gives monthly dashboards to all practices, which include hospital, ED, pharmacy, ambulatory care and surgery utilization; PMPM cost data; membership reports and disease registries; and performance related to select chronic care measures. In addition, each practice is required to define 10 quality targets and receives quarterly reports outlining progress on these measures.

The plan supports practice transformation with monthly payments to practices of \$1,800 per

physician and \$5 per Medicare patient. The plan also offers performance and results shared payment, based on a set of 10 quality outcomes related to encounters per patient, disease-specific care scores, inpatient follow-up rates, percentage of high-risk patients with a care plan or risk assessment and patient satisfaction scores.

For Medicare Advantage patients, PHN implementation was associated with an 18 percent reduction in hospital admissions, 36 percent reduction in hospital readmission and 7 percent reduction in cumulative spending.<sup>26</sup> An August 2009 review of the PHN reported an estimated \$3.7 million net savings, for a return on investment of greater than 2-to-1.<sup>26</sup>

Recognizing that new clinical knowledge can take 14 to 17 years to disseminate into standard practice, and to ensure sustainability and effectiveness of its PHN model, GHP developed a "rapid-cycle innovation" process to continuously monitor data, quickly pilot changes and rapidly disseminate them throughout the entire PHN system. GHP considers the focus on rapid-cycle innovation the most important aspect of its PHN model, based on the system's ability to "adapt to new evidence, efficiently and rapidly translate that evidence into care delivery and focus on patient benefit."<sup>42</sup>

This approach allows for efficient modification and expansion of the PHN model. For example, GHP noticed that although hospital readmissions were high after patients were discharged to skilled nursing facilities (SNF), a full 20 percent of these readmissions occurred during the transition from the SNF to the patient's home. These data allowed the plan to tackle the readmission rate with multiple strategies, such as improving the SNF's handoff to patients' homes and primary care.

## PARTICIPATORY DESIGN OF STANDARD WORK: GROUP HEALTH COOPERATIVE (SEATTLE, WASH.)

Aiming to reduce physician workloads and increase staff satisfaction while achieving Triple Aim goals, GHC implemented a PCMH pilot in 2007 in its Factoria Medical Center in Bellevue, Wash., to learn how to implement PCMH reforms without over-burdening primary care providers.

In its pilot, GHC implemented a Lean management system with improved processes, standardized work flows, an expanded care team, reduced patient panels, lengthened primary care visits and time set aside for providers to conduct virtual outreach to patients. GHC provided \$600,000 in funding to support new staff at Factoria; the plan also implemented an enhanced EMR system with best practice alerts, decision supports and electronic prescribing.

Two peer-reviewed studies of the Factoria pilot found lower ED utilization; decreases in staff burnout (as measured by the Maslach Burnout Inventory) and improved satisfaction; and improved patient care coordination, access, involvement and goal-setting. PMPM upfront investment costs were recouped in full after 12 months, primarily because of \$54 PMPM savings from a decrease in ED utilization.<sup>31</sup> Encouraged by these results, GHC leadership spread the medical home model to three clinics in 2008, 25 additional primary care clinics in 2009 and all its practices by 2010.<sup>22</sup> The model was divided into standard work elements using Lean techniques; each element was tested and refined for nine weeks in three separate pilot sites before being spread throughout the entire system.

As a “learning health system,” GHC combines research evidence with the daily experiences of and feedback from its frontline workforce in a participatory design process; the plan can therefore develop and evaluate initiatives “in the context of its own setting, population, available resources and organizational culture.”<sup>22</sup> Based

Initiative: Patient-Centered Medical Home

Start date: 2007

Practices: 25

Physicians: 1100

Covered lives: 650,000

on this process, certain PCMH elements were adopted system-wide while others were unique to each local area. Standards can be tweaked rapidly from the leadership level in response to changing requirements, upgrades to the EMR or exigent circumstances.

Standardized work flows required a culture change from the medical group;<sup>22</sup> GHC engaged providers in this transformation by demonstrating that the new processes would actually give them more freedom and more time with patients by eliminating waste. The health plan continues to monitor the readiness and ability of each clinic to accept and implement change, as well as their understanding of why certain work is standardized, thus ensuring that the model is both sustainable in its current format and that the PCMH model would be ready and willing to evolve if its scope were expanded.

*As a learning health system, GHC combines research evidence with the daily experiences of and feedback from its frontline workforce in a participatory design process.*

GHC has seen a return on investment of 1.5-to-1 for total medical home costs. Possibly as a result of publicity stemming from the GHC medical home pilots, the health plan noted a 20 percent increase in residency applications in 2010.

## Patient-Centered Care: A Member's Perspective

Before I joined Group Health, I chose my doctors through personal recommendations, not professional. Having a chronic disease that is embarrassing to talk about, I went to specialists in that field. Even so, I often felt intimidated with the discussions. Their attitude was not always professional, and for this reason I failed to build a good relationship with them. I didn't get a sense that they were interested in getting me well and keeping me well. I was always anxious when I had an office visit because I had no rapport with the doctors I went to.

Since I joined Group Health in 1978, the focus has been on my wellness in all areas of concern as well as the chronic condition. The doctors at Group Health have been friendly and interested in me as a person. They treat me with respect and kindness and listen to what I say. They answer my questions in a professional way, which assures me I have been heard.

Until I came to Group Health I did not have a primary care doctor. I went to individual specialists that dealt only with the problem at hand. With Group Health, I have a team of doctors and professionals all working to care for my health care needs. Group Health also provides attention to prevention. The providers have a current history of my visits and the medications I am taking on their computers. Wow! The pharmacists are an important member of the team too and give advice to the doctors when called.

A good example of this was my recent decision not to have surgery for the pain in my knees, which is caused by osteoarthritis. Even though I am 88 years old, I remain very active. I regularly walk, do floor and water exercises and yoga. I participate in activities to stimulate my mind, including serving on committees at my retirement community and being a member of a book club and two writers groups. Socially, I am involved in planning fun things like our Halloween party and dinner and baking goodies for other social hours.

After my primary care doctor ordered X-rays of my knees, instead of sending me directly to an orthopedic surgeon, I was given a DVD and a booklet. These described treatment options and helped me have a well-informed conversation with my doctor. I decided that – at 88 years old – I would prefer to try changing my pain relief strategy to undergoing surgery and rehabilitation. So far, my choice is working.

I know other people who do not have the availability of emailing their doctors. I have a list of all my providers and can email them, too. I always get a quick response within 24 hours. I can refill my medications online and have them delivered to my residence at no charge for mailing. The service provided by Group Health is amazing!

- Betty King, Group Health Cooperative member for 35 years



*Betty King, a member of Group Health Cooperative for 35 years, is grateful for the way she has been treated by her providers.*

Read more about Group Health's initiatives at <http://www.ghinnovates.org>.

### IMPROVING CARE TEAM COMMUNICATION: GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN (MADISON, WIS.)

The main goals of Group Health Cooperative of South Central Wisconsin's (GHC-SCW) Care Team model were to create an infrastructure to facilitate communication among providers and improve continuity of care.

The plan's initiative, which focused on developing care teams and increasing provider proximity, was designed collaboratively with provider and member input. For example, GHC-SCW had received feedback from members regarding their frustration when their primary care provider was not in the clinic on a day they needed care. With the development of care teams, patients could meet with a member of the team who was familiar with their particular concerns.

The plan continues to see the insurance function as critical in care coordination. GHC-SCW supports proactive population health management through practice-embedded and health plan-centralized care managers, provider-specific reports, registries and evidence-based clinical reminders within its EMR. The plan also offers members access to web portals with direct provider communication and auto-release of test results.

To guide quality improvement, GHC-SCW provides practices with quarterly dashboards detailing quality, patient satisfaction, access and utilization measures at the individual physician, care team and clinic level. As a result of these changes, GHC-SCW noted improvement in 17 of 18 measures across five domains related to patient, provider and staff satisfaction as well as in outcome measures like continuity of care and access. Due to the success of its pilot, the health plan board approved the spread of the care team model throughout the entire system.

Initiative: Care Teams

Start date: 2006

Practices: 5

Physicians: 55

Covered lives: 57,815

Every two to four weeks, GHC-SCW staff members meet to continue to design and refine the plan's initiative. Further practice opportunities for improvement are incorporated into yearly organizational strategic planning processes and meetings, which include providers, nursing and other clinical staff as well as staff from the quality improvement division. While GHC-SCW is already following certain outcome measures for its clinical dashboard, it plans to increase the scope of its measurement activities to ensure that it is providing useful, actionable and timely data to clinical staff, care managers and other providers.

A new health plan committee is determining ways to improve care coordination throughout the organization by identifying and operationalizing best practices that are currently being observed by single providers or clinics. GHC-SCW will be encouraging the spread of provider-driven innovations to improve the responsiveness of the model to concerns and feedback from frontline staff.

*GHC-SCW supports proactive population health management through practice-embedded and health plan-centralized care managers, provider-specific reports, registries and evidence-based clinical reminders within its EMR.*

## STANDARDIZATION THROUGH COHESIVE CULTURE: HEALTHPARTNERS (MINNEAPOLIS, MINN.)

Initiative: Care Model Process<sup>®</sup>

Start date: 2004

Practices: 25

Physicians: 780

Covered lives: 1.4 million

The HealthPartners health plan is part of an integrated health care system that was first established in 1957. Thirty percent of HealthPartners health plan members obtain clinical care from HealthPartners Medical Group (HPMG) facilities, while the rest receive care outside the HealthPartners network.

HPMG and its affiliated clinics first began work tied to primary care transformation in 2001 through the Institute for Healthcare Improvement's Pursuing Perfection Initiative. HealthPartners expanded its efforts in 2004 with the Care Model Process<sup>®</sup> (CMP) initiative, which began at three primary care pilot sites and has since spread to all HPMG care teams.

The CMP redesigned care team work flows to ensure standardized and scripted care delivery for a consistent clinical experience for patients. A system-wide EMR includes patient information, disease registries, clinical reminders, safety alerts and evidence-based decision support tools. HPMG patients can go online to view billing and clinical information and services, such as prescription refill requests, medical claims and secure email to care teams. They can even receive prescriptions if indicated for 40 common conditions online through HealthPartners' virtuwell<sup>™</sup> service, which provides high-quality, low-cost and convenient care.<sup>43</sup>

For over a year and a half, the leadership team and doctors discussed cultural shifts that were necessary to implement the new processes.<sup>23</sup> As a result of these concerted efforts to bring about greater trust and respect, the two

parties developed a partnership agreement that paved the way for standardization, emphasizing reliable quality while customizing care to individual patient preferences, values or changes in clinical guidelines."<sup>23</sup> HealthPartners designed the CMP to be sustainable by not assuming added resources; site leadership at each of the pilot sites take ownership of implementation with organizational supports.

HealthPartners leadership credits much of the successful implementation and spread of its CMP initiative to the unique culture of its physician group of "ownership, pride, service and partnership." HealthPartners hires only clinicians who share its core beliefs on the relationship between the organization and its clinicians. By focusing on standardization, collaboration and clinician culture, HealthPartners ensures that providers and care teams believe in the goals of the care model process, without fearing a loss of autonomy.

*The Care Model Process<sup>®</sup> is now standard across all HealthPartners Medical Group care teams.*

All HPMG clinics and care teams currently utilize the CMP approach. HealthPartners members who have a Care Model Process<sup>®</sup> practice providing the majority of their care have fewer primary and specialty care visits and incur lower costs than other members. In addition, CMP practices have seen a 39 percent reduction in emergency room utilization, 24 percent reduction in hospital admissions and 8 percent lower total costs than the Minnesota average over four years, as well as significant improvements in diabetes care outcomes.<sup>26</sup> All CMP sites received NCQA ACO accreditation in 2012.

## CO-DESIGN OF THE PCMH MODEL: INDEPENDENT HEALTH (BUFFALO, N.Y.)

The Independent Health Primary Connection PCMH pilot began in January 2009 with 18 diverse practices across western New York. By offering both increased reimbursement and support personnel, Independent Health aimed to improve care quality, reduce the workload of overburdened primary care practitioners, make primary care more attractive to young physicians and decrease waste.

The intervention was driven by a leadership council comprising primary care physicians, a consumer representative and a health plan employee. Practices were involved in all stages of the program and continue to be the main drivers of innovation.

*“At Buffalo Medical Group and Independent Health, we believe transforming health care is a collective responsibility. As such, we are committed to identifying and implementing sustainable solutions to improve the quality and effectiveness of health care through a long-standing relationship built on trust and transparency.”<sup>44</sup>*

Since the inception of its PCMH program, Independent Health has facilitated monthly provider-led learning collaboratives and ad-hoc work groups that look at condition-specific practices from both primary and specialty care perspectives. Once key initiatives or programs are decided on as priority areas, health plan care coordinators and consultants are responsible for helping practices implement the proposed changes. Health plan practice management consultants are tasked with facilitating EMR use, developing quality improvement teams, creating standardized policy and job description templates and maintaining general oversight of the implementation of NCQA requirements.

Initiative: The Primary Connection

Start date: 2009

Practices: 22

Physicians: 140

Members: 50,000

Data and information have been key to providing enhanced care. The plan invested in new tools to give more accurate and useful information on both primary care practices and specialty practices; Independent Health and its team of analysts work closely with physician practices to share information about performance and areas of opportunity. Quarterly dashboards include measures for acute and chronic conditions, preventive care, cost measures, utilization and patient and provider satisfaction.

In addition to data and staff support, Independent Health provides additional reimbursement to support practice transformation; the reimbursement model has also been modified to include a shared savings component based on meeting a quality threshold.

Between 2008 and 2011, Independent Health PCMH pilot practices had 15 percent lower costs associated with ED utilization than their non-PCMH counterparts. In addition, they demonstrated a 19 percent increase in generic statin prescribing.<sup>26</sup> Overall, the 18 pilot practices saw a 10 percent decrease in overall cost, corresponding to \$2.9 million in savings. The practices also saw an 8 to 10 percent improvement in their measures of quality related to preventive services and acute and chronic conditions. Patient satisfaction and team vitality also improved.

By involving practices in all stages of its Primary Connection initiative, and providing them with the resources necessary to implement components they identified as priorities for transformation, Independent Health has facilitated a collaborative partnership that can adapt to future challenges and changing priorities.

## IMPACT OF INTERNAL AND EXTERNAL CULTURE: KAISER PERMANENTE (HONOLULU, HAWAII)

Initiative: Patient-Centered  
Medical Home

Start date: 2008

Practices: 16 outpatient clinics

Physicians: 128 (primary care)

Covered lives: 226,000

For the Hawaii Permanente Medical Group (HPMG) and Kaiser Permanente Hawaii health plan leadership, primary care transformation was seen as a way to formalize, standardize and improve the care delivery processes that were already in place, as well as improve communication across the medical group and organization. While NCQA provided guidelines and criteria, specifics of implementation were up to each individual clinic.

Each clinic contains teams consisting of physicians as chiefs of clinics who partner with nursing/business supervisors to oversee operations and implement changes. This balance of clinical and operational support enables HPMG to adopt processes to meet the needs of both areas. During the initial planning phases at each clinic, teams completed practice self-assessments to reveal areas that needed to be focused on during medical home transformation. To facilitate subsequent process improvement, HPMG provided monthly dashboards to each practice that included HEDIS outcomes, patient satisfaction measures, utilization and cost-trending data, as well as access to Process Excellence (Lean) consultants.

By standardizing protocols and care processes, HPMG has increased care team consistency and use of evidence-based medicine. From the outset, HPMG has acknowledged concerns about standardization infringing on providers' independence; in response, the medical group attempted to influence established norms by

making population management easier for practitioners, encouraging them to shift to a more proactive model of care focused on outreach and patient education programs.

Two external factors have also influenced HPMG's initiative. The provider group is small relative to other Permanente Medical Groups; it has the freedom and ability to make changes from month to month and week to week. HPMG can quickly adopt best practices that have been vetted in larger systems, and adapt them to the Hawaii region. In addition, because Hawaii is isolated geographically, relationships between providers have been developing over many years, and cooperation is a necessity.

*“My husband has had cancer three times and there were times he thought he would just not make it. There were times when he would want to give up. As he got the phone calls from the nurses to see how he was doing, it would really build his morale. And that kept him going.”*

*- Wife of a Kaiser Permanente  
Hawaii patient*

The medical group has reported consistently high levels (greater than 90 percent) of patient and provider satisfaction, improvement in HEDIS measures from the 50th to the 90th percentile and a decrease in abandoned calls (currently below 5 percent). In 2012, HPMG received a five-star Medicare rating from CMS; in the fall of 2012, NCQA ranked Kaiser Permanente Hawaii the No. 2 Medicaid plan and the No. 7 Medicare plan in the nation.<sup>45</sup>

## CROSS-SITE COLLABORATION: KAISER PERMANENTE (SOUTHERN CALIFORNIA AND COLORADO)

Once a year, Kaiser Permanente hosts a national two- to three-day meeting of primary care leaders, at which each of its eight regions presents on best practices in patient-centered care. Outside this annual in-person meeting, the regions meet monthly to discuss their initiatives and performance, engage each other through informal partnerships and receive regular emails about best practices from throughout the organization. All regions are aligned to the same outcome metrics to more easily compare performance.

In 2007, the Kaiser Permanente regions of Colorado and Southern California both implemented new initiatives to maximize care coordination, access and quality of care delivered, then spread those innovations to the other region.

### Proactive Office Encounter

The proactive office encounter, developed by the Southern California Permanente Medical Group (SCPMG) in 2006, is an “in-reach” innovation whereby, regardless of where a member accesses the health care system, staff are able to bring up EMR snapshots revealing all of that member’s presently held care gaps. All of these care gaps are resolved through referral or during the same visit, saving time and increasing the impact of each visit. Ancillary staff and specialty departments thus have become more involved in preventive screenings and management of chronic care needs.

The proactive office encounter was supported by the implementation of standard work flows that clearly mapped out actions that medical assistants, panel management assistants, care coordinators and licensed vocational nurses were to address before, during and after

Initiative: Proactive Office Encounter

SCPMG Practices: 90

SCPMG Physicians: Over 8,000

SCPMG Covered lives: 3.6 million

each encounter. The emphasis was on shifting perspective, according to SCPMG leadership, from a “reactive care-delivery model to one that is consistently proactive in addressing preventive and chronic care needs.”<sup>26</sup> The design process for the work flows involved frequent communication between front-line physicians and chiefs; the initiative was then implemented top-down throughout the entire medical group.

SCPMG’s proactive office encounter initiative has contributed to increases in screenings for several types of cancer, including colon (30 percent), breast (11 percent) and cervical (5 percent), while increasing cholesterol control by 13 percent. Leadership estimate that the medical group’s rigorous program for PAP smears may have saved at least 100,000 office visits in 2012; overall, the care delivery transformations are estimated to save more than 15,000 lives over ten years.<sup>25</sup>

Due to these successes, the proactive office encounter initiative won the eValue8 Innovation Award from the National Business Coalition for Health in 2010.

After the Colorado Permanente Medical Group (CPMG) saw a presentation from SCPMG on the proactive office encounter initiative, it sent service leaders to California for a week to look at work flows, staff job descriptions and how to implement centralized outreach. CPMG fully implemented the proactive office encounter among its offices within a year, with help and advice from SCPMG.

Initiative: Panel Management

CPMG Practices: 25

CPMG Physicians: 975

CPMG Covered lives: 533,000

## Panel Management

Panel management is the “systematic and repetitive review of the entire population of patients with particular chronic conditions.”<sup>47</sup> A fully implemented panel management system has three goals: improved quality performance, strengthened and more continuous patient/primary care provider relationships and greater reliance on non-physician staff in population care management.

*At Kaiser Permanente, primary care physicians have time set aside to manage chronic care needs for patients who do not visit them in the office.*

Panel management at Kaiser Permanente includes dedicated time set aside for primary care physicians to manage chronic care needs for patients who do not visit them in the office. Reliable work flows ensure the ongoing needs of these patients are not overlooked based on the pressing needs of acute care, in order to maintain time for proactive outreach. Internally developed panel-based registries provide information on care gaps so that dedicated support staff can identify patients with the greatest care needs, gather information for physicians and conduct phone outreach to patients.

To ensure access to care, CPMG limited physician panel sizes and implemented processes for appointment continuity, defined by how often patients see their personal physician. Patient panels were defined using the CPMG EMR, after

which the medical group implemented a simple rule across all primary care sites: If a physician is in the medical office and one of his or her patients needs to be seen, he or she is expected to see that person; otherwise, the patient will see the physician’s “secondary practice partner.”

When physicians are available, incoming patient calls are routed directly to his or her personal physician or care team member, bypassing centralized call center agents. By establishing strong continuity within a defined panel, this allowed the delivery of care to be extended virtually, with scheduled phone appointments or email.

Once providers began seeing their patients more reliably, the effect of their care could be measured and they were eager to know how well they were able to care for their members. In response, CPMG began distributing an actionable dashboard every week, which includes chronic care and preventive screening outcomes.

Both physicians and patients are satisfied with the increase in continuity. The percentage of routine visits with each patient’s primary care provider increased from 50 to 83 percent. Patients with acute injuries or medical needs have access to same-day appointments, while patients who seek routine care can be seen within three days.<sup>26</sup>

SCPMG implemented the panel management initiative after seeing its successful implementation at CPMG, and also engaged CPMG for advice on the NCQA accreditation process.

The Kaiser Permanente regions also work closely with other ACHP member plans, such as Geisinger Health Plan and Group Health Cooperative, both of which have participated in its annual primary care meetings. By sharing ideas and best practices across regions and organizations, the health plans and provider groups stay on the cutting edge of innovations in patient-centered care.

## APPLYING LEAN PRINCIPLES: MARTIN'S POINT HEALTH CARE (PORTLAND, MAINE)

Martin's Point Health Care (MPHC) views its main role as a health plan as giving providers information that facilitates practice transformation in order to improve care. One of the key ways MPHC has supported change at the practice level is by adopting Lean methodology for the entire organization and applying the methodology to the practice transformation effort.

MPHC administrators convened a process improvement group trained in Six Sigma and Lean methodology, a management philosophy based on improving quality and reducing waste,<sup>19</sup> to guide improvement by working with care teams on a weekly basis. These Lean events helped develop processes to improve cooperation between the plan and practices, including sharing access to software systems and platforms, which enabled population health nurses and case managers to look at each other's management of patients and better coordinate care. MPHC also embedded health plan case managers in practices.

*Since transformation, patients are more confident in their ability to manage their health problems.*

Based on conversations at a Lean event, the plan developed a provider reporting program that gives practices medical expense data, a tool to help practices manage expenses and a platform that pulls data from the EMR so providers can identify gaps in care.

Simultaneously, MPHC undertook a concerted effort to build patients' confidence in their ability to control and manage their health problems, as measured by the Consumer Assessment of Healthcare Providers and Systems

Initiative: Care Model Transformation

Start date: 2008

Practices: 9

Physicians: 82

Covered lives: 74,342

-Clinician & Group (CAHPS-CG) survey, starting with an awareness campaign for patients and staff. The plan improved patient instructions, goal setting and written next steps to make full use of the EMR. It also integrated "teach back" techniques into clinical practice, with providers asking patients to reiterate, in their own words, the diagnoses, concepts, decisions or instructions that were discussed at the office meeting. Population health nurses in practices assist the most complex patients with follow-up and confidence building.

Between 2010 and 2012, the prevalence of patients with elevated blood pressure at MPHC decreased from 17.6 percent to 16 percent. One team reduced the number of patients with uncontrolled hypertension from 43 percent to 14 percent between 2007 and 2010. MPHC leaders also note that they have been able to increase patients' confidence in their ability to manage their health problems and keep the medical expense trend lower than the national average.

Lessons learned from the transformation effort have been informing the design of new clinics, which are being built specifically to facilitate medical home elements, such as co-location of care team offices. As MPHC spreads its Care Model to additional sites, the plan is developing a deployment calendar to standardize the order in which initiatives should be implemented at each site. As practices implement new models of care, MPHC will pilot them and evaluate value streams before spreading them to remaining clinics.

## SIMPLIFYING THE CARE PROCESS FOR PROVIDERS AND PATIENTS: PRESBYTERIAN HEALTH PLAN, INC. (ALBUQUERQUE, N.M.)

Initiative: Patient-Centered  
Medical Home

Start date: 2009

Practices: 8 primary care groups  
across 30 practice sites

Physicians: 250

Covered lives: 120,000

Presbyterian Healthcare Services, a not-for-profit, integrated health care system comprising Presbyterian Health Plan, Inc. (PHP), the Presbyterian Medical Group (PMG) and a hospital system, demonstrates how offering a variety of services to assist practices and improve access to care for patients can create a sustainable model of primary care.

PHP has for years supported the development and deployment of PCMH practices across the state of New Mexico among the affiliated PMG as well as seven network primary care groups, serving both urban and rural areas of the state.

In general, practices in its PCMH initiative go through two phases. The first is a pilot phase in which PHP gives each practice a grant to support primary care transformation by hiring staff to do care management, designing or building new processes, pursuing NCQA accreditation or educating providers. Additional payouts are made when there is documented evidence of quality improvements, reduced inpatient admissions and/or reduction in ED utilization for PHP members.

Based on a practice's commitment and outcomes during the pilot phase, the group may move to the second phase, in which it is eligible for a monthly payment per member for care management in exchange for meeting higher expectations for quality and financial outcomes. In this model, PCMH practices receive periodic, tiered incentives based on the

level of NCQA accreditation they achieve as well as a combination of both quality and utilization measures.

PHP offers a variety of services to assist primary care practices in PCMH transformation. Regular utilization reports are generated of their patients who receive services such as ED or inpatient admissions. Another service, Pres Online, streamlines administrative tasks, giving providers and staff an easily accessible way to identify members' eligibility and claims status and freeing them to perform other tasks like pre-visit planning. A PHP-developed tool details how PCMH care managers can best follow up with members who have over-utilized the ED.

The health plan also supplements care management performed at the point of care. Centrally located care managers can help match high-risk members, identified through predictive modeling, to an appropriate level of intervention that may go beyond the scope of the PCMH group. PHP is also participating in a three-year pilot managed by Project ECHO at the University of New Mexico. It is funded by an Innovation Award from the Center for Medicare and Medicaid Innovation, and will coach primary care teams on how to perform additional intensive outpatient management for patients with multiple chronic diseases.

Lessons learned from the program development and evolution include understanding the importance of balancing program structure and the uniqueness of each PCMH program. Leaders more fully appreciate the importance of considering administrative burdens on primary care groups. It is critical, they say, to stay focused on specific outcome measures and interventions, regular data analysis and reporting, care coordination and the incorporation and engagement of providers in the development and refinement of the PCMH model.

## PRACTICE-DIRECTED TRANSFORMATION: PRIORITY HEALTH (GRAND RAPIDS, MICH.)

Priority Health (PH) has a long history of working closely with primary care practices. For over 15 years, the plan has supported outcome improvement through its Partners in Performance program; PCMH transformation was envisioned as a natural next step. In 2009, the health plan began rolling out its PCMH pilot to 16 partner primary care practices.

Unique to the PH PCMH pilot was the independence given to its primary care practices, with the recognition that they varied significantly with regard to each physician's workload, focus and interest and practice goals. While each practice had similar ambitions related to care delivery, the health plan allowed practices to direct their change management processes independently by providing \$2 million in up-front funding to its PCMH sites – allocated based on the merit of practices' individual PCMH proposals – with few stipulations on how money should be used.

Most pilot sites chose to use the grant funding to hire health coaches and care coordinators to implement group visits and open access, create more intensive chronic care education processes, perform population management and registry analysis and redesign office work flows. Priority Health supported practices by leading learning collaboratives for sharing of best practices and offering change management

Initiative: Partners in Performance

Start date: 2009

Practices: 37

Physicians: 111

Covered lives: 250,000

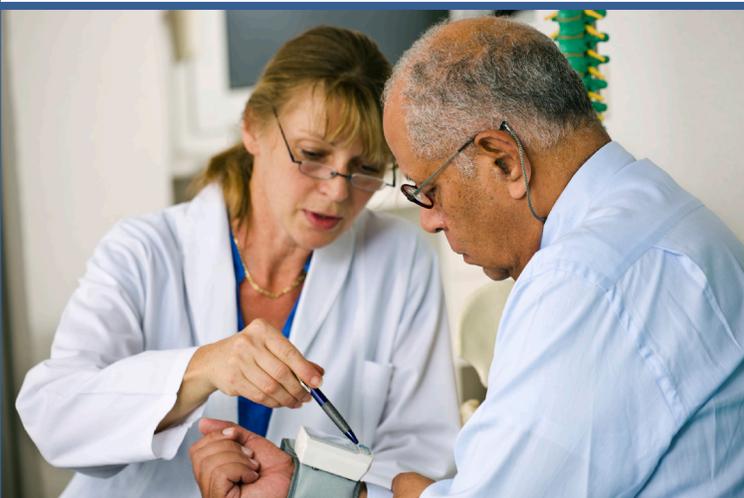
support through TransformED practice transformation consultancy, health information technology and case management, quality measure dashboards, access to risk stratification software and external evaluators and assistance with onsite management of claims data.

*“PCMH transformation was a way to meet our networks where they are and provide tools and resources to help them move forward more effectively.”*

*- James Byrne, M.D.  
Chief Medical Officer  
Priority Health*

Pilot practices, in comparison to matched control groups, showed significant improvements in patient and clinical staff experience, overall quality of care measures and both composite and individual diabetes measures. PCMH implementation was also associated with a reduction of 52.1 visits per 1,000 members in ED utilization.

Priority Health is currently focusing on implementing the program across its entire network. Recognizing the unique role of health plans in supporting infrastructure development, Priority Health has begun providing all network practices access to infrastructure funding. PH realizes that PCMH transformation requires long-term investment and partnership, and the plan will continue supporting practices.



## LEADING COMMUNITY COLLABORATIONS: ROCKY MOUNTAIN HEALTH PLANS (GRAND JUNCTION, COLO.)

Initiatives: Community Care Model, Colorado Beacon Consortium, Comprehensive Primary Care Initiative

Beacon Program:

Start date: 2010

Practices: 51

Physicians: 153

Affected Lives: Over 200,000<sup>48</sup>

For years, Grand Junction, Colo. has been lauded as a prototype of what U.S. health care should be by consistently providing high-quality care at what are among the lowest costs in the nation.<sup>49,50</sup> Rocky Mountain Health Plans (RMHP), given its high market share, community-based focus and close alignment with providers, is one of the main forces that contributes to the low costs and high levels of access.<sup>51</sup>

At RMHP, providers are paid enhanced rates for publicly-insured patients in a risk-sharing system that integrates commercial patients, improving health equity for all patients in the community.<sup>52</sup> The plan shares individual provider performance data with all physicians in its affiliated provider group, which reduces utilization due to peer review, and simultaneously rewards providers for quality, efficiency and care coordination with incentives and innovative reimbursement programs.<sup>49,52</sup>

In 2010, Grand Junction and its surrounding six counties was chosen as one of 17 Beacon Communities by the Department of Health and Human Services, with Rocky Mountain Health Plans as the lead grantee, to build and strengthen local health information technology infrastructure and test innovative approaches to improve health care quality and cost.<sup>53</sup> Quality Improvement Advisors (QIAs) lead transformation efforts among the Beacon

practices. Although they are based in the RMHP office, QIAs visit practices they are assigned to twice a week, helping staff redesign work flows to increase the efficiency and quality of care delivered to all patients, regardless of insurer. A 12-month analysis of the first two groups of practices engaged in the program found increases in patients with low cholesterol (39 to 53 percent), increases in tobacco counseling (from 25 to over 50 percent of patients) and increases in depression screening for patients with diabetes.<sup>53</sup>

RMHP is piloting a continuation of the Beacon program among ten Beacon practices through its Masters 2013 Initiative, which offers financial support for focused care management for high-risk patients, with an emphasis on decreasing total cost of care. To spread innovations, RMHP is also paying for QIAs to facilitate transformation in practices that were not part of the Beacon consortium as part of its Foundations program.

The health plan is one of two facilitators of the Center for Medicare and Medicaid Innovation's Comprehensive Primary Care (CPC) Initiative in Colorado, with oversight over the western part of the state.<sup>54</sup> QIAs are involved with the CPC practices to help them meet quality goals outlined by the center and the health plan.

RMHP and the QIAs have been able to apply their experiences and lessons learned in each initiative to successive programs; their work with Beacon sites is currently being applied to the CPC, Masters and Foundations practices, and will inform future practice transformation efforts. The health plan is also funding learning collaboratives for all practices involved in these programs for further sharing of best practices across the initiatives.

## SPREADING BEST PRACTICES: UCARE (MINNEAPOLIS, MINN.)

UCare first began to partner with primary care practices during its involvement in the Minnesota Senior Health Options (MSHO) program, a dual-eligible fully integrated special needs plan offered by the state since 1997.

The plan views its role as not only tracking enrollment and paying for care, but also coordinating care across systems – including preventive, primary, acute, post-acute, rehabilitation and long-term care – to ensure continuity of medical services and systematic delivery of care. For example, UCare reimburses state-recognized health care homes like Lakewood Health System, an independent, integrated rural health care system in Staples, Minn., for care coordination services provided to recipients of state-funded insurance and its dually eligible MSHO population. UCare care coordinators train practice staff and support them with decision-making processes for the plan’s members; it also provides care management software with risk stratification capabilities to care coordinators employed by partner practices and does joint trainings.

UCare analyzed and shared outcomes that

Initiative: Lakewood Health System  
Health Care Home

Start date: 2008

Practices: 1

Physicians: 15

Covered lives: 700

Lakewood had not been able to measure on its own, such as admissions, readmissions, ED claims and cost of care to determine the impact of the medical home intervention on patients, and provided the clinic with data from the Physician’s Quality Reporting Initiative.

For Medicare, Medicaid and dual-eligible patients in Lakewood’s medical home program, the health plan reported a 37 percent decrease in the total cost of care and an 18 percent decrease in inpatient admissions. Due to this successful experience, UCare has applied the lessons it learned in its MSHO product to other populations. For example, the plan worked with Bluestone Physician Services – a “clinic without walls” that brings physicians and nurse practitioners to nursing homes and assisted living locations – to improve its care coordination capacity.



### Patient Story: Care Coordination

When Jody Kuyava of Bertha, Minn., (left) was diagnosed with multiple sclerosis, her life became dominated by medical visits, phone calls to doctors and constant attention to managing her twenty medications.

As a result of her participation in the Lakewood Health System medical home, with help from her care coordinator Niki, Jody was able to reduce her medications by more than half and improve her quality of life.

“Knowing I have someone I can call who knows me and my medical history has taken so much of the anxiety out of having a chronic illness,” says Jody. “As for Niki and the other medical home staff, well, I call them my angels.”

## HEALTH PLAN STAFF SUPPORT: UPMC HEALTH PLAN (PITTSBURGH, PA.)

Initiative: Partners in Excellence

Start date: 2008

Practices: 163 active sites

Physicians: 602

Covered lives: 143,826

In 2008, the UPMC Health Plan (UPMCHP) Partners in Excellence pilot was implemented in four practices, two of which were UPMC-owned and two of which were contracted network practices. The program has since become standard for all health plan-affiliated primary care offices.

During transformation, UPMCHP embedded practice-based care managers at pilot sites to coordinate care for its members. In order to best match its facilitators to each practice, UPMCHP staff observed prospective pilot sites to identify which care coordinators, based on their unique strengths or skill sets, would best integrate with member populations and existing office dynamics.

Practice-based care managers meet weekly with UPMCHP and are supported by a health plan-based multidisciplinary clinic support team, which includes social workers, specialty care managers, pharmacists, lifestyle health coaches, discharge planners, nonclinical outreach staff and member services staff.<sup>55</sup> UPMCHP also makes process improvement specialists – trained in Six Sigma process improvement methodology and other change management methods – and physician account executives, who ensure that data feedback is accurate and actionable, available to practices.

UPMCHP gives practices access to enhanced, population-level claims data to guide clinical improvement. For example, UPMCHP helped one practice determine the peak hours of ED

utilization for its patient panel; by changing messaging materials and staff processes, this practice reduced total ED visits by 10.6 percent in one year.

Initially, practices receive the highest possible incentive payments, regardless of their actual performance, in recognition of their time spent on the initiative and to transform the clinic culture. Once practices are more established, UPMCHP provides them bonus payments comprising approximately 15 percent of the total claims paid per year, contingent on performance on administrative and quality process measures, with additional funds for independently organized quality improvement projects.

*UPMC Health Plan calculated a return on investment of 160 percent for its Partners in Excellence practices, in addition to quality and efficiency improvements.*

In the first year of the pilot, UPMCHP reported a decline of 12.5 percent in post-hospital readmissions and total medical and pharmacy costs that were 4 percent lower at pilot practices than in non-Partners in Excellence primary care practices.<sup>26</sup> UPMCHP calculated its cost avoidance at \$15.84 PMPM, for a return on investment of \$9.75, or 160 percent,<sup>27</sup> in addition to increases in quality and efficiency measures.

By offering health plan staff support, gaining buy-in through financial commitments and continuing to reward practices for high performance and innovation, UPMCHP has created a sustainable model that is easily adaptable to new clinics.

# VI. Appendices

## Sections

Contact ACHP

Acknowledgments

ACHP Member Organizations

References

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General questions about ACHP can be directed to [info@achp.org](mailto:info@achp.org). More information can be found on our website at [www.achp.org](http://www.achp.org).

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# ACHP MEMBER ORGANIZATIONS

## Capital District Physicians' Health Plan

Albany, New York | [www.cdphp.com](http://www.cdphp.com)

Capital District Physicians' Health Plan, Inc. was founded in 1984 as a not-for-profit IPA model HMO in Albany, N.Y. Since then, Capital District Physicians' Health Plan and its affiliates have grown to serve more than 400,000 people in 24 counties throughout New York state.

## Capital Health Plan

Tallahassee, Florida | [www.chp.org](http://www.chp.org)

Created in 1982, Capital Health is a not-for-profit health plan serving more than 125,000 members in the six-county area of Tallahassee, Fla. Capital Health Plan is a mixed-model HMO that owns two health center complexes where physicians, nurses and allied health care professionals are directly contracted with Capital Health and provide coordinated care to members.

## CareOregon

Portland, Oregon | [www.careoregon.org](http://www.careoregon.org)

CareOregon is a non-profit health services organization providing health plan services, education and community building support to its partners and their members. The organization was created in 1993 by a partnership of the state's safety-net providers. CareOregon serves more than 150,000 members in 20 counties throughout the state.

## Fallon Community Health Plan

Worcester, Massachusetts | [www.fchp.org](http://www.fchp.org)

Founded in 1977, Fallon Community Health Plan is a locally integrated health plan serving more than 160,000 members and providing them with access to physicians and hospitals throughout Massachusetts. Fallon is the only health plan in Massachusetts that is both an insurer and provider of care, providing group and non-group health plan options, including HMO, POS and PPO, as well as Medicaid and Medicare Advantage plans.

## Geisinger Health Plan

Danville, Pennsylvania | [www.thehealthplan.com](http://www.thehealthplan.com)

Founded in 1985, Geisinger Health Plan is a not-for-profit health maintenance organization that serves the health care needs of more than 310,000 members in 43 counties throughout central and northeastern Pennsylvania. Geisinger Health System employs more than 950 physicians who serve a predominantly poor and rural population of 2.6 million.

## Group Health Cooperative

Seattle, Washington | [www.ghc.org](http://www.ghc.org)

Founded in 1947, Group Health Cooperative is a consumer-governed, not-for-profit health care system that integrates care and coverage. Along with its subsidiaries, Group Health Options, Inc., and KPS Health Plans, Group Health serves more than 580,000 members in Washington and Idaho. It employs more than 9,000 staff and operates medical centers, a charitable foundation and a research center.

## Group Health Cooperative of South Central Wisconsin

Madison, Wisconsin | [www.ghcsw.com](http://www.ghcsw.com)

Group Health Cooperative of South Central Wisconsin is a not-for-profit, managed health care organization serving more than 64,000 members. Group Health's five primary care clinics integrate with its insurance arm to provide primary care and health insurance products and, through its partnership with the University of Wisconsin, specialty and tertiary care to its members.

## HealthPartners

Minneapolis, Minnesota | [www.healthpartners.com](http://www.healthpartners.com)

HealthPartners is an integrated health care system that was first established in 1957. Thirty percent of HealthPartners health plan members obtain clinical care from HealthPartners Medical Group (HPMG) facilities, while the rest receive care outside the HealthPartners network. HealthPartners is a pioneer in developing programs that measure health care quality and reward providers who meet high clinical standards of care.

## Independent Health

Buffalo, New York | [www.independenthealth.com](http://www.independenthealth.com)

Independent Health began in 1980 as one of western New York's first HMOs. Independent Health covers more than 365,000 members in New York and across the country with more than 100 plans, services and products. Among other programs, Independent Health is leading a multifaceted program to redesign physician offices to be more patient-centric.

## Kaiser Permanente

Oakland, California | [www.kaiserpermanente.org](http://www.kaiserpermanente.org)

Founded in 1945, Kaiser Permanente is an integrated care delivery organization that provides care for over 9 million members across nine states and the District of Columbia. The responsibility of design, implementation and optimization of care delivery is the responsibility of regional Permanente Medical Groups, while reimbursement is paid via the associated Kaiser Foundation Health Plan.

## Martin's Point Health Care

Portland, Maine | [www.martinspoint.org](http://www.martinspoint.org)

Martin's Point Health Care is an integrated medical organization consisting of a primary care delivery system and several health plans. Together, MPHC provides services to more than 143,000 total customers, including over 74,000 Health Care Center patients and over 68,000 health plan members across northern New England and parts of New York and Pennsylvania.

## New West Health Services

Helena, Montana | [www.newwesthealth.com](http://www.newwesthealth.com)

Founded in 1998, New West Health Services is a provider-sponsored health plan serving residents of Montana. With headquarters in Helena, an operations center in Kalispell and regional offices in Billings and Missoula, New West has partnerships with more than 4,600 medical providers and serves more than 40,000 members and 700 employer groups.

## Presbyterian Health Plan

Albuquerque, New Mexico | [www.phs.org](http://www.phs.org)

Presbyterian Health Plan, Inc. is owned by Presbyterian Healthcare Services, a not-for-profit, integrated health care system consisting of a health plan, medical group and hospital system and New Mexico's largest locally owned health care system. Presbyterian Health Plan serves more than 420,000 members throughout New Mexico.

## Priority Health

Grand Rapids, Michigan | [www.priorityhealth.com](http://www.priorityhealth.com)

Priority Health is a not-for-profit health plan serving about 550,000 members in 65 counties in lower Michigan. More than 12,000 employers offer Priority Health coverage to their employees, and more than 14,000 health care providers participate in its network. Priority Health offers products for employer groups, individuals and Medicare and Medicaid patients.

## Rocky Mountain Health Plans

Grand Junction, Colorado | [www.rmhp.org](http://www.rmhp.org)

Rocky Mountain Health Plans (RMHP), founded in Grand Junction, Colo. in 1974, is a locally owned, not-for-profit organization that serves more than 173,000 members. RMHP is the only health plan in Colorado serving every market segment including employers, individuals, Medicare, Medicaid and Child Health Plan Plus beneficiaries.

## Scott & White Health Plan

Temple, Texas | [www.swhp.org](http://www.swhp.org)

Scott & White Health Plan began operations in 1982 as Centroplex Health Plan, a not-for-profit HMO covering two central Texas counties. Scott & White has grown to more than 194,000 members in 50 counties and offers a variety of insurance plans for members and employers, including a child-only plan, statewide self-insured plan and Medicare prescription plan.

## Security Health Plan

Marshfield, Wisconsin | [www.securityhealth.org](http://www.securityhealth.org)

Security Health Plan is a physician-sponsored, not-for-profit HMO founded in 1986 as an outgrowth of the Greater Marshfield Community Health Plan. Security Health Plan has a membership of more than 187,000 people in 32 counties in northern, western and central Wisconsin, and a network that includes more than 4,350 affiliated physicians, 40 affiliated hospitals and over 55,000 pharmacies nationwide.

## SelectHealth

Murray, Utah | [www.selecthealth.org](http://www.selecthealth.org)

SelectHealth is a not-for-profit health insurance organization serving more than 538,000 members in Utah and southern Idaho. As a subsidiary of Intermountain Healthcare, SelectHealth is committed to health improvement, superior service and providing access to high-quality care. In addition to medical plans, SelectHealth offers dental, vision, life and disability coverage to its members. SelectHealth also administers several government health plans including both state and federal high-risk pools and the Children's Health Insurance Program (CHIP).

## Tufts Health Plan

Watertown, Massachusetts | [www.tufts-health.com](http://www.tufts-health.com)

Founded in 1979 as a not-for-profit HMO, Tufts Health Plan offers health care coverage to individuals and through employer groups in Massachusetts and Rhode Island. Serving more than 743,000 members through a network of 90 hospitals and over 250,000 providers, Tufts has the highest enrollment in consumer-driven health plans in New England.

## UCare

Minneapolis, Minnesota | [www.ucare.org](http://www.ucare.org)

Founded in 1984, UCare is an independent, not-for-profit health plan serving 300,000 members in Minnesota and western Wisconsin. UCare provides health insurance coverage exclusively to individuals who are eligible for state and federally funded coverage through a network of health care providers, including 16,000 physicians at nearly 5,000 locations.

## UPMC Health Plan

Pittsburgh, Pennsylvania | [www.upmchealthplan.com](http://www.upmchealthplan.com)

UPMC Health Plan is owned by the University of Pittsburgh Medical Center (UPMC). UPMC serves 2 million members. As part of an integrated health care delivery system, UPMC Health Plan partners with the medical center and a community network of more than 80 hospitals and 7,600 physicians to serve residents in a 29-county region of western Pennsylvania.

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