Strengthening Primary Care for Patients:

Group Health Cooperative of South Central Wisconsin | Madison, Wis.

Background

Group Health Cooperative of South Central Wisconsin (GHC-SCW) is a nonprofit managed health care organization, with a majority of its membership seeking care at one of four affiliated primary care clinics. The remaining members, approximately 15 percent, seek care at contracted network clinics in the community.

GHC-SCW has been actively looking for ways to leverage its integrated electronic medical record (EMR) since its deployment in the early 2000s and has, over the past decade, rolled out three pilots to GHC-SCW affiliated primary care practices. The first pilot, the Complex Medical Home, was supported by a state grant intended to measure the success that could stem from improved care coordination in a population of children and youth with special health care needs. The second pilot created a high-risk care clinic. The third, which was eventually embraced as the patient-centered medical home (PCMH) pilot, is a general family medicine redesign supporting a care team model.

Initiative Title: Care Teams
Start Date: 2006
Practices: 5
Physicians: 55
Covered Lives: 57,815

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Implementation

While most of the significant components in the Care Team model were those that had been in place practice-wide for decades, they were formalized and expanded as part of the initiative.

Care Teams and Care Managers

The aim of the model is to increase communication among providers, particularly with respect to communication among physicians, mid-level practitioners and nurses. Because GHC-SCW employs a large number of part-time providers, the formalization of care teams was intended to improve the continuity of care patients received. The care teams include primary care providers (physicians, nurse practitioners and physician assistants), registered nurses, licensed practical nurses, certified medical assistants, social workers and reception staff, who all worked together to support and provide care to the patient. Nurses were empowered to better manage

and coordinate the care teams, or, as one health plan leader noted, to act as the "air-traffic controllers" of the team.[1]

As GHC-SCW became more adept at utilizing registries, care managers were embedded in the practices as an added resource for care teams. Complex case management is conducted by centralized health plan care managers, while less intensive care management is delegated to and performed by nurse care coordinators at the practices. Practice-level nurse care coordinators receive post-hospital discharge information to provide telephonic follow-up with patients within 48 hours of discharge. Health educators in clinics educate patients on diabetes, heart disease and asthma. The plan also publishes a quarterly primary care dashboard for providers that includes several feedback measures.

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Health Plan Resources

Proactive population health management is aided by provider-specific reports, registries and evidence-based clinical reminders within the EMR. GHC-SCW developed a work flow to improve medical information documentation in the EMR for patients with complex medical needs, which allows the tracking of patients when they are not seen in the clinic, and helps gather more detailed information during office visits. GHC-SCW also offers members access to web portals with direct provider communication and auto-releases of test results.

Practices receive regular communication from the health plan regarding the addition or deletion of in-plan specialty care, based on care managers' assessment of efficiency and efficacy. The health plan also identifies practice opportunities for improvement with outside contracted facilities, which are incorporated into yearly organizational strategic planning processes and meetings. The annual meetings include providers, nursing and other clinical staff as well as staff from the health plan quality improvement division.

GHC-SCW's Care Coordination Committee meets every two to four weeks to design and refine the PCMH project and determine the timeline for rollout. At these meetings, participants define the scope of the PCMH project, the measures to be used and processes that can be improved throughout the entire care experience~~:~~ from when patients call for an appointment to when they leave the clinic.

Sustainability

Part of the PCMH initiative includes freeing up nursing staff on each care team so that they have more time to perform care coordination and PCMH duties. To achieve this, GHC-SCW is in the process of developing a centralized nurse triage telephone line, which would decrease the time burden on the nurses. One part of this process is identifying patients who are part of the care coordination initiative and who should be referred to their case manager.

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Because GHC-SCW owns its own clinics and pays its physicians on a salaried basis, every care coordination project can pull in representatives. The health plan sees the insurance function as critical in care coordination; for example, its staff members are embedded in clinics a few days a week and talk with providers throughout the day.

Pediatric PCMH

GHC-SCW is operationalizing the PCMH model across all care teams and is including pediatrics in its system. As part of its pediatric PCMH project, the plan is working with colleagues from the University of Wisconsin-Madison to develop a more formalized and efficient way for patients who are aging out of pediatric practices to establish themselves with adult providers. This model will identify ways to make the transitions process more effective and efficient so that parents and patients know how to access care and adult providers have an introduction to each patient before the transition occurs.

The plan conducted two pilots during the development of its pediatric PCMH, in which pediatricians developed patient care plans and transitions processes; however, the original processes were seen as too time-intensive and required a nurse to gather data and coordinate care. An additional limitation was that the EMR platforms did not integrate well between the clinical and insurance side; for example, care managers who worked for the health plan were creating comprehensive care plans that were not easily accessible by clinical coordinators, and vice-versa. In response, the plan developed a comprehensive care coordination tool that is available within both the clinical and insurance systems. GHC-SCW is currently working on making the information more visible and interactive to clinical staff.

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GHC-SCW also developed a comprehensive care plan for pediatric PCMH patients that includes information from the medical record, such as latest consultations and an updated medication list, and is accessible to the primary care physician, parents and hospitals to improve coordination of care. The plan is working on how to keep the data base up to date and ensure its sustainability as it expands it to other groups.

Medical Director Michael Ostrov, M.D., notes that the model is not only sustainable, but in the future will be "critical for us to maintain and achieve the level of quality and cost containment that we really want."[1]

Outcomes

GHC-SCW provides practices with quarterly dashboards, detailing quality, patient satisfaction, access and utilization measures at the individual, care team and clinic level. It also conducted pre- and post-pilot patient (CAHPS® and Press Ganey surveys), provider (American Medical Group Association survey), and staff (HR Solutions of Chicago survey) satisfaction surveys. The statuses of practices' medical homes are assessed through the Medical Home Implementation Quotient (MHIQ) tool, which asks questions across nine modules based on the TransforMED Medical Home Model.

The intended benefit of the pilot was not financial, but was instead aimed at improving both clinician and member satisfaction. The health plan has seen improvements in those areas: As one administrator stated, "This was not a financially driven initiative… to us it was a success because it improved satisfaction; our providers were much more satisfied in the work they were doing. Our nurses were [happier], and our patients were happier."[1]

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GHC-SCW noted improvement in 17 of 18 measures across five domains related to staff and patient satisfaction as a result of its pilot.

Scale

Because GHC-SCW has not planned to scale the care team model outside of its affiliated provider network, its future plans include improving and perfecting the processes that have been implemented within its network of practices. Guided by its Care Team Optimization quality improvement teams, which focus on improving work flows within its clinical services, the health plan is currently working to find the best care team composition to be the most efficient for its served populations, whether pediatric or adult patients. GHC-SCW is using outcomes to determine what has worked and what has not, and implemented a feedback loop with practices to evaluate progress on informal measures.

The plan has expanded the role of its Care Coordination Committee to determine ways to improve coordination throughout its organization by identifying and operationalizing best practices that are currently being practiced by single providers or clinics. It also aims to identify patients who could benefit from the PCMH model, enroll them in the clinics and educate them on how they can access care through the medical home. The plan continues to discuss whether the medical home should be implemented throughout its entire membership or applied only to a small subset of higher-risk members with more complex conditions.

GHC-SCW is also developing a chronic pain management project to change how providers manage the care of members on chronic opioids and is creating a referral management model to change the way providers interface with specialty care.

As new care coordination projects get started, GHC-SCW is looking at enhancing measures to better document the work the plan has been engaged in for decades. While GHC-SCW is already following certain outcomes measures for a clinical dashboard that it shares with providers and clinics, it wants to incorporate a larger system of measurement that clearly provides data that is useful, actionable and timely, to provide better feedback to clinical staff, care managers and other individuals.

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[1] Participant interview with Rebecca Malouin, Ph.D., 2011

A copy of the full ACHP report on strengthening primary care for patients, supplementary profiles on member plan initiatives, a one-page fact sheet and other resources are available online at www.achp.org or by emailing innovations@achp.org.

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