Strengthening Primary Care for Patients:

HealthPartners | Bloomington, Minn.

Background

HealthPartners is an integrated health care system first established in 1957. Approximately thirty percent of HealthPartners health plan members obtain clinical care from HealthPartners Medical Group (HPMG) facilities, while the rest receive care outside the HPMG.

HealthPartners first began initiatives tied to primary care transformation in 2001 through the Pursuing Perfection Initiative in affiliation with the Institute for Healthcare Improvement.[1] Backed by a Robert Wood Johnson Foundation grant, HPMG began rolling out health care redesign to primary care pilot sites in 2004. Known as the Care Model Process© (CMP), HealthPartners' pilot followed four design principles: reliability, customization, access and coordination.[2]

Initiative Title: Care Model Process©
Start Date: 2004
Practices: 25
Physicians: 780
Covered Lives: 1.4 million

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Implementation

The CMP pilot at HealthPartners started at three clinics, which were chosen based on their size, patient population, multi-payer status and overall complexity.[3] HealthPartners led an initial design session, which included care teams, patients and ancillary staff; together, they developed and tested work flows and discussed them in weekly conference calls. After several months, HealthPartners spread this model to more than 20 other primary care locations. Now, CMP is used by all care teams at all HPMG locations.

The Care Model Process© is based on the Chronic Care Model designed by Ed Wagner, M.D., which redesigned care team work flows to ensure standardized and scripted care delivery, leading to a consistent clinical experience for patients. Rather than designing care processes around physicians — such as in the traditional model of care, in which a physician singlehandedly coordinates the actions of nurses, medical assistants, appointment schedulers and patients — the CMP puts the patient at the center and improves care team communication.

Prepared practice teams consist of a physician, rooming nurse who prepares patients for physician visits, receptionist and ancillary members, such as pharmacists, dietitians and care managers, all of whom work with the patient and each other. This care team focuses on addressing a patient's health maintenance and chronic care needs, refilling prescr-iptions and scheduling future appointments. Patients receive a summary after each visit to promote patient education and treatment adherence.

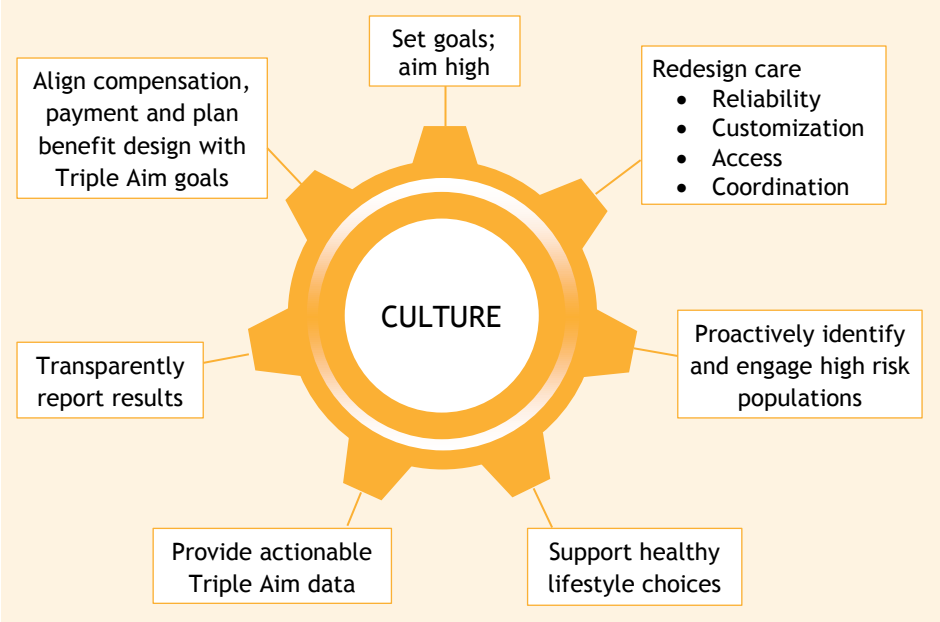


Figure 1: Care Transformation at HealthPartners

In an effort to improve information continuity, all HPMG clinicians have access to an electronic medical record (EMR). Patient information is integrated across all HPMG clinics through disease registries, clinical reminders, safety alerts and evidence-based decision support tools. Chronic disease registry data are also supplied at the clinic and provider level, allowing care teams to track and identify patients in need of chronic care services.

HPMG patients can create an online personal health record, giving them the ability to view their medical history, laboratory test results, preventive care reminders, medication lists and immunization records, as well as track health goals and complete online assessments. Communication with providers and access to care is enhanced through online appointment scheduling, prescription refill requests and secure e-mail to care teams. Patients can also pay medical bills and view their claims history online.[4]

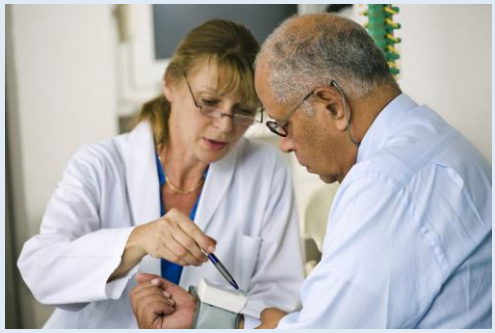
Proactive Outreach and Advanced Access

Proactive identification tools inform HealthPartners which members would benefit from outreach by a chronic disease manager, social worker or health coach. Chronic disease managers can encourage these patients to engage in self-care and communicate with their primary care physician, promote medication compliance and initiate home monitoring. For example, if the tool identifies a member at risk of a behavioral health crisis, disease managers remove barriers to care so that patient can more easily access behavioral health services without a referral.

HPMG clinics offer advanced access scheduling to promote reduced appointment waiting times and increased physician continuity of care. All primary care clinics offer same-day access and 30 percent of primary care visits are same-day appointments.[5]

Advanced access is supported by health plan nurse navigators who provide telephonic assistance to HPMG members through, for example, behavioral health consultations from the Personal Assistance Line; after-hours assistance from CareLine; and pregnancy, postpartum or infant guidance from BabyLine, among other services.[4]

Patient Story: Caring for Patients with Diabetes



HealthPartners is a national leader in improving care for patients with diabetes

Mark had been seeing Dr. David Caccamo at the HealthPartners Cottage Grove clinic for a while. He was overweight, had depression and anxiety disorders and had been recently diagnosed with Type 2 diabetes, a setback that left him feeling worried and upset.

Fortunately for Mark, his health care was in good hands. HealthPartners is a national leader in diabetes care, having developed a treatment program to ensure that patients are as healthy as possible by keeping their blood sugar, bad cholesterol and blood pressure at normal levels and making sure they are tobacco-free and take an aspirin every day.

Within a few months of his diagnosis, Mark's blood glucose levels had dropped from over eight to 6.18, a good indication that his treatment plan was working. And while his numbers were going in the right direction, it was his experience as a patient that had Mark raving about his clinic.

"The entire staff at the Cottage Grove clinic is great, but I would like to single out medical assistant Kelly Lanz for recognition in particular," Mark says. "I went in to see Dr. Caccamo about my diabetes and was very worried and upset, but Kelly's warmth, professionalism, compassion and reassurance made me feel much better."

Kelly remembers that day well, and says that often the most important thing she does is listen.

"Mark blamed himself for the diabetes diagnosis and was really down," Kelly says. "He was already dealing with levels of depression and anxiety, and I simply took the time to listen. Sometimes we have to remember that our patients aren't a list of conditions or a number, but they're real people."

That day, Kelly helped explain that at the Cottage Grove Clinic, everyone is in it together. "I told him, you don't have to do this alone. Your goals are our goals and vice-versa, and together we're going to get you to where you need to be."

Reliability and redundancy is built into the appointment system. A week before each patient visit scheduled in advance, a nurse orders whatever preparations may be necessary, including lab tests and screenings. A member of the care team then calls the patient and gives him or her the opportunity to come in to the clinic prior to the appointment and have the tests done so they may be reviewed by the physician during the appointment. During the visit itself, any outstanding tests or screenings are discussed with each patient.[6]

virtuwell

To increase online access to care, HealthPartners created virtuwell™, an online service for residents of Minnesota, Wisconsin or Michigan. The service is not limited to HealthPartners members; all residents of those three states, regardless of health plan, can get treatment plans and prescriptions via their computers for more than 40 common conditions. Individuals take a quick medical interview online, after which a nurse practitioner reviews the answers, completes a personal diagnosis and — if the treatment plan calls for it — fills out a prescription. Patients receive their treatment plans within 30 minutes.

If the patient needs to see a clinician in person, virtuwell refers him or her to a physician. The cost to use the service is $40 or less, depending on the patient's insurance plan. Common conditions that virtuwell is

equipped to "treat" are colds and the flu, bladder and sinus infections and acne. A recent study by HealthPartners published in Health Affairs showed, on average, $88 per episode cost savings in virtuwell-treated cases and strong outcomes related to care quality, safety and effectiveness.[7] In addition, 98 percent of patients reported that they would recommend using the service.

Home- and Community-Based Initiatives

The EMR supports care transitions for patients with any condition after hospital discharge. Clinic physicians receive an alert when one of their patients is admitted and the hospital's care managers telephone the patient at home to ensure that follow-up appointments have been scheduled, that the patient is aware of his/her treatment and that he/she is prepared to take all necessary medications.

The health plan also works with local employers to develop workplace health programs, including telephonic counseling and educational programs, online health promotional programs and referrals to disease management and workplace resources and programs.

As part of a cultural competency initiative, HPMG instituted a consistent process for collecting demographic information at the point of care, including race, ethnicity, language spoken and any need for interpreter services. It also provides training, resources and tools (such as interpreters, translated materials and educational resources) to clinics. HealthPartners developed a language assistance plan outlining interpreter best practices and held leadership symposiums, community forums, culturally specific preventive services days and other forms of outreach to cultural groups.

Total Cost of Care

Total Cost of Care and Resource Use (TCOC) is the first population-based measure of overall health care affordability to be endorsed by the National Quality Forum. The measure includes all care and treatment costs, including professional, facility inpatient and outpatient, pharmacy, lab, radiology and ancillary services. It can be attributed to medical groups for accountability, measuring a medical group's risk-adjusted cost effectiveness at managing a population for which they provide care, across all health care services. The Resource Use Index is a risk-adjusted measure of the frequency and intensity of all health care services utilized by patients in a medical group.

HealthPartners' Total Cost of Care and Resource Use measure includes all care and treatment costs, including professional, facility inpatient and outpatient, pharmacy, lab, radiology and ancillary services.

Together, the tools can measure overall performance of a medical group relative to other groups, and is illness burden-adjusted for accurate comparisons and benchmarking. It can also sort out price differences and resource use drivers, such as place of service and provider type. Population-based TCOC can be drilled down to the condition level, splitting out price and resource use.

More than two-thirds of HealthPartners plan members are cared for by providers whose payment arrangement includes shared savings based on TCOC performance, with incentives for Triple Aim results. Tiered benefit design uses TCOC as a basis for evaluating cost assessments, and HealthPartners publishes transparent cost and quality measures on medical groups and hospitals.

Sustainability

HealthPartners designed the Care Model Process© with sustainability in mind, aiming to use existing staff and not assume added resources. It did so by ensuring the right person was doing the right work; increasing provider efficiency; supporting the patient-provider relationship; and focusing on the full care team.

HealthPartners charged leadership in each of the three first pilot sites to take ownership of the model at that particular site, allowing practice staff to improve on the design based on feedback and outcomes. HealthPartners then created a rollout plan that balanced speed with effectiveness, including a standardized curriculum and approach with defined timelines and a process to identify and implement changes. Currently, the CMP is standard practice for all HPMG care teams.

Standardization of the Model

For more than a year and a half during the design of the new care model, the leadership team and doctors discussed cultural shifts that were necessary to implement the new processes.[6] A key initiative toward building a positive culture was the creation of its Physician and Dentist Partnership Agreement, which describes an ideal relationship between the organization and its providers. This agreement paved the way for standardization, emphasizing reliable quality while customizing care to individual patient preferences, values or changes in clinical guidelines."[6]

When HealthPartners developed the CMP, it decided not to allow changes to the standard process unless they were good for the whole network. Beth Waterman, chief improvement officer at HealthPartners, led an oversight committee with the primary care medical director and reviewed all change requests to see if they would be beneficial for the entire system. The goal was to reduce variability in care, increase reliability and prevent clinicians and staff from naturally reverting back to the way care had been practiced.

HealthPartners does not allow change to the standard process unless they are good for the whole network, to reduce variability in care and increase reliability.

During the pilot phase, HealthPartners continued to change the model but maintained its basic assumptions and values. According to HealthPartners leadership, standardization and customization are two sides of the same coin; as Nancy McClure, senior vice president of HealthPartners Medical Group and clinics, described, "First, design reliable systems and processes, and then and only then we customize to individual patient preferences, values or changes in clinical guidelines."[6]

Payment

In 2000, HPMG-affiliated physicians were transitioned from a staff model, salaried compensation arrangement to a relative value unit/performance outcome based model.[8] During the transformation, physicians were not provided any added incentives over usual outcomes bonuses.

While the majority of reimbursement for contracted network providers is currently based on fee-for-service platform, the plan now has shared savings contracts with groups that care for over 80 percent of its members. Groups are not eligible for the shared savings unless they meet standards for quality, cost and experience. The plan instituted tiered incentives based on cost and quality, which has had an impact on patient-centered medical home (PCMH) outcomes. The plan also has pay-for-performance for many provider groups as well as some key specialties.

Over 80 percent of members are cared for by groups that are under shared savings contracts.

In 2009-2010, HealthPartners gave a number of network providers infrastructure grants to support primary care transformation work. Many providers in the HealthPartners network were already engaged in work to ensure reliability through independent care redesign efforts; grants to contracted groups helped support these practices and enhanced their patient-centered medical home capabilities. The health plan also shares lessons learned from the HPMG with network providers and other organizations to help them throughout the redesign process.

Training New Staff

Because HPMG was an early implementer of PCMH processes, the model has proven itself to be sustainable, as processes that were first implemented through the Pursuing Perfection Initiative are entering into their eighth year of utilization. Twice a year, HealthPartners upgrades specific aspects of the processes and trains all teams on the new approaches. The model is also reviewed with all prospective physicians to ensure their understanding and support prior to joining the medical group. CMP training is provided as a component of new employee/physician orientation.

> The Care Model Process© initiative has proven itself to be sustainable, as processes enter their eighth year of utilization.

Outcomes

HealthPartners implemented an all-or-none scoring system for practices whereby outcomes are measured in groups instead of being taken in isolation, and credit for improvement is given only when all performance indicators are met (these measures are known as "optimal" measures).[1] For example, HPMG clinics attempt to achieve "optimal" diabetes outcomes by collectively maintaining satisfactory $HbA1_c$ levels, annual lipid screenings, healthy blood pressure maintenance, non-smoking status and aspirin use (if indicated), with success being noted only if all measures are satisfactorily met simultaneously. As a result of initiatives to improve optimal diabetes scores and implementation of CMP, the percentage of patients with diabetes that met the optimal diabetes measure jumped from 6 percent in 2004 to 44.3 percent in 2012.

In 2011, Fontaine et al. reported that HealthPartners members who have an established PCMH providing the majority of their care have fewer primary and specialty care visits and, moreover, incur lower costs compared to those who had fragmented care across clinics or medical groups.[9] The HealthPartners Institute for Research and Education reported significant improvements, measured over four years in care quality and cost, including a 129 percent increase in patients receiving optimal diabetes care, 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 among HPMC members.[10]

> Care Model Process© has led to increases in care quality, particularly around diabetes; reductions in emergency room and hospital admissions; lower outpatient costs; reduced waiting times and increased patient satisfaction.

Additionally, HPMG practices with higher scores on the Physician Practice Connections®-Readiness Survey™, which measures practices on their health care organization, delivery system redesign, clinical information system, decision support and self-management support, significantly reduced outpatient costs ($1282/person) for patients using 11 or more medications.[11]

Overall, advanced access scheduling has led to a 76 percent reduction in average waiting times at 17 clinics between 1999 and 2011 (from 17.8 days to 4.2); the percent of patients "very satisfied" with care quality and service rose from 36 to 55 percent during this same time. Advanced access was also associated by a 5 to 9 percent decrease in urgent care visits and increased continuity of care for patients with diabetes, heart failure, and/or depression.[5]

As of 2012, all 25 primary care sites have received National Committee for Quality Assurance (NCQA) Level III recognition for Patient-Centered Medical Homes. In 2006, HPMG received the AMGA Acclaim Award for its CMP work, and in 2012 received the Acclaim Award again for Triple Aim improvement. In early 2013, HPMG received NCQA accountable care organization accreditation.

Scale

The Care Model Process© at HPMG has spread beyond its original three pilot sites to all HPMG care teams. However, according to Ms. Waterman, HealthPartners does not consider the CMP a single event that happened in 2008; CMP-type work had started long beforehand, and takes constant maintenance to sustain the approach.

The essential components of PCMH spread, according to HealthPartners leadership, are related to culture, the redesign process and health information technology. Even though electronic medical records are just a tool, standardized EMRs throughout multiple practices make it much easier to institute widespread changes. In addition, HealthPartners' Total Cost of Care measure, combined with its focus on transparency, has allowed medical groups to gauge their overall performance relative to other groups on cost and resource use drivers.

Having a similar culture and approach to care throughout the delivery system is another essential element of successful redesign. By focusing on standardization, tools, teamwork and culture, HealthPartners ensures that providers and care teams believe that the CMP is the best way to deliver care, and are confident that they are not giving up their autonomy.

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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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