Strengthening Primary Care for Patients:
Group Health Cooperative | Seattle, Wash.

Background

Group Health Cooperative (GHC) is a nonprofit, consumer-governed health care system that provides coverage to 580,000 members in Washington and Idaho. The Group Health Permanente Medical Group, exclusively contracted with GHC, provides care to two-thirds of GHC members in 31 outpatient medical facilities;¹ GHC also contracts with independent physicians in private practice.

Between 2002 and 2006, GHC implemented multiple primary care reforms that improved provider efficiency and patient access and satisfaction. Unfortunately, these reforms also increased physician workload, resulting in fatigue and decreased work satisfaction. To counteract these trends, GHC implemented a patient-centered medical home (PCMH) pilot in one of its clinics, the Factoria Medical Center in Bellevue, Wash., with the hope of spreading lessons learned to other clinics.²

The health plan sought to measure four main outcomes through PCMH transformation: the maintenance or enhancement of patient experiences; reduction of physician and staff burnout; improvement of clinical quality scores; and the reduction of avoidable emergency department (ED), specialist and hospital visits.²

Implementation

Factoria Medical Center Pilot

In 2007, GHC began its pilot project at the Factoria Medical Center based on five core principles:

- The relationship between the primary care physician and patient should be at the core of all efforts.
- Personal care physicians should be leaders of each clinical team.
- Continuous healing relationships should be proactive and encompass all aspects of health and illness.
Patients should have 24/7 access to care centered on their needs.

Clinical and business systems should be aligned to achieve efficient, satisfying and effective patient experiences.\(^3\)

In developing its medical home at Factoria, GHC implemented a Lean management system with improved processes and standardized work flows and provided $600,000 dollars in funding to support new staff at the clinic. The care team at the medical center was expanded to include medical assistants (one per physician), clinical pharmacists (one per 10,000 patients), licensed practical nurses (two per 10,000 patients), registered nurses (two per 10,000 patients), physician assistants and nurse practitioners. Staff member numbers were increased to support a variety of structural changes.\(^1\)

GHC reduced patient panels from 2,300 to 1,800, lengthened visits from 20 to 30 minutes and set aside time during the workday for team members to respond to e-mails and phone calls and to perform other types of outreach on behalf of their patients. GHC also implemented an enhanced electronic medical record (EMR) system with best-practice alerts, decision supports and electronic prescribing.

Physicians participating in the PCMH pilot were paid a fixed salary and released from their variable compensation package, which incorporated fixed salary payments tied to bonuses based on relative value unit (RVU) adjustments and quality outcomes. Providers were rewarded for engagement in group visits, secure messaging, telephone visits and care management.

The practice worked to increase transparency in its communication with patients by developing scripted introductions that made each particular staff member’s role and intent clear. Physicians worked with patients to develop personal care plans and patients were encouraged to participate in their care decisions. As such, GHC developed video-based decision aids to help adult patients consider their options regarding elective surgical procedures. These videos provided evidence-based and unbiased views of treatment options and the associated risks and benefits of such options.\(^1\)

GHC also collected health service use, cost and clinical data to assess markers of care quality. In 2006 and 2007, GHC used the AmbuCare Experiences survey with two subscales of the Patient Assessment of Chronic Illness Care survey to measure patient experience. It also tracked staff fatigue using the Maslach Burnout Inventory, which 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.\(^4\)

**Standardization of Care**

During the pilot process at the Factoria clinic, GHC developed an understanding of the variables that would affect successful spread of the PCMH model to other clinics, as well as the vital core elements that must be present throughout its spread. Encouraged by results of the pilot, GHC leadership spread the medical home model to three clinics in 2008, to 25 additional primary care clinics in 2009 and to all practices by 2010.\(^3\) During the rollout, the model was divided into seven standard work elements using Lean techniques, and each element was tested and refined for nine weeks in three pilot sites before being spread throughout the entire system.

Leaders in each clinic were involved in the standardization process and frontline staff was encouraged to provide feedback. GHC continues to solicit feedback; it notes all suggestions and determines whether changes need to be made to the standard guidelines through a rigorous evaluation process. The leadership team also determines which work must be standardized and which can be variable across clinics. As part of the team, one person is assigned to each of the seven components...
and coordinates its implementation system-wide. Since the standards are designed by front-line staff, the group practice leadership determines when they can be changed by individual clinics to ensure that work does not vary unless practice staff and leadership agree upon the change.

**PCMH Components**

Care teams manage care for the majority of patients, but GHC’s complex care management program helps to coordinate, manage and optimize care for the sickest — and therefore highest-risk and costliest — 1 percent of GHC members, identified through predictive modeling and physician and self-referrals. Complex case managers are centrally located at the health plan, but travel to clinics to work cooperatively with the care teams to coordinate patient care. GHC has also implemented a palliative care service to help homebound patients with complex conditions through home visits, medication adjustments, medical equipment orders and care planning.

GHC’s medication use management program works to optimize the quality, safety and affordability of prescribing practices through physician education and electronic alerts that provide evidence-based recommendations. The plan also implemented a telephonic anticoagulation management service for patients taking anticoagulation medication who need close monitoring to ensure optimal treatment.

GHC established monthly group visits, led by clinicians, typically for seniors or patients with severe or chronic illnesses and hosts single-session group visits for other purposes, such as preventive care visits for women. Extended access — which entails after-hours urgent care and Saturday morning appointments — is available for minor illnesses and injuries. Primary care appointments are scheduled based on the patient’s preference, with same- or next-day appointments available. Patients also have the option of telephonic appointments.¹

GHC physicians and staff have multiple opportunities for education and training, including process improvement workshops, frontline improvement (Lean management) courses and regional and statewide primary care forums with clinic leadership. It hosts a content-of-care oversight group, which gathers ideas from clinicians on how to improve care, implement Lean methods and define work standards, and provides each clinic with clinical dashboards containing quality, patient satisfaction, productivity and engagement measures.

**Sustainability**

The GHC PCMH model was designed with sustainability in mind by including key stakeholders in a participatory design process. GHC leadership consider the organization a “learning health system,” meaning that by combining research evidence with the daily experiences of its clinical, frontline work force, it can “leverage[e] evidence about ‘what works’ in the context of its own setting, population, available resources and organizational culture.”³ They realize that clinical literature is not sufficient to
guide transformation efforts, so all PCMH components were designed and developed with input from primary care physicians, experts, information technology personnel, researchers and clinic staff. Based on this process, certain elements were adopted system-wide while others were unique to each local area.

Changes to the model, particularly to standard work, are implemented through PDCA (plan-do-check-act) improvement cycles. If, for example, frontline staff request to change a standard component of the medical home, clinic leadership consider the proposed changes among each other, discuss the idea with their staff then reconvene with feedback. It is important that standards can be tweaked rapidly from the leadership level based on changing requirements, upgrades to the electronic medical record or exigent circumstances.

GHC leadership monitors standard work done on certain components throughout the year. Every one or two months, GHC staff tours the facilities to view on-the-ground implementation in a process called the “three actual” model: staff goes to where the actual work is being done by actual people on an actual issue. During these visits, GHC staff visits waiting rooms and surveys patients to ask their perspectives on care processes. In addition to the site visits, clinic staff fills out a proprietary clinic leadership tool every ten weeks to monitor the readiness of each clinic to adapt to change. GHC staff oversees clinics continuously to determine and understand their ability to accept and implement change.

Outcomes

Two peer-reviewed studies have performed 12-, 21- and 24-month assessments of outcomes at the Factoria clinic. At 12 months, in comparison to 19 control clinics, the Factoria medical center had six percent fewer in-person primary care visits, 94 percent and 12 percent more e-mail and phone contacts, respectively, and 29 percent less ED utilization. Staff members noted decreases in burnout and improved satisfaction with their work. Patients, surveyed using the Ambulatory Care Experiences Survey (ACES) and Patient Assessment of Chronic Illness Care survey (PACIC), noted improvements in coordination of care, access, involvement and goal setting. Per member per month (PMPM) upfront investment costs of approximately $16 were recouped in full at the 12-month inventory, primarily because of $54 PMPM savings from a decrease in ED utilization.

At 21 months, the Factoria pilot sustained many of the outcomes reported at 12 months. In comparison to control clinics, there were 6 percent fewer in-office visits, while patients were 80 percent and 5 percent more likely to use e-mail and telephone visits, respectively. Patients who received care at Factoria had 29 percent fewer ED visits compared to control clinics. Hospital admissions were also 6 percent lower, which was associated with $14.18 in PMPM savings. Total PMPM costs at 21 months were $10.30 less as compared to control clinics (p<0.10).

Thus far, GHC is reporting a return on investment of 1.5:1 for total medical home costs, in addition to improvements in staff and patient satisfaction.

Possibly as a result of publicity stemming from the GHC medical home pilot, the health plan noted a 20 percent increase in residency applications in 2010.
A Member’s Perspective on Patient-Centered Care

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 K., Group Health Cooperative member for 35 years

Read more about Group Health’s initiatives at http://www.ghinnovates.org.
Scale

GHC has hosted learning collaboratives for both national leaders in primary care transformation and locally affiliated medical groups; however, health plan administrators have noted that while collaboration and networking has been positive, they have yet to find a way to easily transition fee-for-service-based medical groups into the model. The sustainability of the PCMH is contingent on the alignment of practice process changes supported by appropriate incentives; that is, according to GHC leadership, “an infrastructure with care management systems and data systems [built] around quality and payment schemes.”

As GHC expands its medical home model and partners with local groups, the health plan will need to figure out how to implement lessons learned from its group practice and transfer them to the contracted network model. The plan is currently working on developing the requirements and structure for that transition. As a learning health system, notes Paul Sherman, M.D., executive medical director, GHC will continue innovating around the medical home and other areas to continuously improve results.

6 Participant interview with Rebecca Malouin, Ph.D., 2011