Medical Home

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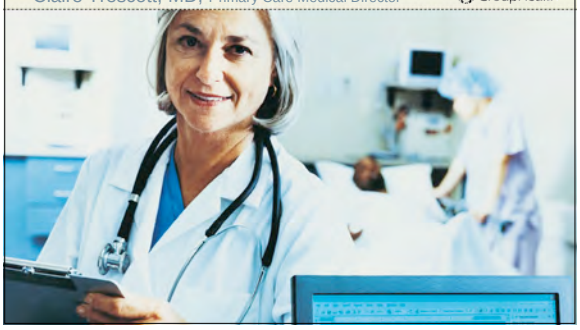
GroupHealth



Agenda

- Why Medical Home?
- Medical Home Pilot Program
- How it works
- Pilot results

Why Medical Home?

GroupHealth

Physician shortage

In less than a decade, the proportion of internal medicine residents becoming generalists declined from 55% to less than 20%.

Group Health's challenges:

- Unsustainable workload
- Growing part-time practitioners
- Recruitment/retention costs
- Need to reverse trend to sustain our primary care based care model

Source: Bodenheimer, NEJM 2006; 355:861

Reduces costs, improves care

U.S. states with higher primary care/population ratios have reduced costs and better quality. Among the states with the highest results:

- Washington
- Minnesota
- Vermont
- Nebraska
- North Dakota
- South Dakota

Source: Medicare claims data, and Area Resource File 2003

Patients prefer it

When you need care, how important is it that you have one practice/clinic where doctors and nurses know you and provide and coordinate the care that you need?

80% of patients surveyed in the U.S. answered:

very important

Source: 2007 Commonwealth Fund International Health Policy Survey

Medical Home Pilot Program

GroupHealth

Principles of the pilot

- Patient-centered
- Team-based
- Collaborative
- Accessible
- Integrated

Patient-centered

- The relationship between the personal care physician and the patient is the core of all that we do
- Delivery of care is organized around this relationship

Team-based

- The personal care physician will lead the clinical team in coordinating and integrating services to meet patients' needs

Collaborative

- Continuous healing relationships between the patient, the personal physician and the care team will be proactive and encompass all the aspects of health and illness
- Patients will be actively engaged to participate in all aspects of their care

Accessible

- Available 24/7
- Maximize the use of technology

Integrated

- Clinical and business systems are aligned to achieve the most efficient, satisfying, and effective patient experiences

How it works

Point of Care

- Best practice alerts
- Health maintenance reminders
- Secure messaging
- After-visit summary
- Increased staffing to reduce patients per physician team
- More time with physician
- Call management
- Previsit review and outreach
- Collaborative care plan

Outreach

- MyGroupHealth
- Health Profile
- Integration with Clinical RPh
- Health Coaching
- Predictive modeling high risk outreach
- Birthday letters
- Hospital/SNF/ER outreach
- Patient outreach
- Group visits
- Living Well with Chronic Conditions

Feedback

- Performance reporting
- Huddles
- Planned Care Exception Reports
- Continuous improvement (Lean)

Lean methods

- Provides us with a standard way by which we engage our teams in designing their own work processes
- Keeps the patient front and center in all of our improvement efforts
- Creates a culture of experimentation and learning so we can continue to improve

Implementation

- From pilot to all 26 primary care medical centers serving 370,000 patients in 2 states (WA/ID)

Standard work

Critical elements to spread:

- Call management
- Access to visits
- Virtual medicine (secure messaging)
- Chronic Disease Management
- Visit preparation
- Outreach workcell
- Smaller panels for family medicine, general internists
- Management standard work

Pilot results

Group Health Center for Health Studies

Medical Home vs. control clinics

Results over 1 year

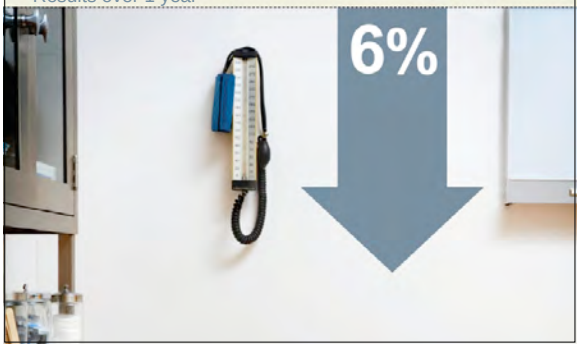
Specific aims of the pilot were to determine impact on:

1. Patient experience
   - Relationship: patient – provider
   - Access
   - Comprehensive care (illness and wellness)
   - Integration/coordination of care
   - Collaborative care planning
2. Doctors and care team
3. Quality (subset of HEDIS measures)
4. Utilization*

*Utilization analyses adjusted using baseline age, sex and prior year's prospective DxCGs using statistical model (GLM)

Face-to-face visits

Results over 1 year



Secure messaging

Results over 1 year

Telephone visits

Results over 1 year

Quality of care

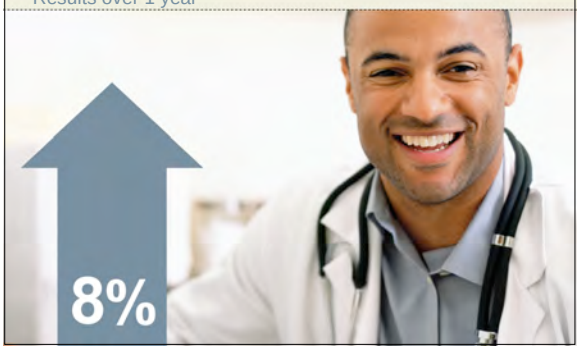
Results over 1 year

Patient satisfaction

Results over 1 year

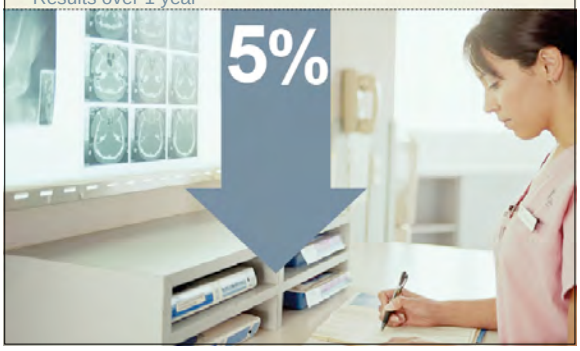
Specialty visits

Results over 1 year



Medical and surgical referrals

Results over 1 year



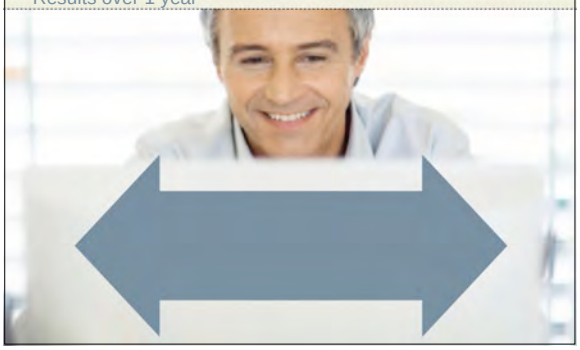
ER/Urgent Care visits

Results over 1 year

Avoidable hospitalization

Cost neutral

Results over 1 year



Net results

Advancing primary care through a Medical Home care model will allow us to provide:

- Higher quality care
- More predictable costs
- Improved patient satisfaction
- Staff satisfaction

Questions?