Implementing the Medical Home at GHC-SCW

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Group Health Cooperative
Group Health Cooperative: a unique health care environment

- Not for profit, staff model HMO
- 33 primary care MDs (Peds, IM and FP), 11 PAs and 3 NPs serving 5 locations in Madison and its surrounding communities
- Provides both health insurance and health care services
- Hospital and specialty care services through University of Wisconsin Hospital and Clinics
- 5 years experience using electronic medical record, 3 years using patient web portal
Why a Medical Home at GHC?

- Improved efficiency of care
- Better disease management = reduced ER, hospital utilization
- PCP and Family driven preventive care is coordinated >> avoids reactive-only type care
- Increased family and PCP buy-in to goal setting
- Increased knowledge helps to improve comfort level of care providers
- Improved member and staff satisfaction
- CYSHCN and families deserve better care

It will make a difference in care our members will notice

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Medical Home Attributes

- **Accessible:** Improved knowledge of member by Urgent Care Providers, improved communication via GHCMyChart, pre-visit planning by nursing staff

- **Family Centered:** Closer relationship with PCP-appropriate time allotted for care, information sharing via GHCMyChart, increased family inclusion in goal making through pre-visit planning

- **Continuous:** Improved satisfaction with GHC and participation in care will help ensure child receives excellent care throughout childhood, and ongoing into adulthood
Medical Home Attributes continued...

- **Comprehensive**: Care is directed by PCP and ensures all issues for CYSHCN are addressed. Improved sharing of health care information with Urgent Care. EMR allows for centralization of pertinent information.

- **Coordinated**: Care plan by PCP/family now centrally located. Shared with consulting providers prior to appts with pre-visit planning goals of patient, family, and PCP noted; all relevant test results, x-rays, etc., sent to consult as well.

- **Compassionate**: The more staff understands the needs, concerns, & goals of the member, the better care they can provide.

- **Culturally Effective**: Special notes & permanent comments can be noted in system as needed.
GROUP HEALTH COOPERATIVE MEDICAL HOME PROJECT TIMELINE

- MH Team Designated by MD
- Care Plan Development
- IT Build
- Capacity Grant
- Enroll Patients
- IM Team
- 30 Minute Appointments
- Capacity Grant
2007 GHC-SCW Board Retreat

Our focus for 2008: “Enhancing the primary care experience”

GHC Commitments:

- Information Systems Department time and resources
- More intensive nursing staff ratio required for team reconfiguration
- Utilization Management Department resource commitment (cross-over from insurance company to clinics)
National Support and Encouragement for Medical Home

- Endorsed by all major primary care specialty societies (AAFP, AAP, ACP, AOA)
- NCQA: Practice Connections certification:
  - Monitor their patients' medical histories
  - Work with patients over time, not just during office visits
  - Follow up with patients and with other providers
  - Manage populations, not just individuals, using evidence-based care
  - Assist patients to manage their own health better
  - Avoid medical errors
Many Existing Barriers to Medical Home at GHC-SCW

- **Traditional Structural Silos**
  - Provider-Nurse dyad: MD/PA/NP with LPN/CMA
  - No structured team accountability for cross coverage of patients
  - No provider education or clinical time allotted to practitioners for population health mgmt

- **Many part-time providers, not all in shared practices**

- **Episodic care orientation**
Other Clinical Barriers to Implementing Medical Home at GHC-SCW

- Increased clerical work for providers with patient web portal access, In-Basket management and other official paperwork (Coding, HIPAA)

- No knowledge of concepts/utility of medical home (nationally a new concept) by both practitioners and many administrators (who appropriate funds)

- Time constraints on RN triage - national RN shortage and no dedicated time for case coordination of SHCN patients
Spreading Medical Home Beyond Pediatrics—Three “Medical Home” Pilot Projects at GHC

2004-present

- Pediatric Medical Home (2004-present)
- Internal Medicine Workflow Project (October 2006-present)
- Integrated Family Practice (April 2006-present; not using comprehensive care planning for SHCN patients as yet)
Pediatric Medical Home

- Provides more comprehensive, coordinated care for children with special needs
- Need dedicated time for RN to coordinate care for complex medical needs; currently nonfunctional due to RN shortages
- Empowers patient and family through use of our electronic **Comprehensive Care Plan** (10 months of IT effort!)
- Urgent Care, ER and Hospital improves care by nonfamiliar providers; reduces costs?
- Facilitates transition to adult care
Internal Medicine Workflow Project

- 2 IM MDs, 1 RN
- More comprehensive, knowledgeable care for adults with complex and chronic illness
- RN coordinates care (nursing home, hospice) for complex medical needs
- Providers more efficient, more available for patient visits
Blue Team
April 2006: 3 MDs, 1 PA, 1 RN and 4 LPNs (Capitol)

- Better workflow, better coverage
- Proactive identification of daily tasks
- Pre-visit prep for new patient and PHE visits
- Improved continuity for patients
- Improved patient satisfaction
- Improved in-basket management
- Greater RN involvement with patient panel
- Improved staff satisfaction
The Approach – Team Care

- Interdisciplinary teams work together to support each other and the patient
- Cover the each other’s in-baskets, clinic hours, and vacations
- NPs/PAs work as support to physicians to care for patients
- RNs triage patient care concerns, coordinate patient care, and oversight of team workflow.
- LPNs/CMAs now cross-cover each other
- Clear roles, responsibilities and accountability
- Care coordination of children and adults with complex medical problems will be improved
GHC’s Medical Home Futures List:

A continuation of 2006-7 Pediatric Medical Home goals:

- Make Comprehensive Patient Summary (CPS) available via GHCMyChart
- Create CPS edited report to meet needs of school health officials
- Further educate GHC-SCW provider and administrative staff about Medical Home
GHC’s Medical Home Futures

List:

New GHC-SCW practice-wide goals for 2008 and beyond:

- Continual re-evaluation and improvement of processes
- Dedicated RN and Utilization Review working together for case coordination.
- Longer Provider appointments for complex patients
- Demonstrate measurable impact of Medical Home and downstream cost evaluation
  - Longitudinal cost/utilization comparisons—Clinic, Urgent Care, ER, Hospital
  - Age/gender matched control group
  - Patient/parent satisfaction survey
2008 GHC Medical Home Grant

Half time dedicated, roving medical home nurse to:

- enroll all GHC-SCW CYSHCN in medical home with their primary care provider,
- do case coordination and quarterly update of care plans
- Train RNs (also utilization management and CMA/LPN) to do enrollment, development of CPS, case coordination —both pediatric and adults
- Develop CYSHCN community resource website (for use by families, providers, case managers)
- Continue to work with pediatric specialists, hospitalists, school nurses and teens on CPS and improving current care and transition to adult care
A Medical Home At

Group Health Cooperative

Questions?