GRAND VALLEY HEALTH PLAN

A case study series on disruptive innovation within integrated health systems

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A HEALTH CARE CASE STUDY

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EXECUTIVE SUMMARY

Grand Valley Health Plan has served the greater Grand Rapids, Michigan, area for nearly 30 years as a regional, for-profit integrated delivery system, specializing in primary care with a guiding focus on wellness and prevention. Though it is a small plan with an enrollment of fewer than 8,000 members, the staff-model HMO has earned national distinction for health care innovation and quality. It is regarded as one of America's "Best Health Insurance Plans," ranked #4, for two consecutive years, by *U.S. News & World Report*/National Committee for Quality Assurance (NCQA) for consumer experience, prevention, and treatment.

Team-based primary care is critical in managing patient health, as reflected by Grand Valley's HEDIS achievements.

Though Grand Valley is a very small-scale health plan and delivery system, it has achieved some of the best results in the nation. A team approach to primary care allows patients to have a high level of access at a low cost of care. This "coordinated" care enables the provision of more preventative care than patients would experience elsewhere and the avoidance of unnecessary specialists and procedures.

Mental/behavioral health services should not be overlooked as an essential component of high-quality, cost-effective care.

Grand Valley has for many years embedded mental/behavioral health services into the delivery of primary care. On-site "Health Coaches" are available on demand during primary care visits and are a critical tool in managing/preventing medical conditions and minimizing specialty referrals and other medical interventions.

It is not necessary to run a hospital or employ specialists to run an integrated delivery system.

Though Grand Valley Health Plan is at risk for all of a patient's health care needs, it has built a delivery system heavily focused on primary care. It pays per diem rates to contracted specialists who are closely aligned with the primary care teams and approach, and it has arrangements to admit patients to local hospitals. "The hospital is the most inefficient unit," said Grand Valley's CEO, Ron Palmer. Grand Valley has not been impaired by not owning hospitals or specialists, as reflected by its stellar quality results in managing their patients' health care.

Being a non-profit is not a key factor in successful integration.

Grand Valley staff feel that being a for-profit or non-profit organization is irrelevant to the ability to successfully integrate. What the organization views as important are investors and board leaders who share a long-term perspective of delivering high-quality integrated care, rather than a short-term focus on stock price.

It is possible to run a small-scale health plan well, though there is a minimum threshold.

Grand Valley was running a robust and financially sustainable health plan for many years, though in recent years, the crises in the local economy have brought membership so low, the health plan is running at a loss. At 10,000 members or below, leaders say it is possible to run an effective delivery system but quite risky on the insurance side (though they use re-insurance). At 15,000 members, cost efficiencies would return to the organization, and at 20,000 members, insurance risk would be better distributed. It is striking that these are far smaller numbers than many policymakers have deemed necessary to effectively run an integrated delivery system.

Medical Tourism can be practiced within the United States.

Grand Valley Health Plan's system is facing consolidation in its local market of specialist groups and hospitals. Members of the organization felt in some cases that patients were being offered services where the price was too high or the quality too uncertain. Grand Valley has started designing pathways of care that involve sending patients out of their local market to centers of excellence in other states for second opinions and treatment. In some cases, Grand Valley is receiving better pricing or bundled pricing commitments at institutions with a far higher frequency of performing complex procedures and having more proven quality outcomes than the local offering.

Even with optimal management of health and prevention, worrisome population health trends are difficult to reverse.

Grand Valley is among the best in the nation in managing conditions like diabetes and heart disease. However, despite multiple decades of prevention efforts and a high percentage of members who have stayed in the system for many years, Grand Valley staff are not seeing a lower incidence of obesity or diabetes in their patient population. This raises issues for whether any health interventions can truly "bend the curve" on health care costs in terms of lowering the level of health care needs across the broader population.

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This case is comprised of three parts. The first section will recount Grand Valley Health Plan's (GVHP) history and its longstanding commitment to its integrated system of health care delivery since its inception in 1982 as a staff-model HMO. The second section will examine Grand Valley Health Plan today, highlighting current innovative practices with disruptive potential. The third section will evaluate key lessons for other systems working to move toward integration as well as consider future paths the organization may pursue as it continues to strive for innovation as a small-scale health plan in a challenging local economy.

I. BACKGROUND AND HISTORY

Background

Grand Valley Health Plan was established in 1982, pioneering the concept of a comprehensive, coordinated health care delivery system in western Michigan. Nearly 30 years later, the organization continues to serve the greater Grand Rapids, Michigan, area as a regional, for-profit, integrated delivery system, specializing in primary care with a guiding focus on wellness and prevention. The health plan currently employs four primary care physicians and nine mid-level providers at its five primary care centers and coordinates care with non-employed specialist providers. In addition to the health centers, the system comprises an Urgent Care Center, two in-house pharmacies, a diagnostic radiology center, and partial ownership of an out-patient surgery center. In 2010, the company had annualized revenues of $294,000 and 91 employees.

Though it is a small plan with an enrollment of fewer than 8,000 members, the staff-model HMO has earned national distinction for health care innovation and quality. It is regarded as one of America's "Best Health Insurance Plans," ranked #4, for two consecutive years, by *U.S. News & World Report*/National Committee for Quality Assurance[1] (NCQA) for consumer experience, prevention, and treatment. It is the only NCQA-recognized Patient-Centered Medical Home in

[1] The National Committee for Quality Assurance (NCQA) is an independent, not-for-profit organization that measures the quality of America's health insurance plans, using a tool called the Healthcare Effectiveness Data and Information Set (HEDIS), which are 75 measures evaluating performance on both care and service. NCQA partners with *U.S. News & World Report* in analyzing this data to produce their joint rankings of America's "Best Health Insurance Plans."

the state of Michigan, receiving accreditation in 2008–2011. As the organization reacts to its local, external environment, it continues to learn and change, committed to what employees describe as a strong "culture of innovation."

The founders were committed to creating an affordable, accessible, coordinated, team approach to family health care.

History

From vision to state licensure and operation (1979–1982)

In 1979, the health care environment in western Michigan consisted primarily of individual practices, and the local community faced issues of access to primary, preventative care. Grand Valley Health Plan emerged from the shared vision of its founders, committed to creating an accessible, affordable, coordinated, team approach to family health care through a staff-model HMO. Central to this vision was a health care delivery system that emphasized prevention and health maintenance and prioritized mental health. Grand Valley founder and current CEO, Ron Palmer, had previously worked in administration with a Medical Education Center and had developed a Personal Medical Home integrating pharmacy, nutrition, and mental health into a family practice. Co-founder Gerald Bax also came from a mental health background, and worked as an administrator of a retirement home for veterans. As Palmer stated, "From our experiences, we both realized that mental health care was 20 years ahead of medical care. We needed to move beyond diagnosis and take a broader, preventative approach." Their non-profit organization assumed the name "Grand Valley Health Plan," grounding the organization in its service to the local, geographic area of Michigan's Grand River.

Leveraging a grant program instituted by the federal government to fund the development of HMOs, Bax embarked upon a one-year feasibility study to understand the health care needs of the local area and develop a blueprint for a delivery system to achieve the following objectives:

- To improve the distribution and continuity of health care services
- To make a positive contribution to improve quality of care
- To contain health care costs
- To carefully monitor hospital referrals for appropriateness
- To maximize the utilization of health professionals through the group practice process
- To increase the accessibility of preventative health maintenance services to the population

In April 1981, soon after the plan's completion, the federal government withdrew funding for the program due to budget constraints. Still committed to Grand Valley Health Plan, the founders assembled what Palmer described as "a group of far-reaching, individual investors, interested in the development of a pre-paid group practice, who had a 10- to 15-year horizon." Through the sale of stock, the organization became a for-profit entity and developed its corporate purpose, stated as: "The mission of the Grand Valley Health Plan is to provide high-quality, health-related services on a pre-paid for-profit basis to meet the health and illness needs of the population that we serve."

By December 1981, the board began its effort to make Grand Valley Health Plan operational. This included applying for licensure from the Public Health Department, developing a Quality Assurance program, initiating recruitment efforts for providers, preparing financial budgets, marketing, and PR plans, and formalizing systems, policies, and procedures. Palmer described it as: "At that time, we were confronted with two major decisions. First, we decided we would be the provider. But we would not be a provider within the existing system, we would pursue innovation. Disruptive innovation has a psychology to it. To do it successfully, you better be aware of the psychology of change. We had to find the people for whom this would be a growth experience. We knew only one in five physicians had the temperament to work in this type of group practice. Secondly, we also decided to be the insurer. We wanted to decide our own risk and alter how we delivered health care." The organization was designed to be simple and flat, with only six employees for the first year. It developed a competitively priced, pre-paid benefit package for employer groups and its own employees. By March 1981, the company conducted marketing to all major, local employer groups.

Grand Valley Health Plan approached the Sparta and Rockford Health Centers and negotiated a contract for these centers to provide health care services to Grand Valley Health Plan members. Concurrently, Grand Valley Health Plan was laying the groundwork to own and operate its own health center in Kentwood. In April 1982, Grand Valley Health Plan received licensure from the state of Michigan to operate a staff-model HMO, serving Kent, Northern Allegan, and Eastern Ottawa counties.

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—Ron Palmer, CEO

The first 10 years: expansion of health centers and services (1983–1992)

The first few years marked a period of growth and expansion for Grand Valley Health Plan. The organization's success in attracting employer groups resulted in growth in membership, revenues, and number of employees. Keeping pace, Grand

Valley Health Plan increased the number of health centers to six by 1985, all strategically located on the periphery of the city of Grand Rapids.

With the entrance of two new HMOs into the Grand Rapids market, membership growth remained flat from 1986 to 1989. During this time, the plan broadened the scope of its services. Specifically, in 1987, the pharmacy program was launched with the first full-service pharmacy opening at the Walker Health Center and services incorporated at each operating health center. By 1990, a second full-service pharmacy was opened at the Kentwood Health Center. In 1988, Grand Valley Health Plan brought OB/GYN care and delivery services in-house. By 1990, the mental health team expanded its focus by initiating a dependency/co-dependency substance abuse program.

Steve Duchemin, group practice manager, reflected on this time of growth in the plan's history and said, "Things were chaotic when I first started practicing here. Patients were seen by multiple providers and there were no systems in place to have patients see the same provider, at least for the same episode of care. [Back t]hen, the focus was on utilization and less on quality. Now we focus on customer value and evidence-based medicine and have systems to insure continuity of care."

The next 10 years: financial success and market challenges; physical expansion and quality initiatives (1993–2002)

As Grand Valley Health Plan reached the important milestone of its tenth anniversary, a new purpose statement was developed to guide the organization. The statement reflected a renewed focus on quality and outcomes, innovation, and utilization of resources (see **Appendix A**).

As local membership at the Kentwood Health Center began to outgrow its facility, the Wyoming Family Health Center was opened in 1994, as the seventh center. In this same year, planning was begun for a Surgical and Diagnostic Center. Beyond the development of surgical capabilities, Grand Valley Health Plan envisioned a medical mall to include a primary care center, centralized radiological services, counseling and wellness, and a pharmacy, all conveniently located under the same roof. This marked the first time that Grand Valley Health Plan had developed secondary care services in an organized fashion.

Toward the end of 1994, membership growth began to decline, driven by external market factors. The competitive environment intensified. Blue Cross and Blue Shield began buying business with below-market prices. Furthermore, they began to require 75% of available members or would terminate the employer group.

Priority Health also embarked upon a geographical expansion. The new competitive landscape occurred against a backdrop of rising health care costs, moving many employers to self-insured plans. Mergers also led companies to enroll with national health plans, such as United. Duchemin reflected on the challenging times, stating, "In the mid-1990s, we were struggling in the market. Our premiums were higher than some competitors. We had escalating medical costs, we had rich benefits – somebody had to pay for that. We never sought to be the lowest cost provider and didn't want to be perceived as the low-end product."

By the late 1990s, Grand Valley Health Plan had achieved a 5–10% cost advantage over BlueCross/Blue Shield through the effective integration and coordination of care by its primary care providers (PCPs). Membership reached its peak at roughly 28,000 members in 1998, though the growth also caused issues of access. The plan was profitable, achieving an 11% profit margin. Profits were used to fund the Surgical and Diagnostic Center and Beckwith Center expansion. The Surgical and Diagnostic Center opened in 1998. In the same year, Orthopaedic Associates of Michigan, the area's largest group of musculoskeletal specialists, bought a 45% stake in this center. Soon after, the eighth health center, Beckwith, opened, along with the Urgent Care Center, Women's Health Services, and Diagnostic Radiology Center, all housed in the East Leonard Medical Complex location. In 1998, the plan ended its affiliation with Sparta Health Center as local membership was minimal. Grand Valley Health Plan was now operating seven health centers.

Membership reached its peak at roughly 28,000 members in 1998.

To accommodate the substantial expansion, a new corporate entity, Grand Valley Health Corporation (GVHC), was formed in 1995. Grand Valley Health Corporation became the parent company to Grand Valley Health Plan, Grand Valley Surgical Center, Grand Valley Health Facilities, and other entities. All shareholders of Grand Valley Health Plan became shareholders of Grand Valley Health Corporation. An employee stock ownership plan was established for employees and now accounts for 18% of shares. "Our shareholders are our employees and family and friends," remarked Jack Heinen, director of financial services. "We have legacy shareholders and nobody here would compromise care due to the impact of share price."

With its major physical expansion initiatives complete, Grand Valley Health Plan turned its focus to reaching even higher levels of measurement and quality. As Duchemin recounted, "During the 1990s, quality of care wasn't where we wanted it to be, but we were growing and making money. We started to think in terms of requiring standards of care and in terms of being a tight group practice. We achieved this by the early 2000s. It took us eight years." In 1998, the plan completed its

first NCQA survey. As Heinen described, "Quality was always in the DNA of this organization. We developed a discipline of documenting what we were doing for quality purposes. We became much more diligent about systems and processes." In November 1999, Grand Valley Health Plan was recognized for its smoking cessation program and was distinguished as the second best HMO in the state of Michigan by Healthgrades. By 2001, Grand Valley Health Plan achieved a rating of "excellent" from NCQA. During this time, the plan researched, developed, and initiated multiple disease state management programs, such as diabetes, asthma, depression, and aging. The programs would grow to achieve national recognition.

With its continued focus on quality and evidence-based medicine, the plan saw a meteoric rise in its national ratings and prominence.

Grand Valley Health Plan experienced recurrent declines in enrollment as the economy deteriorated. As its second decade came to a close, the company developed plans for an Integrated Holistic Health Program, integrating both Eastern and Western treatments. The program was launched at the Wyoming Health Center in March of 2002.

National prominence and re-engineering during economic downturn (2002–present)

In the face of continued deterioration of Michigan's economic climate, Grand Valley Health Plan experienced significant challenges in its third, most recent decade. Nonetheless, with its continued focus on quality and evidence-based medicine, the plan saw a meteoric rise in its national ratings and prominence.

Continued expansion occurred at the East Leonard Medical Facility. The Surgical and Diagnostic Center expanded rapidly and began to serve patients outside of Grand Valley Health Plan, including Blue Cross/Blue Shield, Priority Health Members, and patients from other insurers. Multiple services were added to the center, including Physical Therapy, Sports Medicine, Counseling Services, Specialty Physician Offices, and an Orthopedic Center of Excellence.

The year 2002 marked the beginning of another period of economic decline in Michigan. Steelcase, a furniture manufacturer that was one of the plan's largest customers, contracted with the economic downturn. From 2000 to 2005, Grand Valley Health Plan experienced declining membership from Steelcase and ultimately, the contract was terminated in 2005. Amidst these declines, the plan merged its Cascade Health Center and Beckwith Health Center. In 2006, in an effort to stem enrollment declines, Grand Valley Health Plan introduced a low-cost, non-insurance product called PrimeCare. For a pre-paid, fixed annual fee and

no co-payments, patients were offered basic primary, urgent and preventative care services at the Family Health Centers.

Grand Valley Health Plan maintained a steadfast focus on evidence-based medicine and important HEDIS measures. As Duchemin said, "The process to implement evidence-based medicine was very manual, very resource intensive, involving every discipline on the team. But we finally got away from 'I practice medicine based on my own experience.'" In 2006, Grand Valley Health was ranked #32 in *U.S. News & World Report*'s issue of "America's Best Health Plans." In 2007, the plan moved to #16 and, in 2008, it rose to #4 in the country, where it remained in the "Top 10 Best Commercial Health Plans" for another year. More recently, in 2009, the plan was the first in Michigan to receive Personal Medical Home certification.

The local hospital providers were consolidating and increasing their bargaining power with the small plan.

Also, in 2009, Grand Valley Health Plan was hit hard by yet another economic crisis. As local companies like General Motors and Herman Miller shrunk, they were reducing health benefits packages and moving toward Health Savings/ Reimbursement Accounts. Attrition occurred within many employer groups, and then some dropped Grand Valley Health Plan, often moving all employees to national plans or switching to find the best deal. The company faced competition from Blue Shield, Blue Cross and Priority Health, who moved to an open model. Priority Health, owned by Spectrum Health Care, was able to keep prices very low and compete aggressively. Nonetheless, Blue Cross, Blue Shield, and Priority also lost membership in the downturn. At the same time, the local hospital providers were consolidating and increasing their bargaining power with the small plan. Spectrum Health Care, the largest health care provider in Grand Rapids, now owned Butterworth and Blodgett Hospitals, along with IPA Priority Health, and realized a 70% market share of hospital beds. Metropolitan Osteopathic Hospital and a Catholic hospital accounted for the remaining 30% share.

At this time, Grand Valley Health Plan was also facing concerns about its capabilities to manage sophisticated risk analysis and appropriate pricing. As Doug Calkins, sales manager, said, "We had some challenges on the insurance side of the business. We needed to think in terms of the math and numbers of insurance risk and improve our internal systems for pricing. We had to learn the effects of adjusting rates by class." Furthermore, as layoffs were occurring at employer groups, younger, often healthier staff members were let go, increasing the risk for the company.

In 2009, as Grand Valley Health Plan saw enrollment decline to roughly 7,500 members, it instituted its first layoff in its 25-year history. Along with natural attrition, seven employees were laid off. The company also initiated a major re-

engineering process, focusing on how to improve processes and increase customer value. The Kentwood Health Center, located across the street from Steelcase, was closed and the plan now consisted of five health centers. As Heinen commented on the risks of the plan's current membership level, he emphasized, "It doesn't take too many high-cost cases to tip the balance. We have little negotiating power with hospitals and specialists. From a patient care model, it is fine to work at this size. We are vulnerable from the risk side."

As the organization looks to the future, it has completed a Strategy Map for 2010 to 2012. Three critical priorities have been identified to guide the company over the next three years: cost management, development of population-based programs, and a patient orientation focused on wellness.

II. DISRUPTIVE POTENTIAL OF PRESENT-DAY SYSTEM

Enablers of innovation

Electronic medical record and practice management systems

Critical to Grand Valley Health Plan's quality and operational achievements has been the successful implementation of an integrated practice management (PM) and electronic medical record (EMR) system. In 1994, the organization moved from paper-based processes to a single software platform to support both the delivery and insurance sides of the business. While the system provided an improvement over manual processes, it straddled both sides of the organization and failed to fully satisfy requirements. Neither the medical staff nor the insurance staff assumed ownership of the system, and as a result, the organization did not reap maximum value from its investment.

Grand Valley Health Plan identified the need to implement a practice management system, along with a distinct, more sophisticated insurance system. In 2003, after an 18-month evaluation process, the team converged on the NextGen Enterprise Practice Management system. "NextGen let us customize our standards into the system," remarked Duchemin. "We saw that we could do this ourselves without having to bring in people or use a vendor for implementation. We had more control." For example, the system allowed a customized template for a diabetes visit. For deviations from the standard of care, physicians were required to provide explanation. The system also generated customized reports, such as analyzing the types of visits

scheduled by provider or provider location. The implementation spurred a thorough review of current processes. "We made an effort to ensure that users understood the 'whys' and 'what fors' of the new PM system, not just the 'whos' and 'whats,'" explained Pam Silva, vice president of operations and COO.

The successful implementation of the PM system led the way for the adoption of the EMR system. With the two systems now integrated, documentation of care and coding improved and allowed accurate collection of quality data. Improved utilization and quality data helped the organization better understand costs and allowed the organization to effectively price products and determine insurance rates. This resulted in improved risk-management efforts and enhanced reporting on HEDIS measures. The organization also credits the system with helping to reduce specialty referrals. Quality data in the system identifies which employees provide superior care in specific areas, such as diabetes. Holds in the system create a daily consultation time, when no appointments are scheduled, for employed physicians to consult together, rather than refer patients outside the system. Workflow tasking has also improved. Providers who work in multiple locations are able to easily forward work assignments to any staff member from any location. Finally, the system captures patient-centered information, such as hobbies, to further enhance the relationship between patients and providers. While the system implementation required a substantial investment of time and resources, easy access to a wealth of data has driven both clinical and business improvements.

Investment in providing easy access to a wealth of data has driven both clinical and business improvements.

Quality- and outcomes-focused health management

Grand Valley Health Plan has always maintained a focus on quality and assessment. "The quality team is bird dogging all the time," said Barbara Luskin, quality assurance manager. "It is an organizational commitment."

In the late 1980s, the organization performed an assessment of its strengths and weaknesses and initiated quality assurance audits. As continuous quality improvement began to take hold in the 1990s, the plan expanded its quality assurance into a performance improvement program with staff education to increase awareness of quality objectives.

Today, a product quality manager oversees all clinical quality, utilization, and accreditation efforts and works closely with the population-based program coordinator to create measures. Many of the metrics created are based on NCQA HEDIS factors. Dr. James Kerby, vice president of medical affairs, highlighted

There is "friendly competition" between health centers to achieve quality metrics.

the importance of NCQA's measures, stating, "Having an unbiased third party monitoring practice standards is key to assuring high quality care, and providing a basis for comparison." Palmer cautioned, "We tailor what we do to NCQA, but we don't just look at some metrics that they may measure, that they deem important." Silva added, "We choose what to perform on. I do wish all of the HEDIS measures were outcomes-based. Nonetheless, if we didn't have HEDIS or NCQA, we wouldn't be where we are today. Our delivery system is asking, 'What is the evidence behind that measure?' It is an integrity issue, which is so important in an organization like ours. People here just need to understand 'Why?' and things take off on their own."

Consistent with the entrepreneurial teaming culture at Grand Valley Health Plan, there is direct reporting for each of the health centers and follow-up to understand metrics and drivers for improvement. "We spend a lot of time at health centers telling them what the metrics mean. There is a friendly competition between health centers," said Luskin. "Every other place you have to drag people along to do quality. Here, people ask me, 'Where are my numbers?'" At the board of directors level, there are quality reports. The organization recently established a plan for blood pressure monitoring. Systematized forms, "ticklers" in the computer system, and the team approach make it very hard for patients to be missed in the system. Luskin recalled, "The NCQA team was here and asked us, 'How do you get reimbursed for letting a member come back in and have a nurse take their blood pressure?' We said, 'We don't.' But we do it to meet our standards of care." Standards of care exist for roughly 80% of what the organization does. For the remaining balance, the group practice works together and builds consensus to problem solve for ill-defined conditions, such as back pain.

Grand Valley Health Plan also maintains a focus on quality of the patient visit. They recently implemented an "ICE" approach (Impressions, Concerns, Expectations) to ensure that each visit is personalized. At the end of each visit, patients are asked if their concerns have been appropriately addressed. "A lot of other doctors and health plans come to us for consulting services," remarked Silva. "We don't mind sharing our best practices. People say we are great, but we joke 'How come we're not famous?' We've been in the top 10% on HEDIS factors for a long time and the community here didn't get it, they didn't value it."

Population-based disease state management

Grand Valley Health Plan pursues and implements evidence-based practices for disease states. The population-based program coordinator works in concert with the

quality manager and oversees operational and clinical aspects of Grand Valley Health Plan's population-based program. The coordinator, along with the population-based team, analyzes community trends, regional trends, and membership trends and identifies costly, high utilization populations for implementing population-based programming. For example, west Michigan has a lot of asthmatics due to pollution from Chicago. In addition, diabetes in Michigan has been higher than the national median in all but one of the last 10 years. Grand Valley Health Plan has been providing asthma and diabetes management programs for many years to meet the needs of its community and membership. Grand Valley Health Plan also offers a vascular disease management program, oncology program, pain management, and depression management and is currently working on building a program to address obesity (both childhood and adult). "We ensure that there are mechanisms in place to proactively engage and manage members at risk for or with chronic conditions. Engaging the member to manage their disease includes various types of patient-centered interventions such as consistent PCP visits, health coaching, care management, classes or support groups for peer support and accountability. We make sure we are seeing our population-based patients as often as we need to in order to empower them to self-manage and increase their positive outcomes," remarked Karen Navis, population-based program coordinator. Grand Valley Health Plan executives have embraced the research and theories of Dee Eddington from the University of Michigan. Eddington argues a "zero trends" approach, grounded in the belief that wellness goals should be aimed at maintaining the current health of populations and not allowing declines in risk factors, such as weight loss or smoking. Rather than focusing all resources on improving risk factors for those in poor health, attention to maintaining current health levels for those currently not considered at risk is critical, and may over time demonstrate stronger impact. "We try to at least keep our patients where they are and not let them decline," emphasized Navis.

Using the EMR system, the team recently built four automated, population-based registries, allowing patient lists to be generated by condition. At the push of a button, health center staff can view a list of patients in each program, their clinical data, when they were last seen, and when they are due for their next appointment, further aiding the ability to pro-actively engage and manage population-based members. The population-based team is instrumental in determining what Balanced Score Card indicators will be tracked each year in each program. Indicators include measuring

"We ensure that there are mechanisms in place to proactively engage and manage members at risk for or with chronic conditions."

—Karen Navis, coordinator of population-based programs

performance in clinical, utilization, cost, and service outcomes. Reports are generated quarterly for continuous quality improvement of all population-based programming.

The primary care provider acts not only as a "health manager" delivering health care, but also as a "relationship manager."

Team-based primary care focus

Patient-Centered Medical Home

From its founding in 1982, the innovative blueprint for Grand Valley Health Plan was an accessible, team-based primary care model focused on wellness and prevention, not simply episodic care. Patients at Grand Valley Health Plan become part of a health center or "home," where the primary care provider acts not only as a "health manager" delivering health care, but also as a "relationship manager." In this role, the primary care provider engages the resources of its own primary care team, hospitals, specialists, and administrators to manage its customers' health, especially chronic conditions. The role of the primary care provider is critical, engaging patients in their own health decisions and a broad array of health/wellness services. As stated in the company's strategic vision focus: "The real promise of integrated care is that it will turn the old medical model on its head. Managing health (vs. episodic care) requires continuing contact with customers and a good knowledge of their family, work, and social environments." With an aging population and the rising incidence of chronic health conditions, Palmer feels the model is increasingly relevant. "A well-coordinated, well-integrated, systematized group practice makes a huge difference in tracking chronic conditions over time and knowing the patient history."

Today, this care model has become known as the Patient-Centered Medical Home. While Patient-Centered Medical Home is considered a recent trend, Luskin noted, "We've been doing this since we opened our doors. You have a doctor who leads a team of nurses, patient care coordinators, physician assistants and medical assistants. We've integrated mental health and nutritionists into our services. Everyone works with you to come up with a plan of treatment that is best for you." Dan Wallace, assistant medical director, emphasized, "We provide good preventative care. Sometimes our patients must leave our system unwillingly. Many are eager to come back." Physician Assistant Susanne Pettigrew added, "It was very easy for us to get certification for Medical Home. Patient-Centered Medical Home is where it is and where it is going."

Teaming culture

Woven into the fabric of each primary care team and work group at Grand Valley Health Plan is a pervasive, non-hierarchical culture of teaming. In contrast to typical top-down management structures, Grand Valley Health Plan can be described as a matrix organization where power and decision-making are assigned to teams and work groups. Less emphasis is placed on job titles and more on what expertise and perspectives individuals can offer to accomplish the goals at hand. In this decentralized structure, managers assume a support role to their teams, which make decisions regarding the action plan to accomplish goals and objectives. As depicted in the organizational chart (see **Appendix B**), the Family Practice Health Centers, where front-line employees serve members, are at the center of all activities and functions.

Leaders believe many benefits accrue from the collaborative, teaming culture.

From its founding, the culture at Grand Valley Health Plan was developed organically. Dr. Kerby reflected, "From the time I arrived here as a resident in the 1980s, Ron Palmer and I began to build the 'technology of teaming.' This is a teaming culture. We are a flat organization and we need teams to be self-managing." Palmer added, "Leaders here are autocratic about teaming and it is not an option to do it any other way. People have to make their own mistakes. We are constantly talking about the benefits of this." Central to building the culture was recruiting physicians and providers who could thrive in such a team environment. "It's hard to find physicians to come to a system like this," Pettigrew stated. "They are trained to be autonomous. Fit is a huge issue. Most doctors don't want group consensus." Wallace emphasized, "It takes two years for a new doctor to get comfortable and transition fully into our process." Highlighting the recruitment challenge, Dr. Kerby added, "You are trying to integrate disparate systems where people have a history of being independent. It takes six or seven years to learn how to operate an integrated team. This is much easier to do at the primary care level. If you hire specialists, they only do the team thing 10% of the time."

Leaders believe many benefits accrue from the collaborative, teaming culture. Employees feel empowered to contribute, innovate, and continually grow in their roles. "Here there are no egos," said Wallace. "If a patient care coordinator needs to confront me, it is his or her obligation." Pettigrew added, "The team-based system allows opportunities to shift roles. As a clinician, if I wanted to manage, I could. I spent a few years as the lead for our disease state management programs." Duchemin recounted his experience developing the idea and plans for Grand Valley Health Plan's urgent care center. "I arrived at Grand Valley 18 years ago as

a physician assistant. When I previously worked for a small family practice, I felt ignored. I had good ideas but the culture of the organization didn't really involve me in decisions. I was ripe for the culture at Grand Valley. The organization saw the need and opportunity for an urgent care center. I took a lead in writing the business plan, which was successfully approved. The plan included a description for the urgent care coordinator, which I assumed."

Team meetings, known as "huddles," engage providers across health centers in reviewing complex patient cases.

With a more fluid and flexible work team, Grand Valley Health Plan is better equipped to conveniently serve the needs of patients. "Here we all know what needs to be done. I'm the pharmacist, but have talked to patients about sleep hygiene. Sometimes they can't get a nurse, so they call the pharmacy. We all do as much as we can do," remarked Anne Kozal, pharmacy manager. In addition, the teaming culture supports open and thorough discourse about the full range of treatment options and has led to decreased referrals to specialists. "We have an integrated approach and continually learn from each other. There is a transfer of skill and information between all providers, both behavioral and medical," said Ken Van Beek, counseling and wellness coordinator. "In a traditional setting, someone might say, 'I don't know what to do with this patient,' and refer them out. Here, you go back to your team and see if someone else can help the member or engage them in the process." The health centers have recently moved to staggered hours to better support morning and afternoon team meetings, known as "huddles," with providers across health centers. During the huddles, referrals are reviewed and providers offer peer input and discuss the full range of treatment options for complex cases, resulting in decreased outside referrals.

Investments in new technology or expensive tests are thoughtfully evaluated by a medical opinions team, which researches the technology and in some cases, evaluates alternatives. Mid-levels involve physicians in decisions regarding expensive tests, such as MRIs. "I look at the appropriateness of MRIs that are ordered," stated Wallace. "I never have to say to the patient that the insurance company didn't allow an MRI. I make that decision."

Integrated levels of care: mid-level providers

Primary care teams at Grand Valley Health Plan make extensive use of mid-level practitioners. "Even when we first began, we didn't have large numbers of physicians," explained Dr. Kerby. The *Grand Valley Health Plan Member Handbook* educates patients that patient-centered care is provided through "many types of health care professionals that work together to make sure you receive the very best in overall

health care." In this document, members can learn about roles and responsibilities for each level of care, including those of physicians, physician assistants and nurse practitioners, nursing staff, health coaches, and specialists. Currently, Grand Valley Health Plan employs four physicians, eight physician assistants, and one nurse practitioner. Dr. Kerby delineated the roles, saying, "Physicians are responsible for all patients, but there are levels of care and the physician sees the most complicated cases. Nurses can handle many of the cases and we rely on the physicians to do the balance 'solution shop' work." Mid-levels maintain the primary relationship with patients. Medical assistants manage patient flow and often perform blood draws. In the past, medical assistants were paired with physicians. "This got too territorial," explained Pettigrew. "Now the staffing is more fluid. The nursing staff works for the team and teams with whichever physician is here that day." For OB patients, the majority of deliveries and gynecological care is done by family physicians. An obstetrician reviews every case, and in addition, the family physician makes referrals for complicated cases, such as multiples or cesarean deliveries to the obstetrician.

Mid-level providers maintain the primary relationship with patients.

Pettigrew explained the approach, saying, "The receptionist fills out a telephone blue slip when the patient calls to determine what type of visit is needed, what level of care. We have team-based levels of care, where there is always a physician back-up. We have very experienced mid-levels which allows for more autonomy. We work elbow to elbow with each other. In Grand Rapids, mid-levels are now accepted. When I first came here from Wisconsin, I had to defend my role. We've broken some ground in this community."

Multi-disciplinary approach: "everything under one roof"

Grand Valley Health Plan's provider teams are multi-disciplinary. Services of behavioral health counselors, nutritionists, pharmacy, and holistic medicine are now fully integrated. Grand Valley Health Plan has always realized the importance of integrating counseling and wellness services into primary care. "I joined Grand Valley 25 years ago," emphasized Van Beek. "The whole idea of having social workers and counseling involved in the delivery process was here from the beginning."

Mental and behavioral health

Counseling and wellness are integrated into the primary care program.

A study published by the U.S. Department of Health and Human Services in 1999 concluded that 50%[2] of all behavioral health services are delivered by primary care providers; only 6%[3] of the population is treated within the traditional behavioral health setting. Furthermore, it has been estimated that 70%[4] of primary care visits are driven by psychosocial factors. Of patients who visit a primary care provider, 25%[5] have been found to have a diagnosable mental disorder. Experience with Grand Valley Health Plan has also shown that many patients with medical conditions often struggle with behavioral or lifestyle issues which further augment their risk. These issues, such as lack of support, compliance, or limited financial resources, create barriers for effectively treating and managing health conditions.

In 2002, Grand Valley Health Plan embarked upon an ambitious effort to more fully integrate counseling and wellness into its primary care program. At the time, communication and coordination between primary and behavioral care providers was lacking. Services were being provided at only two locations, which resulted in no-shows and cancellations and further inhibited communication with the primary care team. Often, primary care would prescribe psychotropic medications without involving the behavioral health counselors. Amidst poor performance on behavioral health measures, including high rates of mental health hospitalizations and low HEDIS scores, the organization aimed to re-design its services.

With the aid of a consultant, numerous changes were initiated to improve communication and coordination with the primary care team. Counseling and Wellness staff were co-located within each health center. Rather than having offices, staff saw patients in exam rooms and had workstations in immediate proximity to the primary care team. To reduce stigma and encourage patient participation, staff were given new, broader titles as "health coaches." In an effort to improve accessibility, the traditional counseling model of one-hour appointments was eliminated and

[2] Narrow, W., Reiger, D. Rae, D., Manderscheid, R., Locke, B., "Use of Services by Persons with Mental and Addictive Disorders: Findings from the National Institute for Mental Health Epidemiological Catchment Area Program," *Arch Gen Psychiatry,* 1993:50:95–107.

[3] U.S. Department of Health and Human Services, "Mental Health: A Report of the Surgeon General."

[4] Strosahl, K. "Building Primary Care Behavioral Health Systems That Work: A Compass and a Horizon," *Behavioral Health in Primary Care: A Guide for Clinical Integration,* Madison, CT: Psychosocial Press, 1997, pp. 112–46.

[5] Olfson, M., Fireman, B., Weissman, MM, et al., "Mental Disorders and Disability Among Patients in Primary Care Group Practice," *AMJ Psychiatry,* December 1997, 154(12):1734–40.

15- to 30-minute appointments were established, with 50% provided as same-day appointments. Health coaches try to keep every other half hour open so they can step in on the spot and consult with a patient. Their focus has shifted from traditional psychotherapy to more patient-directed problem solving, focused on interventions. health coaches now perform basic triage, assessment, consultation, and health counseling, augmented with services for lifestyle and behavior factors that negatively impact effective treatment of disease.

In support of the re-design, training was provided to both health counselors and the primary care team to consistently screen patients for behavioral or lifestyle issues. Pettigrew applauded the changes. "I have 15- or 30-minute medical appointments, so if there is a significant psycho-social problem, I would historically have to discount those needs. Eighty percent of the people who come in have this. I can hand it off to the health coaches and move to the next patient. There are times where physicians may do the behavioral coaching. My training is medically based and I don't have time in the schedule to do it all."

Access to services more than doubled in the new model of mental health support.

While implementation of the new model required a drastic shift in the way teams operated, Grand Valley Health Plan experienced significant improvements in access to services, number of patients being seen, and HEDIS measures for effectiveness of behavioral health. By 2006, the Counseling and Wellness staff saw 26.7% of the membership; in a traditional system, less than 10% of patients receive mental health support. Access to services more than doubled, becoming the national benchmark for patients using ambulatory services for mental health. By 2006, as patients were now being treated at the primary care level, referrals to behavioral specialists decreased from 18.7% in 2004 to 6.5% in 2006. Mental health hospitalizations decreased from 0.4% of patients in 2002 to 0.23% in 2009. Grand Valley Health Plan ranked first in the state on all six behavioral health-related HEDIS measures (see **Appendix C**).

While the plan has not undertaken a full cost analysis of the re-design, savings have accrued from fewer hospitalizations and referrals to specialists, and the organization is committed to continuing its financial investment in this model of integrated care delivery at all health centers. "We've done this so long it doesn't seem novel to us," commented Van Beek. "The organizational leadership simply believes in it. Others ask, 'So how do you pay for all that?' We don't struggle with the funding issue, though I do wish we could demonstrate the ROI on behavioral health."

Today, Grand Valley Health Plan employs three-and-a-half full-time behavioral health counselors and one-and-a-half full-time dieticians. A behavioral health

professional is on call 365 days per year. A contracted child adolescent psychologist comes to one health center twice per month. If a psychiatric hospitalization is required, a Counseling and Wellness staff member will coordinate the care within the hospital, coordinate care with specialists, and encourage follow-up after discharge. "You may have known this member," says Van Beek. "You made arrangements for the hospitalization. You communicate with the member when they are leaving the hospital that they need to see someone at the health center within seven days. Our ambulatory follow-up after hospitalization for psychiatric illness is 90% on HEDIS measures. Most providers are at 60 to 70%." For oncology, cardiovascular, and diabetes patients, practitioners now perform regular depression screening, and Counseling and Wellness staff follow with behavioral health services. A tight assessment process exists to determine whether or not to prescribe medications. Data in the EMR system is used to send out reminder cards or do out-bound calling to encourage patients to attend appointments with health coaches.

Wellness

To further support Wellness, Grand Valley Health Plan has invested in a range of health education programs and classes. Stress Management, Healthy Heart, Freedom From Smoking, Tai Chi , and four different Weight Management classes and programs are some of the classes offered free of charge to members. Health plan members provide feedback on classes through quality satisfaction surveys and outcomes are tracked for class quality, biometric results, and self reports focusing on quality of life indicators. Grand Valley Health Plan reported a 97% member satisfaction rating in 2009. A Wellness program manager coordinates education programs with GVHP instructional staff and works together with the population-based team to incorporate health education into disease state management programs, such as diabetes or obesity.

The organization believes that provider encouragement is essential to members' engagement in programs and maintenance of health goals. To promote weight loss and healthy eating, the organization recently developed a program called "10 in 2010." Providers encourage attendance and offer gift card incentives to members who participate and achieve weight loss milestones. The organization has set a target goal of 10% participation among its members over the age of 13.

Patients seeking to treat their obesity with bariatric surgery must get prior authorization; the appropriateness of the procedure is reviewed by the medical director in concert with the care team. Often, the patient is supported to focus on

nutrition and exercise as a first level of treatment. "People want to have the surgery but they don't look at their ability to cope with it, and make lifestyle changes." said Janet Lederman, director of managed specialty care. "We sent one patient who wanted bariatric surgery to Mayo Clinic. They did not recommend the surgery for this patient because he did not want to make behavioral changes." Staff also encourages members to prevent regression on their progress. "I once observed one of our health coaches call a member to say, 'How's that not-smoking going?'" remarked Navis. The organization has accepted the challenge to begin work on NCQA certification for Wellness. "We want the gold standard to maintain customer confidence," said Terri Eudy, health promotion and wellness program manager.

In her role, Eudy works closely with employers on Wellness initiatives and points to the value of the Health Risk Assessment (HRA). If at least 25 employees have completed the HRA, Eudy can create an aggregate group report and return to the company to talk about specific problems their population is encountering, as well as evidence-based methods that uphold wellness as a viable business strategy to reduce costs to an organization. While some employers are customers, Grand Valley also offers Wellness programs to non-customers for a fee. "I'm seeing more and more employer groups selecting Wellness," said Eudy. "Other insurers are embedding Wellness into their health plan, but they can't intervene on the provider side. This makes us unique. I would love to see a rider with Wellness benefits that employees or organizations could use to pay for our Wellness programs, even if they are not members of our health plan."

Grand Valley Health Plan continues to pursue innovation within its Wellness program and is looking for ways to "work smarter," according to Eudy. The organization has plans to pursue online education and telephone coaching to improve access and outcomes. It is currently discussing wellness and the use of social media with Shape Up the Nation, an organization dedicated to building online social networks, to unite people and improve their health through team support and social interaction. Some believe the organization needs to find creative new ways to engage hard-to-reach consumers. "We need to build a patient-centered way of explaining that it's critical to get to a certain level in lipids," said Kara Dunwoody, customer services manager. "They need to understand that if they do this, they can play with their grandchildren."

More employer groups are pursuing collaboration on wellness programs.

An integrated pharmacy facilitates better control and monitoring of costs.

Holistic health

Also integrated into Grand Valley Health Plan's primary care delivery system are holistic health services which include chiropractic services, acupuncture, therapeutic massage, manual manipulation, and Chinese herbs. Patients must be evaluated by the primary care team and recommended for holistic health treatment. A specified number of visits are covered under the plan and patients with demonstrated improvement continue with services. The program was started roughly six years ago to encourage an alternative treatment pathway for patients with ill-defined conditions, such as back pain, fatigue, or dizziness. "This gets you out of doing more of something medical that is not working," stated Palmer. "Holistic health allows us to align with the values of individuals who don't like medications or surgery and offer less intensity of resource use. This will work on some patients but it is hard to determine which ones. Often, it can be better than surgery, for say, back pain, which can have worse outcomes."

Pharmacy

Having a pharmacy is another service which illustrates Grand Valley Health Plan's integrated and multi-disciplinary approach to health care delivery. The plan currently owns and operates two full-service pharmacies conveniently located in the Wyoming and Beckwith Family Health Centers.

In what is described as a "talk and touch system," the pharmacy has open dialogue with providers across all of Grand Valley Health Plan's services, including both medical and behavioral health, to ensure the best, evidence-based care is provided. A Pharmacy and Therapeutics Committee meets monthly to support this open communication. "We have frank discussions with the team about what is the best drug therapy. I can ask a physician, 'Why are you taking these steps with the patient?' It is well received. I call other physicians, specialists outside our system, and don't get the same response," stated Kozal. "Here, just because the doctor writes the prescription, does not mean it gets filled. Sometimes you talk with them and it is fine. Sometimes you make them question." Grand Valley Health Plan does not have a formulary. Almost all prescriptions written by physicians are covered under the plan.

An integrated pharmacy facilitates better control and monitoring of costs. As a closed system, Grand Valley Health Plan is able to buy drugs at lower cost. Members are encouraged, through lower co-payments, to use generic drugs. To control unnecessary use of non-generic drugs, the pharmacy recently eliminated

drug rep visits to physicians and now makes its own generic samples. Drug reps may only detail the pharmacist. "Before, we would have six or seven drug reps coming through, leaving samples. In-house providers had too many pharmaceuticals handy. At the time, Celebrex and Vioxx were being used for ankle sprains," recounted Kozal. "Now we process and package our own samples. We provide seven to 14 days' worth of drugs like generic blood sugar medication and anti-depressants to see if a patient tolerates it. This has worked out really well for the system."

The pharmacy actively evaluates the use of drugs and employs "step therapies," often coordinating therapies with the Counseling and Wellness team. Through the EMR system, the pharmacy is able to effectively track usage and implement changes. Often, patients are encouraged to pursue lifestyle changes before adding a drug. "I tell them, 'You are taking a chemical. The less you can take, the better,'" remarked Kozal. "Sometimes you can keep people off a blood pressure medication if you reduce salt and increase exercise." The pharmacy closely evaluates narcotics use. It is able to run reports through the state of Michigan and circumvent drug-seeking patients. It worked with the Counseling and Wellness team in the development of a required Pain and Comfort class for those using narcotic pain medications. As a result of the behavioral health approach, the pharmacy saw a reduction in the number of calls from patients in need of pain medication, and many patients were able to reduce drug use through other lifestyle changes, such as exercise. Diabetic care is another focus area for the pharmacy. Pharmacists teach the medication portion of the Diabetics course, which is free of charge to members and covers medications, exercise, foot care, and stresses of this chronic condition. All patients on six or more medications are tracked regardless of disease state.

Diabetic care is another focus area for the pharmacy.

For high-cost drugs such as chemotherapy, the pharmacy ensures that protocols are followed and strives to achieve more partnering with oncology providers outside of the system. "Oncology costs are an area we don't have a full grip on. Chemotherapy is often not a cure. Doctors are trying to save people, but end-of-life care is important too. We don't say no to expensive drug treatments, but we try to ensure the physician has followed protocols," reiterated Kozal. The organization also looks closely at authorizations for injectable drugs known as "J-codes." Because these drugs are typically administered by specialists outside the system, the plan is not able to purchase them at wholesale prices. Lederman observed, "One dose of cancer therapy at one specialist's office is billed at $49,000. The actual drug cost is $18,000. Even jewelry is not marked up that much." In response, the pharmacy determines if the drug can be administered at the health center; if nebulized or

oral medications can be substituted effectively; or if a "home going" drug, which patients can self-administer, can be prescribed. Grand Valley Health Plan helps encourage and train people to self-inject, further engaging patients in their own health care. For diabetic patients, meters are given free of charge; patients can bring meters to the health centers where they can view results with the primary care team.

Costs at Grand Valley Surgical Center are typically 50% lower than a traditional hospital setting.

End-of-life care

The team approach has recently been applied to end-of-life care. A physician, oncologist, hospice physician, pharmacist, and case manager comprise the end-of-life care team to perform case review, dialogue about the path of care, and develop and review options. "Everybody agreed on the right structure and path for making decisions, until there were patients," said Lederman. Despite its high level of integration, the organization continues to struggle with end-of-life care. Organizationally, Grand Valley has launched a program on advanced directives for its employees. "We are trying to get people to think about planning. Our national culture doesn't embrace end-of-life planning. There is a lot of avoidance," remarked Lederman.

Alternate venues and appointment structures

Ambulatory surgery center

Grand Valley Health Plan's stated commitment is to provide its members with "the right care, in the right setting, at the right time." In 1998, Grand Valley Health Plan opened Grand Valley Surgical Center. In the same year, physicians from Orthopaedic Associates of Michigan bought a 45% ownership stake in the center. Seventy percent of surgeries for the plan's members are performed at the out-patient center. The organization believes the setting provides the best scenario for its patients, as costs are typically 50% lower than a traditional hospital setting for similar outcomes with lower rates of infection. "The surgical center provides a way for us to get out of paying hospital overhead," emphasized Palmer. Over 4,000 procedures are performed at the center annually.

Currently, Grand Valley Surgical Center is in the midst of a legal dispute between its owners. In 2008, EthosPartners, a management company hired by Orthopaedic Associates of Michigan, made an offer to buy Grand Valley Health Corporation's interest in the surgical center. Believing the offer was below market value, Grand Valley Health Corporation declined to sell its shares to the physician group, which shifted all of its surgical patients away from the center. Grand Valley Health

Corporation sued, alleging some of the physicians were putting their financial interests above the welfare of patients, who were required to move their surgeries to more expensive hospitals and hospital-owned surgical centers.

Out-of-area treatments

As the local hospital environment in Grand Rapids continues to consolidate and the remaining hospitals maintain an orientation of becoming large, costly, academic-like centers, Grand Valley Health Plan has become creative in sending its complex patients outside the local community to other states for both outside review and treatment. In its effort to look nationally to identify the best care pathways, the organization has partnered with organizations such as the Cleveland Clinic and Mayo Clinic, which regularly review and advise upon treatment plans. Recently, the plan had a child member diagnosed with cancer. After careful research, the team determined that St. Jude's in Tennessee had treatment success rates five times that of other centers', and was one-third less expensive. The patient was sent out of the community for treatment, and St. Jude's also covered travel expenses for the patient and their family. Grand Valley is currently looking for a center of excellence for its back surgery patients. "You have to find institutions with good care pathways. At some of the hospitals here, they are trying to be seen as academic centers and loading up on costs. The quality of care is problematic," Palmer noted. "Does the right hand know what the left hand is doing?"

Grand Valley Health Plan has sent complex patients outside the local community to other states for both outside review and treatment.

Innovative appointment structures

An outgrowth of the effort to improve the integration of behavioral health services was a unique restructuring of appointments and how services are delivered to members. Specifically, three new appointment alternatives are now being used. "Curbside appointments" provide the flexibility of bringing in a health coach, on the spot, during a regularly scheduled appointment if the practitioner and patient determine it would be beneficial. Convenience and access to behavioral health services are greatly improved under the new appointment system. In addition, "conjoint appointments" offer members the ability to pre-schedule appointments with both a practitioner and health coach within the same appointment. Finally, "shared medical appointments" offer the option of scheduling a disease state management orientation. Members spend up to 90 minutes with a practitioner and, together with a group of other members, share similar health concerns. During these appointments, members can break out and have individual time with their

practitioner to address medical concerns, ask questions, or receive a medical exam. Prescriptions can be changed or refilled and any medical tests can be discussed and scheduled. Members find there is an added benefit of sharing and discussing their health issues in a supportive, interactive environment. Shared appointments have only recently been instituted so there is not yet data on their efficacy. Providers agree, however, that they are an effective use of resources, especially for conditions such as chronic pain and diabetes.

For days when the health centers are fully booked with appointments, patients can be seen in express care. The Beckwith Center has an urgent care center with an open schedule all day long. The center is also open on weekends and holidays. E-visits have yet to be implemented in Grand Valley Health Plan. "I think patients will demand it and we need to respond," said Pettigrew. At the same time, practitioners are hesitant about e-visits and not being able to physically see patients and perform exams before advising. Finally, the organization is also discussing performing home visits for patients not coming into the health centers. As for expansion into retail clinics, Grand Valley does not yet view this as a strategic fit for their organization. The organization feels that its multiple health centers provide wide coverage for its members.

III. LEARNINGS FOR OTHER HEALTH SYSTEMS

Building an integrated delivery system

Integration at the primary care level is critical

Grand Valley believes that the best path to true integration is at the primary care level. The organization argues that the health system must move to using more allied health professions to execute care and that physicians need to be focused and rewarded on health care management; physicians should be employed to assess risk and decide upon the best care pathway.

Consistently, the organization was apprehensive about achieving effective integration around a hospital. "The hospital is the most inefficient unit," said Palmer. "No one who developed a good integrative system ever tried to control the market." As Dr. Kerby put it, "We're anti-hospital." He added, "They want to be the focus and their resource use is intense. In recent years, they have wanted to own us." Furthermore, the organization fears that some integrated systems with hospitals can have the potential for price fixing. "A system integrated around a hospital can manipulate what their health plan charges. The hospital can change prices monthly

to their own health plan if they want to," cautioned Palmer. "In our market, there is a system which essentially has a monopoly and was investigated for manipulating the market."

The organization also believes the established health insurance model will not lead to effective integration. Palmer described it as "predicated on driving discounts from care providers in exchange for delivering a subscriber base. The kinds of things that would be progressive in the care arena are not reinforced by the insurance arena. We're trying to really keep care at the right place, at the right time and with the right people. The insurance system has not really made those differentiations. The payment systems are not evolving, nor are they properly rewarding physicians who do a good job managing care." Grand Valley emphasized the need for integrated delivery systems to maintain a strong health care orientation, rather than being the insurance-driven organizations typical of the 1990s.

As part of its recent re-engineering effort, Grand Valley Health Plan changed its system for specialty referrals.

Staff model does not have to include specialists

Grand Valley Health Plan does not employ a full array of specialist physicians. Instead, the organization uses its primary care team to closely coordinate care with select specialists. "Our initial vision was to integrate specialty providers," explained Dr. Kerby. "We found it very difficult to find specialists who don't perceive themselves to be at the center. They didn't have the mindset for Grand Valley."

As part of its recent re-engineering effort, Grand Valley Health Plan changed its system for specialty referrals. Specialty care conferences were instituted as a vehicle to bring together physicians, review research and case information, and understand patient treatment expectations. Physicians consult with colleagues to determine what specialty care services are needed and now create written plans for complex patients. Physicians are thoughtfully analyzing information and collaborating better, instead of quickly reacting with specialist referrals. As Silva pointed out, "Now, it's the delivery system saying 'yes' or 'no' to a certain treatment protocol, not the insurance side of the business." Physicians closely track specialists once a referral has been made. The physician generates a letter in the EMR system, which outlines the patient's case and current medications. In return, the specialist must send a letter back to Grand Valley Health Plan following the appointment, which summarizes the visit and future path of treatment.

From 2004 to 2006, Grand Valley Health Plan switched from using their own providers for hospital rounds to using hospitalists. At the time, the organization believed this would improve patient care. But with hospitalists, patients felt

Grand Valley Health Plan has successfully partnered with some key specialists to work on site.

disconnected to their care team during hospital stays and patient satisfaction deteriorated. Costs and utilization increased as the primary care team physician was no longer coordinating care and building relationships with specialists. Finally, integration back into primary care following hospitalization was failing. After a three-year experiment, Grand Valley Health Plan put its own physicians back into rounding. Under the new plan, one physician is assigned to all rounding for an entire week. The organization quickly saw improvement in length of stay, cost per day, rate of specialist referrals, and communication with the primary care team. "One small change had a huge impact," recounted Silva. "Now our biggest issue is getting hospital admissions under us, versus the hospitalists."

Despite its tighter control of specialist referrals, Grand Valley Health Plan finds it increasingly difficult to find local specialists who share a similar philosophy. "You need to find those people vested in outcomes and evidence-based medicine who will work with you," Wallace said, adding, "If you refer to a surgeon, expect for surgery to be recommended. We don't have a secondary gain in those procedures and can be objective. We try to assure that our specialists have similar philosophies. We'll move to another group if they are doing too much surgery." Duchemin described a recent review of local specialists: "We looked back at some of the relationships we had with specialists. Usage and costs kept going up. We started to be more discerning and reversed the overutilization that was occurring as a result of getting too close to some of our specialists." Silva added, "We need our specialists to consult, call, chart, review, and give advice – not always just 'cut.' We need to make sure our specialists are looking at options with patients. We need specialists who are 'option developers.'" Further restricting the pool of local specialists is recent activity by Spectrum Health, which has begun building its Spectrum Health Medical Group and employing more specialists.

Grand Valley Health Plan has successfully partnered with some key specialists to work on site. The organization currently has per diem contracts with an obstetrician, a psychiatrist, and two cardiologists, with the balance of specialty care delivered under a fee-for-service arrangement. Describing the symbiotic relationship with its contracted cardiologist, Dr. Kerby stated, "Our cardiologist has that inner sense that the way Grand Valley operates is right." Palmer added, "I really want to depart from how medicine is being practiced. This means not hiring within the comfort zone and asking providers 'How will you evolve our program?' We have a true partnership in cardiology. That individual is coordinating care, assisting us with information systems and identifying what the care pathways are that we are

going to use nationally. We are beginning to move cardiovascular care out of this community. If we have a heart transplant patient and we need an evaluation, we now go to the Cleveland Clinic." Grand Valley Health Plan hopes to develop future, strategic partnerships in other specialties, such as oncology and back surgery. "We hope to get more specialists on contract," stated Heinen. "Right now, it does not make operational or economic sense to make them employees due to the limited demand for their services because of our membership size."

Insurance component must be of equal quality to delivery

Early on, the founders of Grand Valley Health Plan made the decision to be a health care provider and an insurer. "We decided we needed to be an insurer. We knew this was risky, but so is innovation," commented Palmer. "We didn't want to get involved with other payer sources and continue to participate in the norm. We can control how care is being delivered and alter behavior of providers. In a sense, we are shaping our own risk." Dunwoody reiterated, "Our core is delivery. Insurance is the mechanism we use to fund our delivery system."

"We decided we needed to be an insurer. We knew this was risky, but so is innovation."

—Ron Palmer, CEO

As the historical focus has been on delivery, the insurance side of the organization has faced challenges it is working to overcome. "We've worked to improve our insurance function," stated Silva. "We created a multi-disciplinary Benefits and Eligibility team to design and support what patients need. We have taken away barriers on preventative health and we do not have formularies. We put the delivery system in the driver's seat." Sales Manager Doug Calkins explained, "People in this organization needed a better understanding of health insurance. We didn't have an actuary on site and the appropriate systems to price products." He continued, "In Michigan, we have community rating by class. You can adjust pricing by group-specific demographics, such as age, gender, and contract size. Early on, we didn't understand this well. Our pricing was actually lower for older folks than what could be found within the marketplace." By 2006, Grand Valley Health Plan began to use age and gender rate adjustments, and by 2008, "our book of business was pretty clean," said Calkins. In 2009, economic recession hit again and membership declined, increasing risk for the small plan.

Grand Valley Health Plan continues to enhance its insurance operation. It is moving to improved actuary services and the organization has recruited staff with more insurance expertise. The number of agents has been dramatically reduced from 400 to 88, with further reductions planned. These select agents who find true franchise value with Grand Valley Health Plan receive marketing materials and leads

and are motivated to promote its products. "Before, we said anyone can sell our product," said Calkins. "Now, our agents have access to Grand Valley programs that others don't, thus creating the value for those with a GVHP agent appointment."

The currently small scale of the organization continues to raise concerns.

Leadership, not non-profit status, is driver of successful integration

The Grand Valley organzation feels that being a for-profit or non-profit organization is irrelevant to the ability to successfully integrate. "Being a non-profit makes no difference," said Palmer. "By far, the most aggressive player in this community is a non-profit. Here, the for-profits all believed it was important to pursue the best interests of the community. But Michigan has not been a very collaborative state."

What Grand Valley views as important are investors and board leaders who share a long-term perspective of delivering high-quality integrated care, rather than a short-term focus on stock price. "The only people we are beholden to are our investors, who have long-term goals," explained Palmer. "This allows us the capability of developing a different model of care." Dr. Kerby recognized that "Our ROI has not been spectacular. We are swimming upstream against traditional health care providers."

Small scale raises issues of risk and cost efficiencies

Grand Valley has seen its health plan membership swing from a high of roughly 30,000 members in the late 1990s to its current membership of fewer than 8,000 members. The currently small scale of the organization continues to raise concerns. "Some would say that at 8,000 members we are not viable," remarked Silva. "Ideally, we'd like to be at 20,000 from an actuarial perspective. We are sustainable now but it is harder to invest in innovation and business ventures when you are this small."

At its current size, the organization struggles to manage risk. Its current membership is comprised largely of federal and manufacturing employees, often with lower levels of education, negatively impacting healthy lifestyle choices. Grand Valley Health Plan is vulnerable to cost swings and a handful of complex cases can have an immense impact on the company's financials. "A couple of years ago we had a $1.6 million baby that was treated and later died. This year we had eleven and a half good months and two bad weeks," stated Heinen. "Our care model is fine at this size and we can still provide an exemplary patient experience. However, at this size, we are vulnerable from the risk side." Adjusted community rating laws for the state of Michigan mean the company can't exclude patients with negative risk profiles. The company does utilize re-insurance, but risk remains a concern.

As a primary care-focused delivery system without hospital ownership, Grand Valley finds managing the cost of hospital care challenging. "Our size is a problem in negotiating contracts with hospitals," admitted Lederman. "The hospitals ask how many patients we will bring and we don't have enough. Our cardiologist is an alumnus of an out-of-state hospital and he can help us send patients there. Where we don't have partners, it is more difficult and costly."

In the current Michigan economic climate, keeping a control on cost and premiums is paramount. "At this point, not many are willing to pay more to buy quality health care," noted Calkins. "Michigan is struggling to stay alive. Here, people buy things they can afford. Cost is number one and more important than quality right now." Silva emphasized, "If we could remove high-cost cases, you would see that our total costs are lower than other providers. Our LOS, pharmacy, and ER visits are much lower than everyone else. We invest and are more expensive on the primary care side." Business Development Manager Mike Messinger remarked, "Our target profitability is 5%, which would be incredible for our health plan in this economy. We would like medical costs to be 85% of our revenue and administrative costs to be 10%. The patient mix is key. How do you manage your population to help you become profitable?" Duchemin added, "The folks that stick with us are the patients who are the sickest. They know how we operate and they give us the highest marks on customer satisfaction. The healthier folks leave us if their employer offers a slightly cheaper plan. They have the least experience with us and may not realize the value of staying with GVHP."

Patient mix is key to cost-effectiveness of the system.

The ability to invest in staff, capital equipment and growth opportunities are also constrained with the current scale of the organization. "If we don't have profitability, we can't reinvest," remarked Duchemin. "We haven't been able to give anyone even a cost of living increase in the last three years. When we were making money, we didn't have to be as concerned with purchasing new technology. Now it is hard. We are still on film radiology and we need to be digital. At some point, patients start to question." Grand Valley Health Plan is currently evaluating expansion to the southwest portion of Michigan. The current scale of the organization presents a financial dilemma in moving forward with plans.

Perspectives on the optimal size of Grand Valley Health Plan were generally consistent within the organization. Most felt that at 15,000 to 20,000 members, cost efficiencies would return to the organization and operating at this level would be comfortable. "This is very comfortable to run at 20,000 members," stated Palmer. "Actuarially, you are sound at that level. At 10,000 members, it is easy to

run as a provider since we have not integrated through sub-specialists. If you've integrated through sub-specialists, you have to feed the sub-specialists." Dunwoody highlighted the benefit of not growing too large. "Being small does mean that we can be responsive and flexible. For the way we currently deliver health care, 50 to 60,000 members would be the maximum membership."

Managing hospital needs may get harder as local competitors consolidate.

External environment

Impact of consolidation of local hospitals and physician groups

The trend toward consolidation persists in the local Grand Rapids market. Hospitals continue to merge and acquire group practices. For Grand Valley Health Plan, the trend translates into fewer, local hospital choices and decreased bargaining power. In addition, as local hospitals continue to purchase physician groups, there are fewer specialists not aligned with a hospital and motivated to steer patients and increase utilization. "Spectrum [Health Care] is buying hospitals right and left," said Messinger. "It is challenging to get good contracts because we don't have the size." Silva added, "Managing our hospital needs is going to get harder. We need to look for new systems and other places to work and other people to partner with. Just because they are in our community, the local hospitals are not the only option. We'll start with what's best for the patient and then figure out the financial component. Sometimes the local hospitals here want to do research and they don't yet have the volume of cases to assure us of outcomes. Sometimes they are more expensive. The specialists want us to stay local, but we will be going many places."

Local market dynamics

The team at Grand Valley Health plan emphasized the importance of local market characteristics in shaping the success of a staff-model, integrated delivery system. Grand Rapids is characterized as a conservative, frugal, family-oriented community with a strong work ethic, committed to local providers. It has a low Medicaid base. Members are frequently long-term, sometimes spanning three generations. "Even when people have to leave Grand Valley due to increasing costs or changes with employers, they often come back, if they can," said Navis. At the same time, Michigan is a strong union state, which presents challenges for a small-scale HMO. "Unions still have five-dollar drug cards in this state. The balance between the cost of utilization and premium revenue is delicate if you are not big enough," cautioned Calkins.

Historically, the Grand Rapids market was comprised of large employers who were paternalistic, offering generous health insurance programs. Employers were supportive of integrated care. However, as companies have downsized and now lack the capability to do sizeable programs, the influence of employers has declined. "Today, we try to sell employers on investing in preventative maintenance of their human capital," said Messinger. "We focus on health care as a way of avoiding absenteeism and increasing presenteeism."

Grand Rapids was the second largest community in the U.S. without a medical school. As such, Grand Rapids avoided having a large, costly, academic medical center. It had few large group physician practices and did not face the challenge of physicians pulling profitable services away from hospitals. The dynamics spurred the growth of Grand Valley Health Plan. "It was a market of largely good community citizens, who tried to respond to community needs," said Palmer. Today, the market dynamics have shifted in the face of hospital and physician group consolidation.

Replicating Grand Valley Health Plan in the current local market presents challenges. "For a successful staff-model HMO, like ours, you need progressive, forward-looking employers who are willing to invest in the health of their employees," cautioned Palmer. "You need a provider community open to participate, including a hospital. This would not work here now because of the current competitive environment." He added, "We used to have four community hospitals. Hospitals are like department stores. You want to pick and choose the best departments from each. Now, we are left with little choice in this market."

Employers who were supportive of integrated care are cutting benefits due to economic struggles.

How payment reform can improve incentives for primary care

The organization believes strongly in creating the capability for patients to access primary care inexpensively. There is skepticism about the current move towards health retirement accounts (HRAs) and health savings accounts (HSAs). "The idea of putting health care dollars into retirement plans or savings accounts confuses the issue. We need transparency here," cautioned Palmer. "In general, people can be horrible with managing their 401K plans. Now that wages have come down, people are putting away less for benefits and have very high deductibles. This makes primary care available to a small portion of the population. Let's make primary care and preventative care accessible. We can then create tiers about how people will participate in things that are five times the cost."

Figure 1 *Comparison of co-payment rates for in-network and out-of-network services*

Service	Grand Choice (GVHO's extended network)	Co-payment for Grand Valley Health Center
Primary care visit	$20	$0
Specialty care visit	$40	$20
Urgent care visit	$60	$40
ER visit	$100	$100
In-patient care (coverage after deductible)	80%	100%

With respect to current insurance mandates, some expressed concern that tax penalties don't go far enough to gain participation. "It doesn't make sense to have a penalty as small as the requirement being put into place, $695 or 2.5% of income by 2016, for an individual that does not purchase insurance, especially, if you need to spend $3,600 for the insurance," said Calkins. Effectively addressing the uninsured population was viewed as a critical step in lowering total health system costs.

Future paths

New products expand beyond staff-model HMO

In response to declining membership and increased competition from open models, Grand Valley Health Plan created its Grand Choice product in July 2009, to attract members insisting on physician choice. With its strong union culture, Michigan is often depicted as an entitled population, requiring physician choice. "We structured a product with two benefit levels, where you can go to any physician you want at one benefit level, while incentivizing access with better benefits offered through our core delivery system," described Calkins. "The lowest patient cost share within the program comes for services offered and coordinated by the Grand Valley Family Health Centers. Next, there is a larger network of physicians referred to as GVHP's extended network that patients can access without obtaining a referral." In a departure from the way HMOs typically market out-of-network services, Grand Valley Health Plan anchors consumers to prices for out-of-network services (see middle column of **Figure 1**), and subsequently demonstrates the discount (right column) for obtaining services through Grand Valley Health Centers.

The product has generated roughly $2 million in new business after less than one year. "Many people want physician choice, while others just want access to quality care," summarized Calkins. "Now, groups who have never been our customers before are purchasing. They are telling us, 'Now that you have a product with choice, we are happy to be with you.' We have to be a value answer on multiple levels: flexibility, price, and cost sharing." Messinger added, "Our hope is that we've removed the choice barrier by offering this product, and that they will try our delivery system, use it, and stay." Dunwoody said, "We are trying to design different products, with no co-pays, so nothing is a disincentive to primary care. However, during the recession, some employers implemented higher co-pays."

In an effort to use its current capacity and grow, Grand Valley Health Plan has also expanded into other products. PrimeCare is a non-insurance product which provides direct access to a range of primary and urgent health care services for a low, pre-paid annual fee without co-pays. Enrollment in PrimeCare Access costs $360 annually for eight Primary or Urgent Care visits, while PrimeCare Basic costs $190 for four visits. An annual physical, sick care, treatment of minor injuries, health coaches, a 24-hour nurse advice line, and discounts on classes and over-the-counter drugs are included in the plan. "We initially designed the product for college kids," said Dunwoody. "We found that other market segments were also interested in these products. It's a way to meet a need in the community and use some of the extra capacity we now have." With their MIChild program, Grand Valley has partnered with the Michigan Department of Community Health to offer comprehensive health benefits to the uninsured children of working families. In 2008, Grand Valley Health Plan also began to provide services to Medicare patients.

PrimeCare is a non-insurance product which provides direct access to a range of primary and urgent health care services for a low, pre-paid annual fee.

While some in the organization applaud the move to new, open access and other products, there is hesitance from those on the delivery side of the organization. The shift from a "pure staff-model HMO" into other products presents new challenges. "We have to get outside of ourselves and get good at Medicare reimbursement and Grand Choice," said Pettigrew. "We have to learn to code accurately and know what's covered. When a patient walks into a visit, we need to know it's not a Grand Valley patient and determine what financially feasible options exist. For Grand Choice patients, if they don't choose us, we are not really in the loop anymore. This will be challenging. If they don't come to Grand Valley, Grand Choice will become like a PPO. There are too many specialists out there who do not practice evidence-based medicine. This will challenge us on what to pay." Silva added, "Now, not everyone is a member. If Medicare doesn't cover dieticians, our patients still get

access. Right now we can do this because we have built-in capacity in our delivery system two years above where membership is."

The organization expressed confidence about its readiness for health care reforms.

The organization points to initial success of its Grand Choice product as evidence that integrated delivery systems must sometimes respond to consumer preferences. Some argue that the Grand Choice product signals a departure from the company's mission of Patient-Centered Medical Home. At the same time, the product design identifies with three important consumer-purchasing behaviors: patients want to choose or keep their own physician, co-payments are aligned to service levels, and flat co-payments create certainty in out-of-pocket expenses. In marketing the product, the team removed all language surrounding "in- and out-of-network." It does not market out-of-network services. By removing the physician choice barrier, Grand Valley Health Plan hopes to gain new patients who will ultimately try services at Grand Valley and remain within the system.

Regulatory environment and Medical Home model positions organization for reform

The progressive regulatory environment in Michigan is viewed as important to Grand Valley Health Plan's preparedness for health care reform. Overall, leadership felt that Michigan has been a progressive state, supportive of HMOs. The state of Michigan has been on the leading edge of reporting requirements for a long time. "Michigan's requirements have set us up to be more prepared for the future," emphasized Silva.

As the only staff-model HMO in Michigan and the first in the state to earn NCQA Patient-Centered Medical Home accreditation, the organization consistently expressed confidence about its readiness for future reforms. "We are well-positioned for health reform," said Duchemin. "Culturally, we'll go with the flow. If there is a wall, we'll figure out how to get around it. We'll make the necessary changes to be part of the solution and not end up on the side. There were many years in the past that we were too ahead of the curve, too out there. Customers didn't appreciate us. Now, because of the whole health care debate, customers are better educated." Heinen added, "Our system is optimistic about health care reform. We've been doing for 27 years what Obama is now talking about." While Grand Valley Health Plan's model remains a rarity, the organization believes it has a more central role today, as health care moves toward greater coordination across the care continuum and places more emphasis on prevention and wellness. "We're going to be cool again," said Calkins.

Appendix A *Grand Valley Health Corporation's Purpose Statement*

Grand Valley Health Plan Purpose Statement (1982)

The Grand Valley Health Plan is a regional health care organization dedicated to influencing health care outcomes by providing and managing an integrated, coordinated system of health related services and products. To accomplish this goal, it is essential that we have integrity with respect to the following values: interdependence, proactivity, effectiveness, innovation, customer orientation, resource efficiency, and profitability. We believe that we can influence the qualitative well being of humans, that innovation is the only effective response to change, that the collective problems of the individuals will only be resolved through the collective efforts of individuals, that the measure of quality is outcomes, that quantity is important only to the extent that it enhances or facilitates quality and that there is a better way.

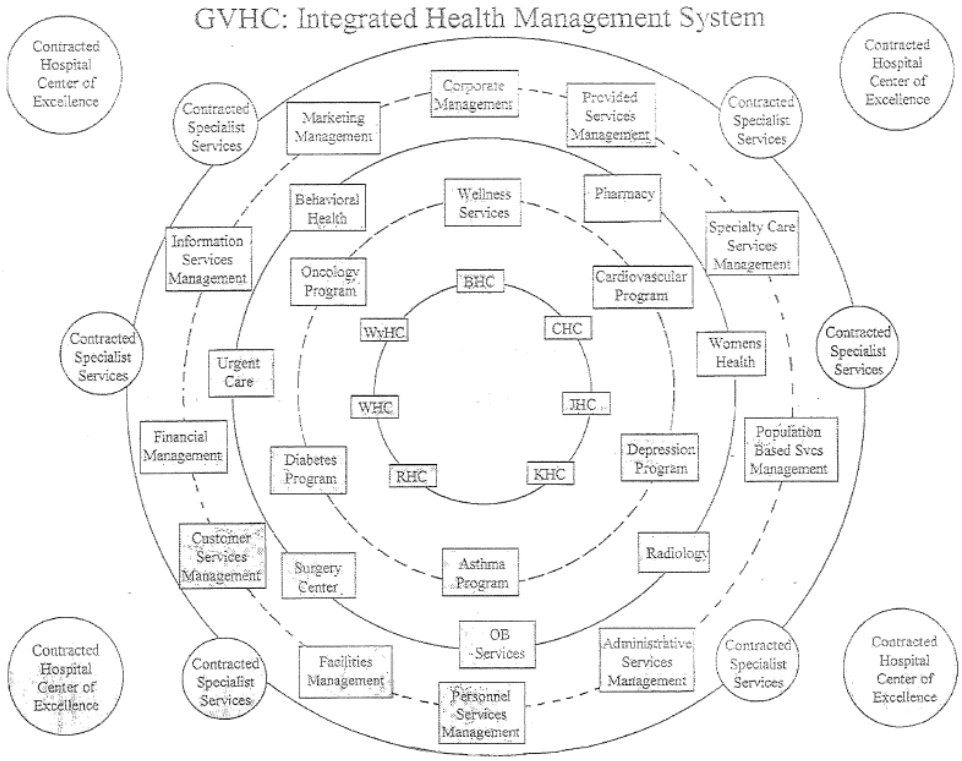
Grand Valley Health Corporation Purpose Statement (current)

Grand Valley Health Corporation is an integrated Health Management Organization, dedicated to managing health and managing relationships by providing the multi-disciplinary health care team structure, the primary care relationships, the integrated health care system, and the value-added services that our customer populations require to maintain or optimize their health.

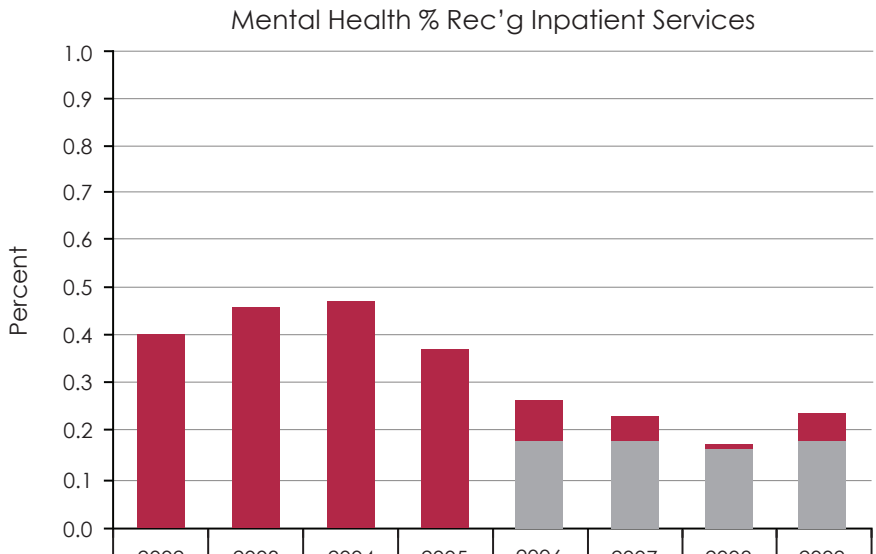
To accomplish this purpose, while providing great performance for our customers, it is essential that we develop and operate an integrated, coordinated health management system whose culture can walk the talk with the following values:

- Focus on Customer Value
- Develop Partnering Relationships
- Accept Individual Responsibility for Behavior
- Share Team Accountability for Performance
- Seek Effectiveness in Outcomes
- Be Innovative During Change
- Product a Profitable Result

Appendix B *Grand Valley Health Corporation's integrated Health Management System chart*



Appendix C *Grand Valley Health Corporation Counseling and Wellness Services: Impact of 2003 integration*



	2002	2003	2004	2005	2006	2007	2008	2009
GVHP	0.40	0.46	0.47	0.38	0.27	0.22	0.18	0.23
Nat'l 25th%					0.19	0.19	0.17	0.19

A) Graph: Decrease in GVHP referrals to behavioral health specialists (Decrease from roughly 20% of patients to under 10%—internal data)

B) Graph: Decrease in patients receiving inpatient mental health services (Decrease from roughly 0.45 PKPY to 0.25 PKPY, below both national HMO average and Michigan HMO average—NCQA HEDIS data)

About the case study series

Disruptive innovations in health care have the potential to decrease costs while improving both the quality and accessibility of care. This paper is part of a series of case studies that uses disruptive innovation theory to examine integrated delivery systems and aims to identify the critical factors necessary to achieve many of the desired quality, cost, and access improvements called for in current reform proposals. By providing a historical and strategic analysis of integrated fixed-fee providers, this project hopes to accelerate the adoption of disruptive innovations throughout the health care delivery system.

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About Innosight Institute

Innosight Institute, founded in May 2007, is a 501(c)(3) not-for-profit think tank whose mission is to apply Harvard Business School Professor Clayton Christensen's theories of disruptive innovation to develop and promote solutions to the most vexing problems in the social sector. Innosight Institute's case studies are for illustrative purposes only and do not represent an endorsement by Innosight Institute.

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